Department of Health | Medicaid Redesign Team

Transition of Nursing Home Populations and Benefits to Medicaid Managed Care

January 2015

Transition Dates

- Transition begins February 1, 2015:
  - New York City counties of the Bronx, Kings, New York, Queens and Richmond.
- All eligible recipients age 21 and over in need of Long Term/Custodial Placement will be required to enroll in MMCP or MLTC.
- Current custodial care beneficiaries in a skilled nursing facility prior to February 1, 2015 will remain FFS and will not be required to enroll in an plan.
- Long Term NH care is presently a benefit for enrollees of MLTC.

Nursing Home Transition Phase-In Schedule	
Month	**County**
February 1, 2015 **Phase 1**	New York City – Bronx, Kings, New York, Queens and Richmond
April 1, 2015 **Phase 2**	Nassau, Suffolk and Westchester
July 1, 2015 **Phase 3**	Albany, Allegany, Broome, Cattaraugus, Cayuga, Chautauqua, Chemung, Chenango, Clinton, Columbia, Cortland, Delaware, Dutchess, Erie, Essex, Franklin, Fulton, Genesee, Greene, Hamilton, Herkimer, Jefferson, Lewis, Livingston, Madison, Monroe, Montgomery, Niagara, Oneida, Onondaga, Ontario, Orange, Orleans, Oswego, Otsego, Putnam, Rensselaer, Rockland, St. Lawrence, Saratoga, Schenectady, Schoharie, Schuyler, Seneca, Steuben, Sullivan, Tioga, Tompkins, Ulster, Warren, Washington, Wayne, Wyoming, Yates
October 1, 2015	Voluntary enrollment in Medicaid managed care becomes available to individuals residing in nursing homes who are in fee-for-service Medicaid.

Transition Policy

- Existing MMCP enrollees will NOT be dis-enrolled if they require long term custodial placement.
- MMCP will be responsible for the NH benefit after January 31, 2015 for enrolled members.
- No individual will be required to change nursing homes resulting from this transition.
- New placements will be based on the individual's needs and the plan's contractual arrangements.
- Plans must ensure that placement is in the most integrated, least restrictive setting available to meet the enrollee's needs.

Transition Payments

- For at least 3 years after a county is deemed mandatory for the NH population and benefit, plans will be required to pay contracted NHs either:
  - Benchmark Rate (FFS Rate)
  - Negotiated Rate which is agreed to by both parties

After the 3 year transition period, plans and NHs will negotiate a rate of payment

Pharmacy Services

- Pharmacy will be covered by the MMCPs.
- Over the counter drugs, Physician administered drugs (J-code drugs), medical supplies, nutritional supplements, sickroom supplies, adult diapers and durable medical equipment will continue to be the responsibility of a nursing home and will be reimbursed within the nursing home benchmark rate.
- Immunization services inclusive of vaccines and their administration will remain in the nursing home benchmark rate.

Pharmacy Services, cont.

- Absent a negotiated agreement for this service the following will prevail:
  - During the 3 year transition period MMCPs must honor the current arrangements NHs have with pharmacies.
  - If an enrollee is using a non formulary drug, MMCPs must allow the member to continue receiving the drug for 60 days.
  - After the 60 days, the MCO and provider may transition the member to a drug on the plan's formulary, as appropriate.

Primary Care Provider

- All MMC enrollees must have a PCP.
- Members may retain their PCP when they transition from the community into a NH .
- MMC plans may use the NH physician as the PCP for a member but must inform DOH and ensure that the NH physician maintains the responsibilities similar to those of other network PCPs, including but not limited to:
  - Disease management, referrals, and hours of availability.

Reserved Beds - Bed Holds

- MCOs are required to continue following the current methodology during the transition period unless an alternative is negotiated and agreed to.
- Three types of reserved bed days are eligible for payment
  - Temporary Hospitalization shall be reimbursed at 50% of the Medicaid FFS rate.
  - Professional Therapeutic shall be reimbursed at 95% of the Medicaid FFS rate
    - 14 days in a 12 month period, combined aggregate of temporary hospitalizations and professional therapeutic leave days
  - Reserved bed hold for an absence not related to a professional therapeutic leave or temporary hospitalization shall be made at 95% of the Medicaid rate.
    - 10 days in a 12 month period
- LDSS-3559 will be revised to include an indication of bed hold

Network and Contracting

Managed Care Network Requirements

- Standard NH Requirement:

  8 – Queens, Bronx, Suffolk, Kings, Erie, Nassau, Westchester, Monroe

  5 – New York, Richmond

  4 – Oneida, Dutchess, Onondaga, Albany

  3 – Broome, Niagara, Orange, Rockland, Rensselaer, Chautauqua, Schenectady, Ulster

  2 – All other counties (or 1 if only one NH in the county)

Network Requirements

- Specialty Nursing Homes
  - A minimum of two of each type if available in each county.
- If plans do not have a nursing home to meet the needs of its members, it must authorize out of network service.
- Members will be allowed to change plans to access the desired nursing homes (no lock–in).
- If beds are not available at the time of placement, the plan must authorize out of network service.

Network Requirements

- Veteran's Nursing Homes:
  - Plans must contract with at least one Veteran's NH that operates in their area.
  - If a plan does not have a Veteran's NH in their network a member may change enrollment to a plan that has a Veteran's NH in their network.
  - Pending the member's request to change plans, the plan must:
    - Allow the member access to the Veteran's NH, and
    - Pay the FFS rate until the member has changed plans.

FIDA NH Network Requirements

- FIDA NH Requirements
- FIDA Plans are required to have contracts with 8 nursing homes in each county where the plan operates
- FIDA plans must have contracts or payment arrangements with all nursing homes in each county the plan operates

Provider Contracting

- All agreements must be negotiated in good faith.
- All Agreements will have the “New York State Standard Clauses for Managed Care Provider/IPA Contracts”.
- Due process rights must be included for providers that allow the provider to appeal any termination by the MCO.
- In the event a contract is terminated, for reasons other than imminent harm or fraud and abuse, the MCO may not require members to transfer to a participating NH.
- The rate of payment for the OON provider will be the fee for service rate in effect at the time of service.
- MCOs will establish a process to train contracted providers relating to claims adjudication.
- Required contract provisions are discussed in the MCO and IPA Provider Contract Guidelines available on the Department's web site at:

http://www.health.ny.gov/health_care/managed_care/hmoipa/docs/guidelines.pdf

Credentialing

- Delegation of Credentialing NH employees to the NH.
- Plans must have a process to verify the NH is complying with Federal and State requirements.
- Plans will credential NH, but will minimize additional NH requirements.

Eligibility and Enrollment

Eligibility and Enrollment

- The decision to enter into a nursing facility involves the individual, family members, community members, and skilled professionals.
- The plan should focus on the needs and desires of the individual and his or her goals.
- Family members, community supports and professionals must understand that the plan must support the values of the individual and his or her objectives.

Long Term Placement

- Nursing home physician or a clinical peer makes the recommendation for permanent placement.
- Recommendation is based upon medical necessity, functional criteria, and the availability of services in the community, consistent with current practice and regulation.
- Nursing home transmits the recommendation and supporting documentation to the MCO for review and approval.
- Once MCO has authorized the long term placement, the NH sends LDSS-3559 form with the approval from the MCO to the local district.

Long Term Medicaid Eligibility Process

- The nursing home and the MCO work together to assist the member in gathering documentation required by the LDSS to perform the eligibility determination.
- MCOs should utilize processes already in place at the NH for compiling required documentation and submitting the application for eligibility determination.
- Once an application is received, LDSS has 45 days to complete the eligibility determination for long term placement.

Eligibility Determination

- Consumers in need of long term placement will have eligibility determined using institutional rules, including a review of assets for the 60 months look-back period and the transfer of assets rules.
- Post eligibility budgeting rules are used to determine the net available monthly income (NAMI) that must be contributed toward the cost of nursing home care for individuals who are otherwise eligible and are not subject to a transfer penalty.

Eligibility Determination

- For individuals who are Medicaid eligible under MAGI, the same look-back and transfer of assets rules are used, but there is no resource test and post eligibility budgeting rules do not apply.
- If LDSS determines there are uncompensated transfers during the look-back period, a transfer penalty is imposed and the individual is ineligible for coverage of nursing home care until the completion of the penalty period.

Eligibility Process

- MCOs must recoup for any period of ineligibility resulting from a transfer penalty.
- MCO is responsible for collecting any NAMI but may delegate this function to the nursing home.
- For current enrollees, MCOs are responsible for paying the nursing home the fee for service rate or agreed upon negotiated rate for that facility while long term eligibility is established by the local district.
- Individuals not currently enrolled in managed care and in need of long term placement will obtain long term eligibility determination from the local district prior to enrollment.

Restriction/Exception Codes

- Once re-budgeting and long term eligibility is approved, the LDSS will enter specific Restriction/Exception (R/E) codes into WMS to:
  - Identify the type of long term placement for managed care enrollees, or
  - Trigger enrollment process for consumers new to Medicaid or managed care.
- These R/E codes will appear on plan rosters.
- ePACES will also reflect this information.
- R/E codes will also drive MC premium rate payment.

Nursing Home Transition Rate Code Billing Matrix and R/E Codes

R/E Code	Equivalent Rate Code	Description	Managed Care Program			
			MMC	HIV/SNP	MLTC	FIDA
N1	1821	Regular SNF Rate - MC Enrollee	X	X		
N2	1822	SNF AIDS - MC Enrollee	X	X		
N3	1823	SNF Neuro-Behavioral - MC Enrollee	X	X		
N4	1825	SNF Traumatic Brain Injury-MC Enrollee	X	X		
N5	1826	SNF Ventilator Dependent - MC Enrollee	X	X		
N6	3479	Partial Cap 21+Nursing Home Certifiable(valid through 3/31/15)			X	
	3478	MLTC Partial Cap Age 18+(effective 4/1/15)			X	
	3489	Primary FIDA, Age 21+, Dual Eligible				X
N7	N/A	NH Budgeting Approved- Awaiting M/C Enrollment				

NOTES:

- Rate derivation billing logic will be implemented for MMC only. All other Managed Care program plans will follow program specific billing guidance
- PACE, MAP, and MA plans will not be impacted by the transition

Rosters

- MCOs will receive pertinent enrollee information via the Roster system and a distinct Nursing Home report.   Included on the distinct report will be:
  - District
  - CIN and Case Number
  - Restriction Exception (R/E) Code (N series)
  - NH Provider ID
  - Effective Date of Long Term placement
  - NAMI amount

Nursing Home Rosters

- Nursing Homes will continue to receive their Fee For Service (FFS) roster for Medicaid consumers in the current method of delivery.
- The State is developing an electronic Medicaid Roster for Nursing Homes that would include the existing FFS information as well as data on managed care enrolled NH residents.

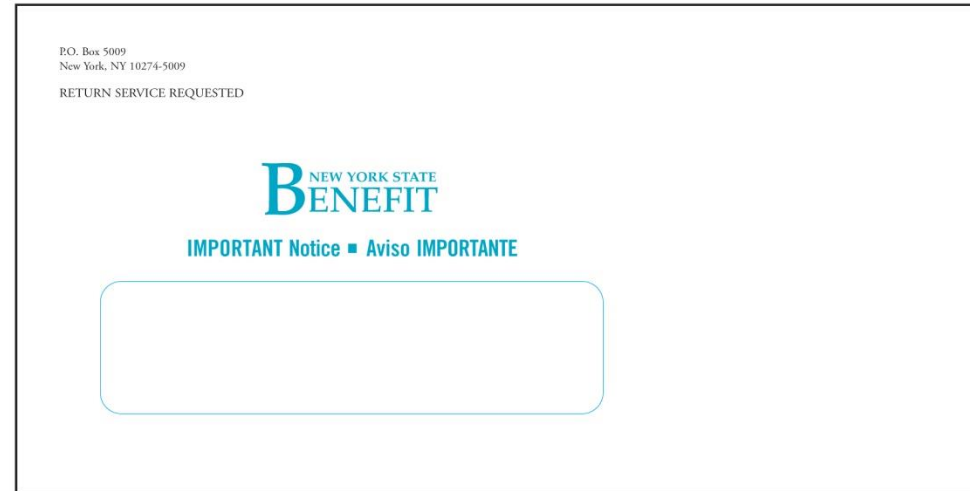
Plan Selection and Enrollment

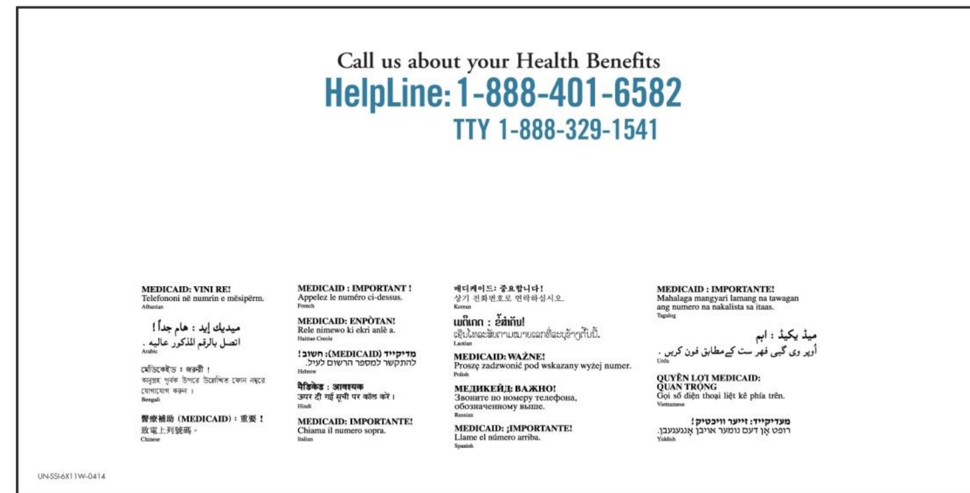
- After transition date, beneficiaries residing in a nursing home who are newly determined eligible for long term placement have 60 days to select a plan for enrollment.
- New York Medicaid Choice will be available to assist beneficiaries with education and plan selection.
- Beneficiary will select from plans contracting with the nursing home in which the individual resides.
- If a plan is not selected within 60 days, a plan that contracts with the nursing home will be assigned.
- Lock in rules will not apply to these individuals.
- If a enrolled beneficiary wishes to transfer to another nursing home not contracting with his or her current plan, the individual will be allowed to transfer to that plan.

Mandatory Packet

- Mandatory packet will be mailed to the address indicated on the Medicaid application as well as to a members appointed guardian, proxy, POA, etc.
  - Content:
  - Mandatory Notice
  - Brochure
  - Plan List (s)

- *Note: Mandatory packet available in English, Spanish, Chinese and Russian*





Mandatory Enrollment Outreach

Day	Notice
1st Day	Mandatory Notice
30th Day	1st Reminder Notice
45th Day	2nd Reminder Notice
60th Day	Auto – Assignment Confirmation Notice

- NYMC or LDSS staff will reach consumers by phone throughout the mailing process

Note: Auto- Assignment will not occur when a consumer is placed in a nursing home that does not have a participating MLTC partial plan.

These cases will be referred to NYMC field staff for education and enrollment services

Complaints

- Consumers, family members and representative have the right to file a complaint with any of the following:
  - Health plan member services department
  - New York Medicaid Choice
  - State Department of Health by phone or in writing

    MMC Complaint line

    800-206-8125

    MLTC Complaint line

    866-712-7197

Consumer Representation

- **Verbal**: Consumer identifies family member or representative to the counselor
- **Written**: Consumer submits a letter or consent form designating a person as their representative. This letter includes:
  - Date, duration of request
  - Consumer CIN/SSN
  - Representative's name, clinic or hospital association
  - Authorized contact to receive case letter
  - Consumer's signature
- **Consumer Representation**: Representative must state their relationship to the consumer and verify the consumer's demographic information including the social security number and/or Medicaid number

Note: Translators and employees of health plans contracted by the SDOH cannot serve as representatives of consumers

Access to Care and Transitions

Guiding Principle

A member of the MCO or the member’s designated representative is included in determining the most appropriate setting for the receipt of services, equipment and supplies.

The choice of settings will consider the MCO network, the needs of the member and the most integrated least restrictive setting to meet those needs.

Transitions: Hospital to Nursing Home

- Hospital Role:
  - Checks eligibility; Notifies MCO of stay and possible need for LTC
  - Assembles discharge planning team
  - Arranges meetings with enrollee, family and team
  - Conducts PASRR, PRI
  - Obtains information from MCO participating NHs on placement openings that meet enrollee needs
  - Physician makes recommendation for transition and care plan based on:
    - Clinical needs of enrollee
    - Functional criteria
    - Availability of services in the community
  - Communicates recommendation, care plan (specific enrollee needs) and supporting documentation to MCO for authorization

Transitions: Hospital to Nursing Home

- Nursing Home Role:
  - Responds to request for placement openings that meet enrollees needs
  - Communicates with Hospital and MCO on care plan development
  - Obtains authorization for stay prior to admission
  - Conducts mandatory assessments

Transitions: Hospital to Nursing Home

- MCO Role:
  - Provides plan liaison; reaches out to hospital when notified of stay
  - Has knowledge if enrollee already in receipt of LTSS
  - Member of discharge planning team, ensures:
    - person centered care planning
    - enrollee choice, enrollee education about care options
    - decisions not based on financial incentives for hospital, plan or nursing home
  - Provides list of participating nursing homes/community providers
  - Assists in matching needs of enrollee to available providers or securing out of network
  - Assists in compiling documentation for authorization review

Transitions: Hospital to Nursing Home

- MCO Role (continued):
  - Upon receipt of recommendation for transition
    - Assesses care plan and clinical needs
    - Approves or adjusts the care plan to ensure member's needs are met
    - Considers member choice
  - Authorizes care plan and placement in timely manner and before discharge
  - Notifies providers, enrollees of determination
  - Arranges for UAS-NY assessments in NH

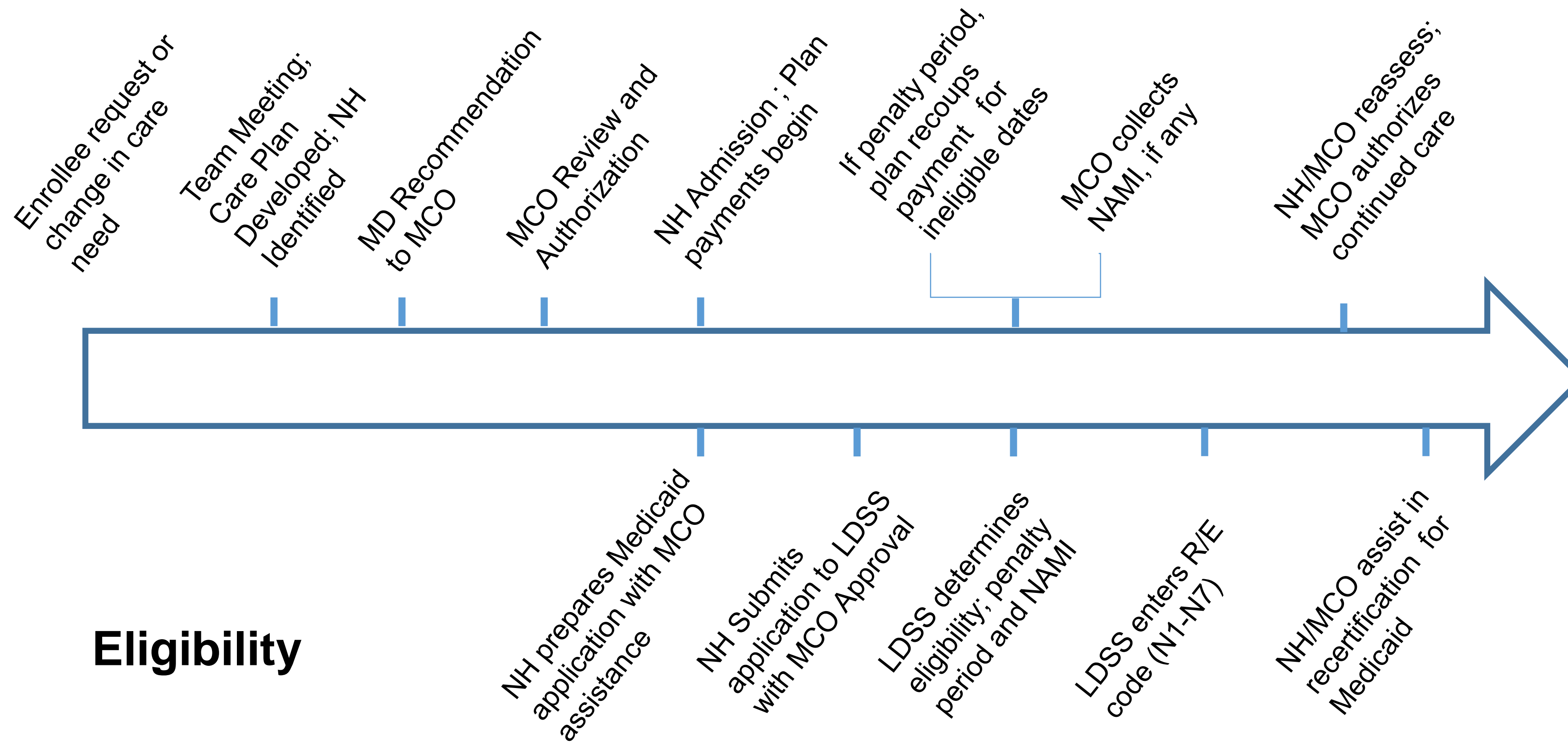
Transitions: Community to Nursing Home

- Nursing Home Role:
  - Checks eligibility; notifies MCO of need for long term stay
  - Conducts mandatory assessments
  - Arranges meetings with enrollee, family and team
  - Physician or clinical peer makes recommendation for transition and care plan based on:
    - Clinical needs of enrollee
    - Functional criteria
    - Availability of services in the community
  - Communicates recommendation, care plan (specific enrollee needs) and supporting documentation to MCO for authorization
  - Obtains authorization for stay prior to admission

Transitions: Community to Nursing Home

- MCO Role:
  - Provides NH plan liaison
  - Member of care planning team, ensures:
    - Person centered care planning
    - Enrollee choice, enrollee education about care options
    - Decisions not based on financial incentives
  - Assists in compiling documentation for authorization review
  - Upon receipt of recommendation for transition:
    - Assesses care plan and clinical needs
    - Approves or adjusts the care plan to ensure member's needs are met
  - Authorizes care plan and placement in timely manner
  - Notifies providers, enrollees of determination
  - Arranges for UAS-NY assessments in NH

Timeline of Eligibility and Placement



NEW YORK STATE Department of Health | Medicaid Redesign Team

Appeals/Fair Hearing

- Timeframes in model contracts, provider manuals, member handbooks and determination notices
- Expedited where appropriate
- Enrollee has right to appeal to plan and right to fair hearing
- External appeal available for medical necessity denials
- NH has own plan grievance and external appeal rights

FIDA - Appeals/Fair Hearing

- FIDA Requirements
- Integrated appeals process
- Four levels of Appeals
- Care remains same until appeal determined
- Aid continues pending appeal
- Part D not integrated and follows the current Part D process.
- Providers can file an appeal on behalf of a Participant but does not have a FIDA-specific right to appeal plan payment decisions.

Patient Care After Placement

- No change in Nursing Home responsibility for care
  - Conducts required mandatory assessments and evaluations
- MCO now part of care plan development
  - Person centered care plan
  - MCO arranges for UAS-NY assessment every 6 months and when enrollee condition changes
  - Coordinates with nursing home to share assessment data
  - MCO may review for service coverage and medical necessity
  - MCO reauthorizes stay under concurrent review at identified intervals, e.g., at time of assessment
- Care management
  - MCO oversees quality of care provided; care plan implemented and sufficient to meet enrollee's needs
  - MCO arranges for other covered services enrollee needs
  - MCO ensures enrollee has PCP
  - Refer to case management, if needed
- MCO and NH coordinate efforts to meet quality goals

Authorization for Transfers

- MCO may have on-site or on-call provider to examine enrollee
- Enrollee hospitalization
  - Emergency Care - No prior authorization
  - Urgent Care – No authorization if transferred to a network hospital
- NH notifies MCO of enrollee transfer to hospital and which hospital
- Prior authorization needed for non-network hospital in non-emergency cases
  - Unavailability of network hospital or clinical needs cannot be met at network hospital
  - If MCO not available 24/7 and all info submitted by NH on next business day, urgent on non-business day transfer covered while review pending

Authorizations for Other Care

- NH and MCO will follow authorizations procedures in the provider agreement for routine and elective care
- Medical necessity determinations made as fast as the member's condition requires and in accordance with contractual requirements
- MCO appeal, external appeal, fair hearing and complaint rights apply

Finance and Reimbursement

Benchmark Rates

- The benchmark rate will include all aspects of the Nursing Homes reimbursement for a FFS patient, including but not limited to Operating, Capital, Per Diems, Cash Assessment and Quality.
- The benchmark rate will be updated and published on the DOH Public Website at least twice a year.
  - http://www.health.ny.gov/facilities/long_term_care/reimbursement/nhr/
  - Plans and providers should coordinate through the contracting process how to incorporate the benchmark rate into Nursing Home reimbursement.
  - The Department does not object to Plans and providers appending benchmark rate sheets to contracts.

Capital Component

- DOH is confident that CMS will approve the continuation of capital component of the benchmark beyond the three year transition period.
- This current proposal is intended to maintain stability and provide Nursing Homes with the resources to continue to pay long term debt commitments and access capital markets for future investments.

Net Available Monthly Income (NAMI)

- It is anticipated that NAMI will be collected by the Plans, however, Plans may delegate the responsibility to the NH via the contract process as currently allowed under MLTC.
- Upon the completion of the eligibility process the Local District will notify the Plan of the NAMI amount to facilitate the collection process.
- Distribution of the Personal Needs Allowance should be coordinated between Plans and providers during the contracting process.
- The State is proposing to take over the collection of the NAMI for NH residents in the future.

Billing/ Cash Flow

- The Department has taken steps to ensure that Nursing Home cash flow will not be negatively impacted by the shift to Managed Care. For example,:
  - Scenario 1 – Mainstream Managed Care patient is at NH for rehabilitation and applies for long term care eligibility, the Plan will pay the NH at the benchmark rate during this period.
  - Scenario 2 – Managed Long Term Care patient regresses from the community into a long term NH stay, the Plan will pay NH the benchmark rate during the eligibility process.
  - Scenario 3 – FFS patient requires long term NH stay and goes into eligibility process, the NH must wait until a determination is made and the member is deemed eligible for long term placement. At that point, NH can bill FFS retro to the eligibility date. Once enrolled in Managed Care, the NH must bill the Plan.
- Clean Claims:
  - DOH has implemented a readiness review survey to ensure that Nursing Homes can submit clean claims to Plans on a quarterly basis.
  - Active discussion to develop uniform billing codes among Plans and NH
- As an emergency stop gap when there are unavoidable billing problems between Plans and providers, the Department can eliminate or temporarily reduce the two week cash lag.

Plan Billing

- The following illustrates how an ancillary service such as physician services will be handled:
  - Mainstream – Included in premium/benefit

    Scenario 1 – NH does cover physician benefit (in benchmark), Plan pays NH as part of benchmark rate

    Scenario 2 – NH does not cover physician benefit (not in benchmark), Plan pays physician
  - MLTC – Not included in premium/benefit

    Scenario 1 – NH does cover physician benefit (in benchmark), Plan pays NH as part of benchmark rate

    Scenario 2 – NH does not cover physician benefit (not in benchmark), physician bills FFS
- Therapeutic/ Hospital Leave days where a Nursing Home is required to reserve the bed for the patient the Plan will be required to pay the NH. The cost associated with these days have been included in the base data and are reflected in the premium.

Benchmark Rate Billing Matrix

	Mainstream Managed Care	Managed Long Term Care
Ancillary is included in the benchmark rate & is part of MC benefit package	Plan pays NH as part of benchmark rate	Plan pays NH as part of the benchmark Rate
Ancillary is not included in the benchmark rate & is part of benefit Package	Plan pays administering provider	Plan pays administering provider
Ancillary is not included in the benchmark & is not part of benefit Package	N/A	Administering provider bills Medicaid FFS

* Ancillary services can include: Lab Services, Electro-cardiology, Electro-encephalogy, Radiology, Inhalation Therapy, Podiatry, Dental, Physician, Psychiatric, Hearing Only, Medical Directors, Medical Staff Services, and Utilization Review.

Retroactive Rate Adjustments

- DOH commits to updating the FFS benchmark rates as timely as possible.
- The FFS benchmark rate will be updated at a minimum of twice a year to account for case mix updates.
  - As previously discussed and outlined in the Finance Sub-Workgroup, Plans will be responsible for ensuring that any retroactive changes to the benchmark rates will result in a payment to Nursing Homes that are utilizing the rate in their contracts.
  - Plans and providers who choose to negotiate an alternate payment arrangement that is not based on the benchmark will likely avoid retroactive payments.

Finance Rate Structure

- MLTC blend NH with current rate
- MMC separate rate cell
- Risk Mitigation Pools
  - Community High Need Pool – inform risk adjustment and transition to the UAS.
  - Nursing Home High Cost Pool – encourage Plans to contract with homes based on outcomes rather than price.
- Rate development includes crossover claims
- Intent to continue Capital after transition period
- FFS rates will continue to be set by DOH after transition

Nursing Home Transition Information

- NH Policy Paper
- Frequently Asked Questions
- Today's (1/22/15) Power Point Presentation

available on-line:
http://www.health.ny.gov/health_care/medicaid/redesign/mrt_1458.htm

- Questions - MRT@health.ny.gov

Scenario 1 – Current Enrollee Prior to 2/1/15

Example:

1/31/ 2015

- ✓ Permanent placement is recommended by NH for current MMCP enrollee
- ✓ Individual is dis-enrolled to FFS Medicaid

8/1/2015

- ✓ LDSS completes long term eligibility determination
- ✓ Enters eligibility determination into SDOH systems
- ✓ Notices sent to NH
- ✓ NH is responsible for collection of NAMI & assists with Medicaid renewals

Scenario 2 – Current Enrollee Post 2/1/15

Example:

2/1/2015

- ✓ Permanent placement is recommended by NH for current MMC enrollee
- ✓ NH transmits recommendation to MCO for approval
- ✓ NH transmits LDSS-3559 with approval from MCO to LDSS

6/1/2015

- ✓ LDSS completes long term eligibility determination, enters results of determination and RE code into SDOH systems
- ✓ Notices are sent to MCO and NH
- ✓ Roster is sent to MCO, including date of eligibility and NAMI
- ✓ NH receives its fee for service/negotiated rate from MCO during the period eligibility is being established
- ✓ MCO can bill retrospectively for appropriate enhanced rate for periods of eligibility
- ✓ NH can bill MCO retrospectively for appropriate enhanced rate

Scenario 3 – New Enrollee Post 2/1/15

Example:

2/1/2015

- ✓ Permanent placement is recommended by NH
- ✓ NH transmits LDSS-3559 to LDSS

6/1/2015

- ✓ LDSS completes long term eligibility determination, enters results of determination and RE code into SDOH systems
- ✓ Notices are sent to NH
- ✓ Beneficiary selects MCO for enrollment within 60 days or is auto assigned to a plan contracting with the nursing home
- ✓ Dually eligible individuals must enroll in MLTCP

9/1/2015

- ✓ Effective date of plan enrollment
- ✓ Roster is sent to MCO, including associated NAMI, if applicable
- ✓ MCO can begin billing prospectively
- ✓ No retroactive enrollment or billing for period prior to enrollment