

25. ADMINISTRATIVE AND MANAGEMENT DATA SYSTEM

Overview of Managed Care Systems

The State and local districts in New York operate eligibility, enrollment, and claims systems under the current voluntary managed care program for nearly 650,000 enrollees, making it one of the largest Medicaid managed care programs in the nation.

The current general systems design will continue under the new program, with modifications to accommodate Partnership Plan policies. The remainder of this section provides a brief description of existing systems and identifies Partnership Plan enhancements for each of the following activities:

- Enrollment
- Disenrollment
- MCO Notification
- Provider Notification
- Claims Processing
- Encounter Data Collection and Analysis

Enrollment

Enrollment activities are conducted by the LDSS or the enrollment broker. The LDSS/enrollment broker is responsible for entry of individual enrollment form data and for transmitting that data to the State's Prepaid Capitation Plan (PCP) Subsystem.

Data Exchange Activities

The State's and New York City's Prepaid Capitation Plan (PCP) Information Subsystem maintains enrollment records. The LDSS is responsible for collection and entry of enrollment forms. Transfer of enrollment information may be accomplished by any of the following:

- LDSS directly enters data into PCP Subsystem
- LDSS directly enters data via an eMedNY software package

An example of the data exchange time frame for the enrollment process follows:

03Sep06	04Sep06	05Sep06	06Sep06	18Sep06	01Oct06
Client completes enrollment form	LDSS enters data	WMS updates	Files sent eMedNY & fiscal agent	Rosters created & sent to LDSS & Plans	eMedNY & CSC reflect enrollment

Rosters are available on the HPN (Health Provider Network) for MCOs and local districts according to the SDOH Medicaid Monthly Pull-down Schedule which is produced in November for the year ahead. All MCOs are required to utilize an Internet Service Provider (ISP) to access the HPN for purposes of accessing the Medicaid and Family Health Plus roster site.

The Internet site through which to access the HPN is:

<https://commerce.health.state.ny.us>

This is a secure site with access granted by the Bureau of Managed Care Financing. The HPN requires each user to possess a User ID and password to enter the roster application. Providers are not granted access to this site without proper authorization.

Providers do not have access to other providers' files nor do they know that these files exist.

Automatic Assignment

Individuals who do not select an MCO within the required time period will be automatically assigned using an algorithm that computes both access and capacity, giving preference to certain PHSPs as specified in State law. In June 2001, the auto-assignment algorithm was modified to include preference based on plan quality performance, as authorized by statute. The revised methodology will be implemented in counties that have completed one year of operation under the Partnership Plan.

A description of the automatic assignment process is attached as Appendix 12.2. The auto-assignment function is designed as a process which will automatically update the PCP Subsystem. ***An enrollment reason code of "05" will be indicated on the roster for auto-assignees*** in order to permit tracking of all automatically assigned individuals.

The actual algorithm used for auto-assignments and the criteria it incorporates are also provided in Appendix 12.1. A detailed description of the algorithm incorporating quality is included in Appendix 12.1a.

Exclusions/Exemptions

Recipients who are identified in advance as excluded or exempt will have codes automatically posted to their eligibility records that will prohibit automatic assignment from taking place. Individuals who are exempted from mandatory enrollment as a result of requesting an exemption will also have their eligibility records "flagged" to prevent auto-assignment. Persons who self-

identify to the LDSS and who are found to meet exclusion criteria will have their eligibility records “flagged” to prevent participation in the program. Persons who are eligible for an exemption or exclusion, but cannot be identified in advance by the State will be auto-assigned consistent with the process used for other mandatory populations. (See Chapter 12 for more detail).

The LDSS shall be responsible for collecting and processing exemption applications and entering the exemption identifier into the eligibility records of those granted the exempt status. The local districts shall follow State established guidelines as described in this Protocol for granting exemptions from mandatory enrollment.

Disenrollment

After the enrollee completes the disenrollment form, the process is essentially the reverse of the enrollment systems support. The PCP subsystem file is end dated, and MEVS and the fiscal agent are updated to return to fee-for-service processing. The recipient is removed from the MCO’s roster. There are also expedited disenrollment procedures in place as described in Chapter 12.

MCO Notification

MCOs access the roster information through the SDOH Health Provider Network (HPN).

Provider Notification

Ancillary providers are notified by MEVS of the enrollment of a recipient in a managed care plan. All providers are required to verify eligibility through MEVS before providing services. At this verification (essentially a credit card type swipe card) providers are informed that the recipient is in managed care, the MCO in which the recipient is enrolled, and the services covered by the MCO.

Claims Processing

Managed care plans bill for their monthly capitation payment based on the recipients on their roster, with certain adjustments. The fiscal agent calculates the rate due based on the actuarial class of the recipient, using the data on the Statewide eligibility file (WMS) and the individual’s eligibility status. If all conditions are met (as described in Chapter 17), the MCO is paid.

Fee-for-service claims are paid only if the claim is for a service that is not included in the capitated benefits package. Claims processing edits are based on the benefit package in the MMC/FHPlus contract. These edits reside in the Managed Care Scope of Benefits and are used to determine whether a claim is paid or denied. Separate claiming procedures are in place for reimbursing MCOs for claims in excess of the stop-loss (reinsurance) limits provided by the State and elected by the MCO.

Encounter Data Reporting and Analysis

Encounter data is collected and validated according to the specifications and procedures outlined in Chapter 22 of this Protocol document.

25. ADMINISTRATIVE AND MANAGEMENT DATA SYSTEM IN FHPlus

This is the same for FHPlus with the exception of Automatic Assignment and Exclusions/Exemptions, which are not features of FHPlus.