



Department of Health

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ADMINISTRATIVE DIRECTIVE

TRANSMITTAL: 15 OHIP/ADM-01

TO: Commissioners of Social Services

DIVISION: Office of Health Insurance Programs

DATE: April 1, 2015

SUBJECT: Transition of Long Term Nursing Home Benefit into Medicaid Managed Care

SUGGESTED DISTRIBUTION:	Medicaid Staff Legal Staff Fair Hearing Staff Temporary Assistance Directors Staff Development Coordinators
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ATTACHMENTS:	Attachment I: Table 1, Nursing Home Transition Timeline

Filing References

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Soc. Serv. Law & Other Legal Refs.	Manual Ref.	Misc. Ref.
04 OMM/ADM-6 06 OMM/ADM-5 10 OHIP/ADM-5	None		SSL 364-j(3)(e) PHL 4403-f	None	MRT 90 MRT 1458 GIS 14 MA/016

I. PURPOSE

This Office of Health Insurance Programs Administrative Directive (OHIP ADM) advises Local Departments of Social Services (LDSS) of the transition of the long term nursing home (NH) benefit to Medicaid Managed Care for adult consumers age 21 and older. For Managed Long Term Care, consumers in long term care and in permanent status in a nursing home are no longer excluded and will be enrolled in a Managed Long Term Care Plan.

For purposes of this OHIP ADM, the term “managed care” includes Medicaid Managed Care (MMC) and Managed Long Term Care (MLTC). The term “Medicaid Managed Care Plan” includes mainstream Medicaid Managed Care and HIV Special Needs Plan products. The term “Managed Long Term Care Plan” includes Partial Capitation and Medicaid Advantage Plus (MAP) products only. The term “dually eligible” refers to a consumer in receipt of Medicaid and Medicare.

Note: This change in policy does not apply to the Fully Integrated Dual Eligible (FIDA) program, Program of All-Inclusive Care of the Elderly (PACE), consumers residing in Intermediate Care Facilities (ICF), or to consumers in Alternate Level of Care (ALC) status in a hospital.

II. BACKGROUND

Previously, long term nursing facility services were covered through the fee for service (FFS) Medicaid program or by Managed Long Term Care plans (MLTCP). For consumers enrolled in a Medicaid Managed Care plan (MMCP), the plan covered nursing home admissions for rehabilitation services only. Unlike consumers enrolled in MLTC plans, MMCP enrollees permanently placed in nursing homes were an excluded population, and were disenrolled from the plan when the admission was determined to be permanent.

Beginning February 1, 2015 in New York City, the long term nursing home benefit transitioned into Medicaid Managed Care. Nassau, Suffolk and Westchester counties transitioned in this benefit on April 1, 2015, with the rest of State to follow on July 1, 2015. This is for non-dually eligible individuals in receipt of Medicaid, and does not affect the short term or rehabilitation nursing home benefit currently covered by MMCPs. The schedule for the transition of the nursing home benefit is reflected in Table 1, “Nursing Home Transition Schedule” (Attachment I).

Also on February 1, 2015, dually eligible individuals in receipt of long term nursing facility services are no longer excluded from enrollment in MLTC. These consumers moved from excluded to a mandatory population.

Under this policy, consumers entering a nursing home for long term placement are required to remain in or enroll in a managed care plan, either MMCP or MLTCP, if otherwise eligible, and to access this benefit through the managed care plan’s network providers. Enrollees selecting a nursing home outside the MMCP or MLTCP service area or outside the plan network are required to transfer to a plan that contracts with the selected nursing home, or obtain approval from the plan to enter the out of network nursing home. Consumers who are new to managed care or new to Medicaid will be educated regarding enrollment in a plan that contracts with the nursing home of choice, and will be enrolled in a plan once eligibility is established. Consumers may not remain in or disenroll to fee for service Medicaid if otherwise eligible for MMC or MLTC.

III. PROGRAM IMPLICATION

Effective February 1, 2015, all Medicaid eligible consumers age 21 and over in New York City in need of long term placement in a nursing facility are required to be enrolled in or remain enrolled in a Medicaid Managed Care Plan or Managed Long Term Care Plan in order to receive this benefit as a covered service. This policy will apply to additional counties according to the schedule appearing in Table 1, “Nursing Home Transition Schedule,” attached.

Eligible individuals age 21 and over who become permanently placed in a nursing home on or after the transition effective date for the individual's county of residence are required to be enrolled in a MMCP or MLTCP, unless otherwise exempt or excluded from enrollment.

Current MMCP and MLTCP enrollees who require long term placement in a nursing home on or after the transition effective date for that district are required to remain enrolled in a managed care plan in order to receive this benefit. Enrollees will select a nursing home from the plan's contracted provider network. Enrollees selecting a nursing home outside the provider network must obtain authorization from the plan for the out of network placement or transfer to a plan contracting with the nursing home selected. If transferring to another plan in order to access a nursing home outside the District of Fiscal Responsibility (DFR), the new plan must operate in both the DFR and the district where the NH is located, and the transfer to the new NH will coincide with the effective date of plan enrollment.

All current Medicaid eligible long term placement consumers (non-duals) residing in a nursing home prior to the applicable transition date for the county will remain in fee for service Medicaid and are not required to enroll in a MMCP. This also applies to Medicaid eligible consumers in permanent status prior to the transition date who are discharged to a hospital for an inpatient hospital stay with bed hold. However, if bed hold is exhausted or not in place, consumers entering the nursing home for long term care after the transition date are required to enroll in a managed care plan.

Consumers with a date of permanent placement prior to the applicable transition date are not required to enroll in mainstream Medicaid Managed Care once eligibility is established. As of October 1, 2015, this population will become exempt, rather than excluded, from enrollment into managed care and these consumers may choose to enroll on a voluntary basis. As above, choices for enrollment are limited by contractual network and DFR.

For the MLTC program, dually eligible long term placement beneficiaries residing in nursing homes are no longer excluded from MLTCP enrollment. Dually eligible consumers who become permanently placed in a nursing home on or after the transition date must enroll in a MLTCP after establishing eligibility. These consumers may no longer remain in fee for service Medicaid. Consumers in long term placement status and enrolled in Medicaid Managed Care, and who later gain Medicare coverage are required to transfer to a MLTC plan, and will not be disenrolled to fee for service Medicaid. Consumers enrolled in a MMC plan having a contracted MLTC product will be passively enrolled in the sister MLTC upon receipt of Medicare. Consumers whose plan does not have a contracted MLTC product will be required to enroll in another available MLTC for enrollment, based on contractual network and DFR.

The LDSS is responsible for coordinating enrollment to an appropriate product for MMC enrollees in long term placement who become excluded from MMC enrollment.

Consumers residing in a nursing home located out of state will remain excluded, and are not required to enroll in managed care. All other program specific exclusions and exemptions from enrollment remain unchanged.

IV. REQUIRED ACTION

The following provisions will be phased in as reflected in Attachment I of this directive, and apply to consumers who become permanently placed in a nursing home on or after the applicable transition date. In determining eligibility for these consumers, there are no changes to the eligibility rules that districts use to determine eligibility for Medicaid coverage of long term nursing home care (permanent placement); including when the 60-month transfer of assets look-back period applies or the application of a transfer of assets penalty period.

Note: For Medicaid recipients who were not enrolled in mainstream managed care, who received more than 29 days of short term rehabilitation services prior to a change in status to permanent placement, a transfer of assets look back would have already occurred for Medicaid coverage beyond day 29.

Districts continue to have 45 days from the date of application or a request for an increase in coverage to complete an eligibility determination for Medicaid coverage of long term nursing home care. If a disability determination is required, the district has 90 days from the date of application or the request for an increase in coverage to determine Medicaid eligibility. The district may exceed these time periods if it is documented that additional time is needed for a consumer, or the consumer's representative, to obtain and submit required documentation.

Note: LDSS staff will accept the LDSS-3559 or approved local equivalent, in conjunction with authorization by the plan, as the determination the enrollee's condition is appropriate for long term placement.

A. New Applications and Conversions of Medicaid Fee for Service Recipients

1. Eligible for Medicaid Coverage of Long Term Nursing Home Care

For active Medicaid fee for service recipients who become permanently placed in a nursing home, as authorized on the LDSS-3559, "Residential Health Care Facility Report of Medicaid Recipient Admission/Discharge/Readmission/Change in Status," form or an approved local equivalent from the nursing home, the district must enter a Restriction/Exemption (R/E) code 90 (Exclusion from Managed Care) in eMedNY to prevent enrollment in a plan prior to the eligibility determination for Medicaid coverage of long-term nursing home care.

For new applicants and fee for service Medicaid recipients who are determined to be eligible for Medicaid coverage of nursing home care, the district must enter the begin date of coverage and any Net Available Monthly Income (NAMI) in the Principal Provider subsystem on the Welfare Management System (WMS) and a Medicaid card code of "R" (Roster) on WMS. Any available third party health insurance information, including Medicare, must also be entered into eMedNY. The entry of the data into the Principal Provider subsystem allows Medicaid payment to the nursing home pending enrollment into a managed care plan.

In addition, for consumers who are not exempt or excluded from enrolling into managed care, the district must end the R/E code 90, if applicable, and enter a new R/E code "N7" (Long Term Eligibility Budgeting Approved – Not Enrolled) into eMedNY to identify the consumer as approved for long term nursing home care. The R/E code "N7" is used for consumers who are determined financially eligible and required to enroll in either a MMC plan or a MLTC plan. The effective date of the R/E code N7 is the date that the district is making the transaction in eMedNY. The eligibility "Notice of Decision on Your Liability Towards the Cost of Care" continues to be sent to both the consumer and the consumer's representative, if applicable, with a copy to the nursing home.

Consumers who are exempt (not excluded) from enrollment may elect to enroll in managed care, and are not subject to auto assignment. The R/E N7 code is not entered for cases with a valid reason for exemption.

For districts using New York Medicaid Choice (NYMC) as the managed care enrollment broker: the daily eligibility file update from eMedNY will trigger a commencement of the 60 day period to choose a managed care plan once the N7 R/E code appears on a consumer file. The plan selected for enrollment must be one that is contracted with the nursing home in which the consumer is placed. The enrollment broker will provide outreach, education materials, plan selection, and auto assignment if a plan selection is not obtained within the allowed time frame for plan selection. Districts will also receive an enrollment file from NYMC indicating cases with a managed care enrollment.

For districts not using the enrollment broker: the LDSS must institute an internal process to provide outreach, education, and auto assignment after the 60 day choice period if a plan selection has not been obtained. The plan selected for enrollment must be contracted with the nursing home in which the consumer is placed. Additional instructions to districts not utilizing the enrollment broker will be forthcoming.

Once enrolled, the district must end date the R/E code N7, effective the date the district is making the transaction, and enter the appropriate R/E N code (N1-N6) in eMedNY based on the managed care enrollment, i.e., MMC or MLTC, and bed type. (See section "VI. Systems" of this directive for further information regarding the new R/E "N" codes used). The effective date of the R/E code (N1-N6) for long term nursing home care is the first day of the month of enrollment (the enrollment effective date will follow regular pull down rules). The Principal Provider entry must be end dated with code "00" effective the first day of enrollment of the managed care enrollment effective date. This will ensure the nursing home receives Medicaid payment for the last day of the month prior to the managed care enrollment. The LDSS must change the R card code to N/P as applicable if a Medicaid benefit card is needed.

In New York City, once the district receives an enrollment file from New York Medicaid Choice, the system will end date the Principal Provider Code and R/E N7 code, and will enter R/E N1 for MMC enrollment and R/E 6 for MLTC enrollment. NYC staff must manually change the R/E code to N2-N5, if applicable. The start date for the N1-N6 is the effective date of the managed care enrollment.

Once plan 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 will be pulled from the Medicaid budget stored in Medicaid Budget Logic (MBL). The plan, in place of the nursing home, must receive a copy of any eligibility notice sent regarding an enrollee's NAMI.

Districts should note that a consumer who was eligible for fee for service Medicaid in the community with a spenddown requirement, including provisional coverage, who is subsequently determined eligible for Medicaid coverage of long term nursing home care with a NAMI, is otherwise eligible for enrollment into mainstream managed care.

2. Not Eligible for Long Term Nursing Home Care – Transfer Penalty

For consumers in FFS or new to Medicaid who are determined to have made a prohibited transfer and are subject to a transfer penalty, the consumer is not eligible for enrollment into a managed care plan for coverage of long term nursing home care for the duration of the transfer penalty, including a partial penalty month. Since the consumer may be eligible for community coverage or community coverage with community-based long term care, the district must enter R/E code 90 on the active case to prevent enrollment in managed care. Once the transfer penalty period has expired, the consumer is otherwise eligible for enrollment into a managed care plan and the LDSS must end date the R/E code 90. At recertification, if a transfer penalty period has expired and the consumer is still residing in the nursing home, the district would follow the same steps listed above to provide payment to the nursing home pending enrollment into a plan. Upstate districts should use Anticipated Future Action Code 505 (End of Property Transfer Prohibition) to track the end of a transfer penalty.

B. Managed Care Enrollees - Permanent Placement in a Nursing Home

Consumers who are enrolled in managed care, who require permanent placement in a nursing home on or after the transition date, are not to be disenrolled from the Medicaid Managed Care or Managed Long Term Care plan. The nursing home must submit the LDSS-3559 or an approved local equivalent to indicate the need for permanent placement, and attach the plan's authorization for the permanent placement. For MMC, the plan will pay the nursing home the benchmark rate until the eligibility determination is made for Medicaid coverage of long term nursing home care.

1. Eligible for Medicaid Coverage of Long Term Placement

When a consumer is determined to be eligible for Medicaid coverage of long term nursing home care, the district must enter the R/E code that corresponds to the appropriate nursing facility or bed type (i.e., N1 for Regular NH Rate for mainstream Medicaid Managed Care). (See section "VI. Systems" of this directive for further information regarding the new R/E codes). The effective date of the R/E code is the first day of month that the consumer is in permanent

placement status and eligible for Medicaid payment of long term nursing home care. In most cases this will be the first day of the month the consumer was in permanent placement status; however, when an increase in coverage or permanent placement is requested, the district can go back three months from the month notification is received of the need for the increase in coverage or permanent placement. This notification can be receipt of the LDSS-3559 or its approved local equivalent, a verbal request from the recipient or recipient's representative with appropriate documentation to follow, Supplement A to the Access NY Health Care Application, or email communication from Department staff on behalf of a recipient receiving coverage through New York State of Health (NYSOH), and must indicate facility or bed type. If the district is not notified timely of the need for an increase in coverage or permanent placement, the effective date of the approval may not go back to the first month of permanent placement status. When the R/E code is entered for coverage of long term nursing home care, the MMC plan will receive a rate increase to include the nursing home benefit. The plan must receive copies of any eligibility notices that include a NAMI.

2. Nursing Home Not In Plan Network

If the nursing home in which a consumer resides is not in the consumer's managed care plan network, the consumer must transfer to a plan that includes the nursing home in its network, or obtain approval from the plan for an out of network placement. Pending the transfer, the consumer's current plan is responsible for authorizing the permanent placement. Once the placement is authorized, the district must enter the appropriate R/E code (N1-N6) in eMedNY based on the type of facility or bed type and plan type (MMC or MLTC). For both MMC and MLTC, the current plan is responsible for payment to the nursing home until the new plan enrollment becomes effective. When the new plan choice is made, and the new plan authorizes the permanent placement, the district must send the new plan copies of any eligibility notices issued on or after the effective date of enrollment and include NAMI information.

3. Not Eligible – Transfer Penalty

If an eligibility determination for Medicaid coverage of long term nursing home care renders a consumer not eligible for nursing home care due to a transfer of assets penalty period, the nursing home will refund to the MMC plan any plan payments received since the date of permanent placement status. The consumer will remain enrolled in a mainstream MMCP for coverage of community-based care and services. The district must recalculate the individual's eligibility for coverage of community-based long term care as directed in 06 OMM/ADM-5, "Deficit Reduction Act of 2005 – Long-Term Care Medicaid Eligibility Changes." If the recalculation results in a spenddown, the district should apply any medical bills, such as the nursing home bill, to offset the amount of a spenddown and issue appropriate notice to the consumer and the plan. Such consumers will remain enrolled in the mainstream Medicaid Managed Care plan. For MLTCP enrollees, the consumer must be prospectively disenrolled from the plan for the duration of transfer penalty period, unless the consumer transitions back to the community to receive Community Based Long Term Care Services, as indicated on the LDSS-3559, or approved local equivalent, sent by the NH and authorized by the plan to notify the district of a change in condition.

Once a transfer penalty period has expired, the district must enter the appropriate R/E "N" code to allow nursing home payment from the managed care plan. In NYC, this will be done at the time of redetermination or upon notification to the district, whichever occurs first. For consumers who require enrollment into a MLTC plan, the district must enter R/E code "N7", if no plan selected, or "N6", if a MLTC plan has been selected. If no MLTC plan is selected (R/E code N7), the district must authorize payment to the nursing home by entering the appropriate information in the Principal Provider subsystem. When a plan is selected, the district must change the N code to "N6" effective the first day of the month of enrollment into the MLTC plan, based on the managed care pull down date. The Principal Provider entry must be ended effective the first day of the month of the MLTC enrollment.

C. Change in Status Discharge

When a managed care enrollee is discharged to a hospital or to the community, the district must end date the R/E N1-N6 code in eMedNY effective the end of the month of the discharge as indicated in the LDSS-3559 or its approved local equivalent sent by the NH and authorized by the plan. The consumer will continue to be enrolled in managed care while hospitalized. In cases where a consumer retains a bed hold in the nursing home while in a hospital, the R/E N1-N6 code is not end dated. If the consumer is discharged to the community, the district must redetermine eligibility based on the applicable community budgeting rules, and update the card code as appropriate. If the budget change results in a spenddown, the consumer must be disenrolled from the Medicaid Managed Care plan and enrolled in an appropriate managed care product effective the first day of the month following timely notification of the eligibility change.

Nursing homes are required to notify the district of a change in residential status, with plan authorization, within 48 hours through the submission of the LDSS-3559 or its approved local equivalent.

V. NOTICES

The LDSS must have in place a method to send notices to the consumer, and the managed care plan, if appropriate. LDSS staff must enter the managed care plan address in the Associated Name fields on screen 7 in WMS as appropriate. If the address fields are not available, the LDSS must use an alternate system for sending notices to MMCPs and MLTCPs.

The LDSS must send notices to the managed care plan at the same time the enrollee is notified of the results of the eligibility determination, NAMI amount and any penalty period. The LDSS must send any changes in NAMI to the managed care plan through the roster system, utilizing the addresses entered in the Associated Name fields. Because the NAMI amount for the following month is pulled from a stored budget and may not accurately reflect the NAMI owed for a specific month, such as during a retro period or partial month, the LDSS must also notify directly the managed care plan of any change in NAMI amount that is not reflected in the budget. The LDSS must issue a notice to the plan and enrollee in hard copy for NAMI amounts that may be different from the amount appearing on the roster, including retroactive changes. Notices sent in hard copy to the plan and enrollee that include a change in NAMI amount supersede a NAMI amount appearing in the roster. Notices may be generated either electronically or manually by the LDSS.

For consumers new to Medicaid or not yet enrolled, the LDSS must send notices to the consumer and the nursing home where the consumer resides. For consumers enrolled in MMC or MLTC, the LDSS must send notices to the consumer and the managed care plan, including any changes not reflected on the roster. The MMC plan or MLTC plan is responsible for notifying the nursing home provider of these changes. This ADM supersedes all previous directives regarding NAMI notices sent to consumers enrolled in MMC or MLTC plans and who are in permanent placement status.

MMC plans and MLTC plans are responsible for ensuring that Nursing Homes with which they contract are informed in a timely manner of any NAMI or a change in NAMI amount to be collected, if the plan has a contractual arrangement with the NH for NAMI collection.

VI. SYSTEMS

For all existing long term placement cases, or those whose permanent placement status is dated prior to the transition date for the county, the LDSS will enter the Roster (R) card code and Principal Provider (PP) code in WMS for the case as per current processes.

A. New Restriction/Exception Codes

LDSS staff must enter new Restriction/Exception (R/E) codes into eMedNY to identify the

type of long term placement for managed care enrollees. These R/E codes are used to determine the correct premium rate payment. R/E code 90 is also used to prevent enrollments for consumers in FFS Medicaid pending an eligibility determination for nursing home care.

LDSS staff must enter the R/E code that corresponds with the appropriate nursing facility type, using the list below, for current managed care enrollees in permanent placement status dated on or after the transition date for the county and who are determined eligible. For current enrollees, the N code effective date equals the date of permanent placement. For consumers in permanent placement and not yet enrolled, the N code effective date is prospective, reflecting the effective date of plan enrollment.

The R/E codes for managed care enrollment are:

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:

N6	MLTC Enrollee	NH – any
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MMC and MLTC R/E Code:

N7	Not Enrolled	Long Term Eligibility Budgeting Approved
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B. Enrollments

Once the consumer has enrolled in a MMC plan or MLTC plan, the R/E and PP codes must be changed to reflect the enrollment. The PP code must equal “00” on the same date as the begin date of managed care enrollment. The LDSS must end date the N7 code the last day of the month prior to the effective date of the managed care enrollment and update the entry using the N code (N1 – N6), as indicated by the nursing home and plan authorization, equal to the date of enrollment.

In New York City: Once NYC receives an enrollment file from New York Medicaid Choice, the system will end date the PP code and N7 code, and enter R/E N1 for MMC enrollment and R/E 6 for MLTC enrollment. LDSS staff will enter manually the appropriate N2-N5 R/E code that corresponds with the type of nursing facility. The start date for the N1-N6 is equal to the date of managed care enrollment.

C. New York City Systems Process (NYC Only)

Once the consumer is enrolled in managed care, the system will:

- End-date R/E N7
 - If the MC enrollment is starting next month, R/E N7 will be end-dated at the end of this month.
- Close Principal Provider record
 - If the MC enrollment is starting next month, Principal Provider will be closed at the end of this month. PP code must equal “00” on the same day on which MC enrollment is starting.
 - If there is no PP record on the case, do not process the case. Send error message “No PP record with N7” on new error report to HRA. This report will be sent to HRA at print queue “QMEP” with banner header “Howard Black.”
- Enroll client in R/E N1 (for mainstream plan) or N6 (for MLTC plan).

- R/E N enrollment From date will be greater than or equal to the MC enrollment From date.
- R/E N enrollment From date will always be first of the month.
- Use nursing home provider ID, obtained from Principal Provider record.

Override the current edit to allow Principal Provider record and MC enrollment to exist together on NH clients until PP record is force closed. These records cannot overlap the coverage period.

NYC Systems Process:

MC enrollment is required before nursing home consumers are enrolled into new R/E codes (except R/E N7).

Open-ended R/E "N" codes cannot be enrolled with other open-ended "N" codes. If more than one R/E N code is enrolled on the case, the enrollment period cannot overlap. Unlike the other NH codes, N7 will not drive a rate code.

R/E N7 code identifies new applicants who have just become Medicaid eligible and have successfully completed chronic care budgeting for NH care. LDSS staff will use this as an indicator to the auto assign process to bypass the immediate assignment and trigger the 60 days choice period for managed care enrollment mailings.

New R/E codes are entered via:

- R/E one-step process (in initial eligibility)
- On-line R/E subsystem

The batch process will generate the R/E N7 code at initial eligibility. The R/E N7 can be entered on screen NCEM15 when the application is created.

All existing R/E edits will apply to this record before it is stored. Any records failing R/E edits (non-CEM edits) will be reported along with reasons for the failure in the daily R/E error report.

This report will be sent to HRA at the print queue "QMEP" with banner header "PatriceD." R/E "N1-N7" One-step Error Report Format:
Fields and sort by - Last Name, CIN, Case Number

When an Eligibility transaction has been processed,

- R/E subsystem will generate an R/E N7 record with From Date equal to transaction date.
- The worker ID on this record should be "NYONE".
- The new R/E codes with open-ended "To Date" will always appear on "CLIENT INFORMATION" screen NQIN2A. When new R/E codes are end-dated, the R/E record will disappear from "CLIENT INFORMATION" screen.

On-line R/E subsystem:

Worker will be allowed to enter R/E codes N1, N2, N3, N4, N5, N6, and N7 to create R/E transactions on active NH cases.

- If R/E N1-N6 is entered, NH provider ID is required to be entered.
- If R/E N1-N6 is entered, From date is required to be entered. This From date can only be first of the month.
- If R/E N7 is entered, system will generate From date equal to transaction date.

- If R/E N7 is entered along with From date, system will overlay From date equal to transaction date.
- If R/E N7 is entered, Provider ID is not required.

Disenrollment process:

If a NH consumer is disenrolled from a managed care plan, the LDSS is responsible for end-dating the R/E N1-N6. On the R/E subsystem, end-date will coincide with the end of the managed care enrollment.

R/E "N" end-dating auto process:

If NH client is disenrolled from a managed care plan but R/E "N" remains open-ended, the system should end the R/E "N" code. Before generating the R/E end-date, the auto process must check the MC disenrollment begin date. If the MC disenrollment (95) begin date is older than last three MC pull down dates, the system will end-date R/E "N." The system will also enter the end-date on R/E "N" if the client is deceased. The R/E end-date will be equal to the transaction date. Every month, the R/E end-date process will run after the PCP auto disenrollment process.

Example:

Client is auto disenrolled from managed care plan on 2/15/14, effective 3/1/14
(Next MC pull down dates are 3/22, 4/19 and 5/24)

R/E end-date system checks on 3/25. No action taken.

R/E end-date system checks on 4/25. No action taken.

R/E end-date system checks on 5/25. R/E "N" end-date will be generated.

Card Code "R":

MAXIMUS will bypass the card code "R" edit to allow MC enrollments for permanently placed NH consumers. WMS will bypass the card code edit for NH consumers with R/E N1-N7.

VII. REPORTS

Nursing Homes will continue to receive a FFS roster in the current method of delivery. The managed care plans will receive pertinent enrollee information via the Health Commerce System (HCS) Roster/Reporting system, including the new R/E N code.

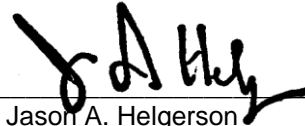
A new systems report (Nursing Home Report) is associated with this transition. The Upstate files (district and provider) will be called "mnhumdd." The NYC files (provider) will be called "mnhnmdd." These reports will be produced monthly and are available through the district's HCS reporting system and BICS.

The file layout will be:

DISTRICT	PIC X(02)
CIN	PIC X(08)
CASE-NUM	PIC X(12)
EXC-CD	PIC X(02)
NH-PROVIDER	PIC X(08)
RE-FROM-DATE	PIC X(08)
PCP-PROVIDER	PIC X(08)
NAMI-AMT	PIC X(10)
ERROR	PIC X(20)

VIII. EFFECTIVE DATE

The provisions of this Administrative Directive are effective February 1, 2015, except where otherwise noted.



Jason A. Helgerson
Medicaid Director
Office of Health Insurance Programs