

13. COMMUNICATIONS: MCOs AND THE LOCAL DISTRICTS (LDSS)

Overview of the Enrollment Process

The LDSS is responsible for processing MCO enrollments and forwarding data to the State. MCOs obtain enrollment information via rosters from the State.

MCOs are permitted to assist individuals in completing enrollment forms according to procedures established by the State and in locations authorized by the LDSS. However, all recipients must submit their forms directly or by mail to the LDSS. See Appendix 13.1 for a discussion of the guidelines governing the “MCO assisted enrollment” process.

Some MCOs are also contracted as Facilitated Enrollers (FEs), which allows them to assist people in applying for and/or recertifying for Medicaid, Child Health Plus or Family Health Plus benefits. During that process the FEs help the applicant choose a health plan.

Potential Medicaid managed care enrollees in mandatory local districts other than New York City and the other counties using the State-contracted Enrollment and Benefits Counselor (Maximus) are either sent a managed care enrollment packet along with their re-certification notice, or it will be provided at the time of their re-certification interview. At the point at which the recertification process is complete and continuing eligibility is established, the packet is provided and the 60 day enrollment “clock” begins. The LDSS is responsible for tracking the 60-day choice period. If a district elects to mail enrollment packets, any returned packets will trigger a follow-up to ascertain the recipient’s correct address. In that case, the 60 day “clock” begins when the individual actually receives the packet at the interview. Mailed packets which are not returned as undeliverable or “address unknown” are deemed to have been received within 5 days.

If a recipient fails to return his/her enrollment materials within 30 days of their provision, the LDSS sends a reminder notice. If the 60 day “clock” expires and no enrollment materials have been received, the individual is automatically assigned to an MCO and is so notified by the local district. All newly enrolled participants (including those who are auto-assigned) have 90 days from the effective date of their MCO coverage to change MCOs.

Counties using the State-contracted Enrollment and Benefits Counselor (Maximus) pursue a slightly different enrollment process.

- In counties outside NYC using Maximus, Maximus staff meet with new applicants and consumers who are recertifying their benefits, and provide an overview of the mandatory program. Those consumers may choose a plan with the Maximus counselor. Maximus holds that plan choice until the eligibility has been updated or established, and then processes the enrollment. If the consumer does not choose a managed care plan, after the eligibility is recertified or established, Maximus will mail an enrollment packet which will begin the 60-day choice period. Individuals for whom the mail is returned will have

their auto-assignment clock stopped, and the case will be reported to the local district for follow-up. No actions are taken by the Enrollment and Benefits Counselor until an updated address is received.

- In New York City enrollment packets are mailed by Maximus to all eligible participants. Maximus will use eligibility data passed by the State to Maximus on a daily basis to develop mailing files. These cases are generally new Medicaid cases or recertifications, or cases that have been updated with new information. This will allow the Enrollment and Benefits Counselor to receive and use the most current address and telephone numbers for the clients. The 60 day “clock” begins 5 days after the packets are mailed. The “clock” is stopped for all recipients where the packet is returned by the U.S. Postal Service as undeliverable or addressee unknown. The Enrollment and Benefits Counselor will re-mail the packet if the address is corrected. Individuals for whom the mail is returned will have their auto-assignment clock stopped, and the case will be reported to the local district for follow-up. No actions are taken by the Enrollment and Benefits Counselor until an updated address is received.
- In all districts serviced by the Enrollment and Benefits Counselor, the Enrollment and Benefits Counselor also provides 30-day reminder notices to all individuals receiving enrollment packets for whom no enrollment forms have been returned in the first 30 days after the mailing. Maximus also sends a second reminder notice 15 days prior to the expiration of the choice period. This second notice includes the name of the MCO to which they will be auto-assigned if no other choice is made by the recipient.
- In June 2003, Maximus implemented a phone enrollment program that allows consumers to enroll over the phone. Enrollment packets allow consumers to return the enrollment form provided in the packet, or to call the Helpline to confirm their enrollment choice. Consumers that enroll over the phone are sent a confirmation notice that includes a pre-printed enrollment form and a return envelope.

The State sends MCOs a complete list (roster) of all enrollees approximately fifteen days prior to the MCOs’ obligation to assume medical risk for that enrollee. The list includes dates of recertification for each enrollee on the roster. MCOs are then required to notify their new enrollees of their effective date of coverage 14 days in advance whenever possible. This notice must also inform the recipients of their right to change plans in accordance with State-specified timeframes (see chapter 12). Currently all enrollments are effective the first of the month. Notification to MCOs can be accomplished via paper transmission, magnetic media, or via an electronic bulletin board. A copy of the roster layout description is contained in Appendix 13.2. The State also shall forward an error report as necessary to each MCO. A copy of the error report is contained in Appendix 13.3. Medicaid providers can be notified via the Medicaid Eligibility Verification System (MEVS) of the enrollment status of a recipient. When the State-issued benefit card is “scanned,” the provider is notified if the individual is in an MCO. All providers are required to verify eligibility through MEVS before providing services. Upon verification (a magnetic card swipe, phone inquiry, or eligibility software link) 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.

Communications between MCOs and the LDSS

MCOs and the LDSS shall initiate protocols for communications for the purpose of resolving discrepancies between the rosters and the recipients for whom the MCO is at risk.

MCOs must report any changes in status for their enrolled members to the LDSS. Changes in status include the following:

- Address changes;
- Family composition changes, including births;
- Changes in conditions which may qualify an individual for voluntary status or excluded status, if known;

Also, MCOs must notify the LDSS regarding any members that they were unable to reach and/or for whom the MCO received returned mail, including the following information:

- Names of enrollees who have been continuously enrolled for at least 90 days whom the plan was not able to contact within their first 90 days of enrollment and who have not presented for any health care services through the plan.

MCOs must notify the LDSS of changes in status within five business days of such information becoming known to the MCO. Notification procedures and communications methods are established by the MCOs and the LDSS, according to methods the LDSS deems most efficient.

13. COMMUNICATIONS: MCOs AND THE LOCAL DISTRICTS (LDSS) IN FHPlus

For the FHPlus program, the data exchange activities and communications parallel those under the Partnership Plan, with the exception of the MCO enrollment choice period timeframes. The eligibility application and MCO enrollment choice coincide in the FHPlus program.

The Enrollment and Benefits Counselor is not responsible for issuing enrollment kits, but continues its role in processing the MCO enrollments, disenrollments and transfers, and complaint process for FHPlus.