Department of Health | Medicaid Redesign Team

Transition of Nursing Home Populations and Benefits to Medicaid Managed Care

Webinar July 29, 2015

Transition Dates

- Transition began on February 1, 2015 for the New York City counties of the Bronx, Kings, New York, Queens and Richmond.

- Transition began on April 1, 2015 for Nassau, Suffolk and Westchester counties.

- Transition for Rest of State began on July 1, 2015.

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 Population

- All eligible recipients age 21 and older in need of Long Term/Permanent Placement will be required to enroll in MMCP or MLTC.
- Current custodial care beneficiaries in a skilled nursing facility prior to July 1, 2015 will remain FFS and will not be required to enroll in a plan.
- Long Term NH care is presently a benefit for enrollees of MLTC.

Transition Policy

- All eligible recipients age 21 and older in need of Long Term/Custodial Placement will be required to enroll in MMCP or MLTC.
- Existing MMCP enrollees will NOT be dis-enrolled if they require long term custodial placement.
- 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 NH 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.

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 Hospitalizations – reimbursed at 50% of the Medicaid FFS rate.
  - Professional Therapeutic – 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 is being revised to include an indication of bed hold (DOH-5182).

Reserved Beds - Bed Holds

- The NH is responsible for notifying the plan that an enrollee was transferred to a hospital and to which hospital the enrollee was transferred.
- Prior authorization is not required if an enrollee is transferred from a NH for:
  - emergency services at any hospital
  - services at a network hospital
- Prior authorization is required if seeking to transfer an enrollee to a non-network hospital due to un-availability of a network hospital or member's clinical needs cannot be met by a network hospital.
- If plan not available to authorize on non-business day, the MCO is required to cover urgent hospital services provided and applicable bed holds while authorization is pending.

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 revised LDSS-3559 (DOH-5182) 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.
- The process currently in place at the NH for compiling required documentation and submitting the application should be used for eligibility determination.
- Once a complete 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 consumers who are otherwise eligible and are not subject to a transfer penalty.

Eligibility Determination

- For consumers 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. The NAMI amount for this MAGI population is zero.

- 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

- 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.
- 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.
- MCO is responsible for collecting any NAMI but may delegate this function to the nursing home.

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 and the consumer 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.

Net Available Monthly Income (NAMI)

- Consumers may not be disenrolled for non-payment of NAMI.
- NAMI collection arrangements are based on the contract between the plan and the Nursing Home.
- When a Nursing Home is the NAMI collector they would not need to reimburse the plan or the State for the NAMI amount; unless other arrangements are reflected in their contract.

Restriction/Exception Codes

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.
- These R/E codes will appear on plan rosters.
- ePACES will also reflect this information.
- R/E codes will also drive MMC premium rate payment.
- N7 is entered once the eligibility determination is complete, and any penalty period has lapsed to begin the outreach and enrollment process.

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

			Managed Care Program		
R/E Code		Description	MMC	HIV/SNP	MLTC
N1		Regular SNF Rate - MC Enrollee	X	X	
N2		SNF AIDS - MC Enrollee	X	X	
N3		SNF Neuro-Behavioral - MC Enrollee	X	X	
N4		SNF Traumatic Brain Injury-MC Enrollee	X	X	
N5		SNF Ventilator Dependent - MC Enrollee	X	X	
N6		Any MLTC enrollee			X
N7		NH Budgeting Approved- Awaiting M/C Enrollment	X		X

MCO Rosters

- NH MCO Roster Report will appear on the HCS/report id;
- Upstate mnhummdd and Downstate mnhnmmdd
- 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

Plan Selection and Enrollment:
Enrollment Broker Counties

- After transition date, consumers 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 consumers with education and plan selection.
- Consumer 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 consumers.
- If an enrollee 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.

Plan Selection and Enrollment:
Non Enrollment Broker Counties

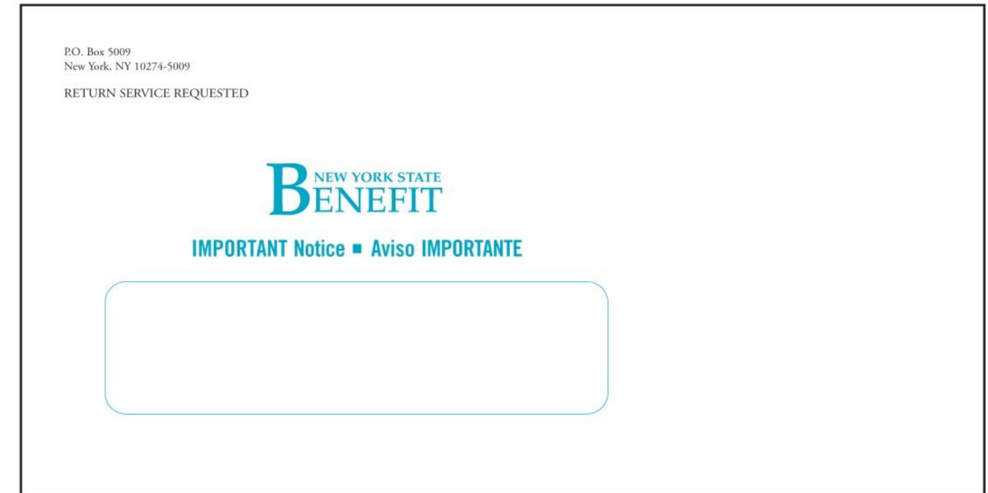
- After transition date, consumers residing in a nursing home who are newly determined eligible for long term placement have 60 days to select a plan for enrollment.
- Local district is responsible for providing consumers with education and assisting with plan selection.
- Local district is responsible for identifying the plans contracting with each nursing home as part of the assistance provided to consumers.
- If a plan is not selected within 60 days, the LDSS is responsible for assigning an appropriate plan for enrollment.
- Lock in rules will not apply to these consumers.
- If a enrollee wishes to transfer to another nursing home not contracting with his or her current plan, the LDSS is responsible for appropriately effectuating that transfer.

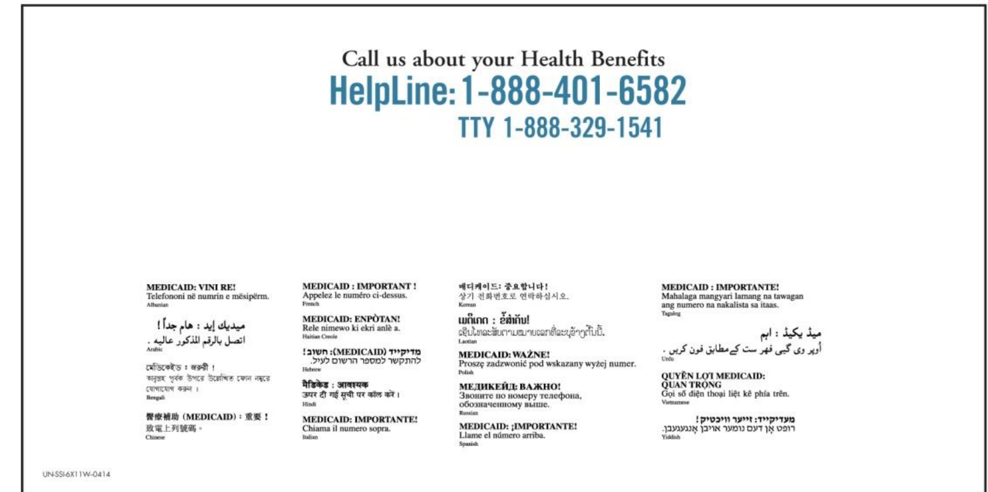
Mandatory Packet

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

Applies to enrollment broker counties

Note: Mandatory packet must be available in English, Spanish, Chinese and Russian as appropriate





Mandatory Enrollment Outreach:
Non-Enrollment Broker Counties

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

- LDSS is responsible for contacting consumers by phone throughout the mailing process

Mandatory Enrollment Outreach:
Enrollment Broker Counties

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

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

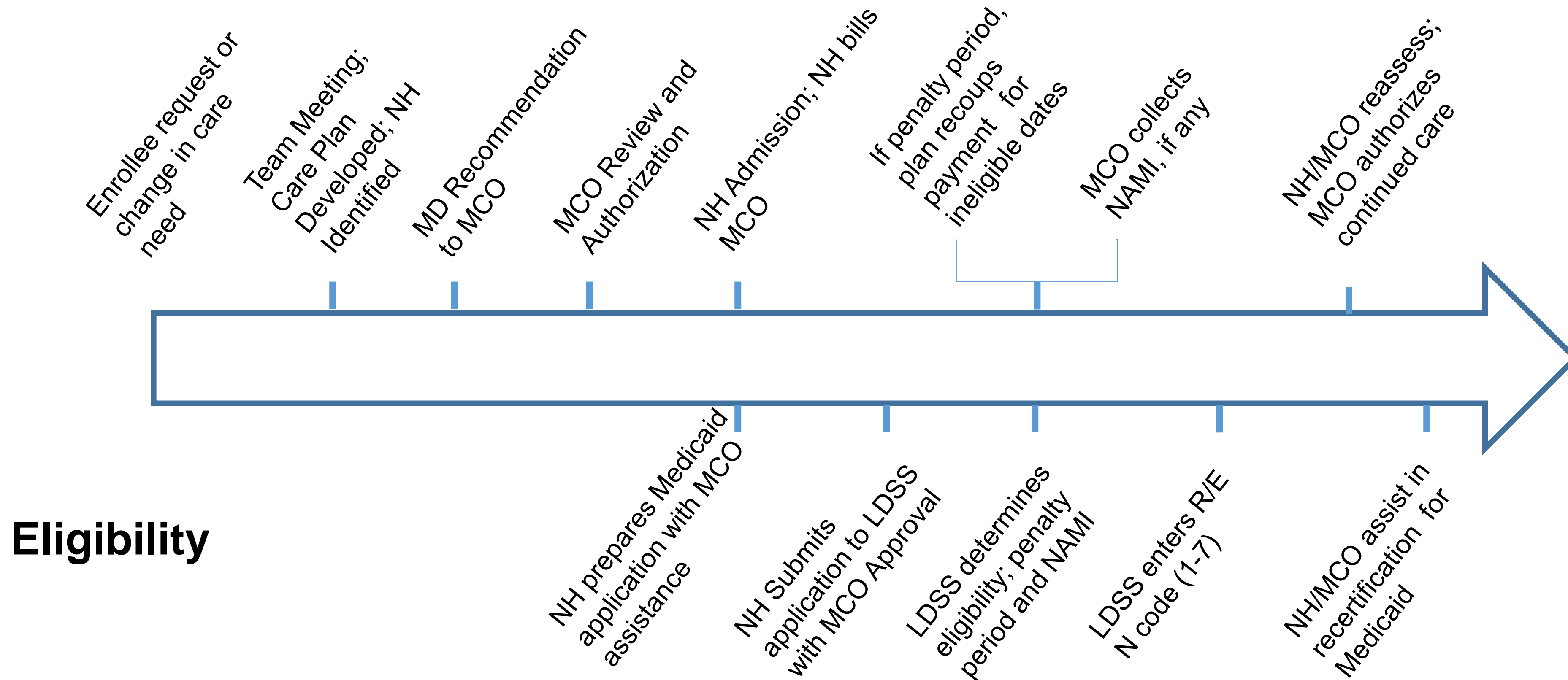
Consumer Representation

- **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

Timeline of Eligibility and Placement

Example for Current MMC Enrollee



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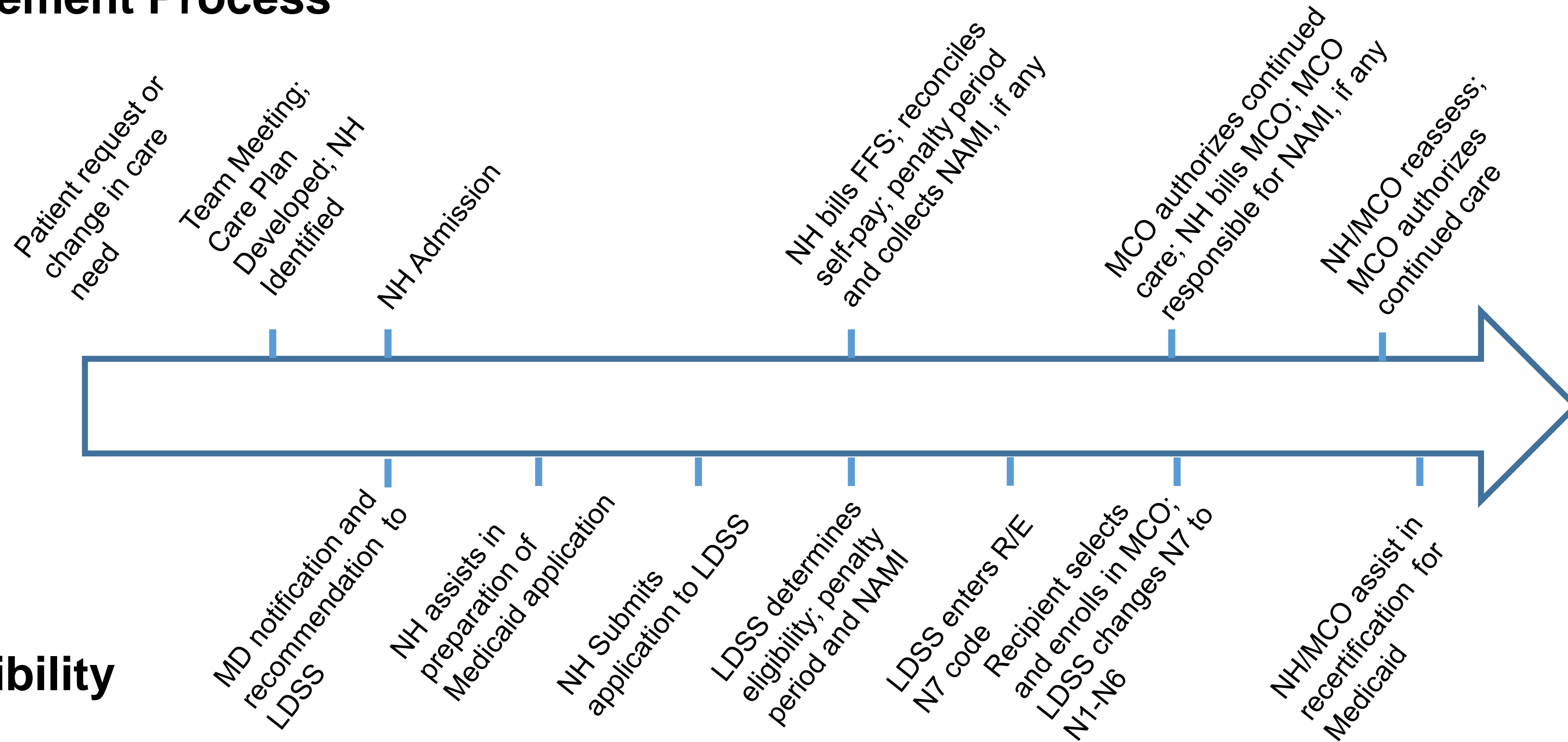
Timeline of Eligibility and Placement

Example for Individual Not Currently Enrolled



Network and Contracting

Plan Network Requirements

- Specialty Nursing Homes
  - A Plan's network must have 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 services.
- 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 services.

Plan 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.

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 of only one NH in the county)

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”
- In the event a contract is terminated, for reasons other than imminent harm or fraud and abuse:
  - The provider must be given due process rights, including the right to appeal a contract termination
  - The MCO may not require members to transfer to a participating NH

Provider Contracting

- 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/hmopia/docs/guidelines.pdf

Credentialing

- MCOs are required to credential all providers participating in the plan network.
- Nursing homes are required to credential, or decline to credential, any physician wishing to practice medicine in the nursing home.
- Enrollees may retain their PCP in the community after transitioning from the community into a NH.
- A PCP who is not credentialed by the NH may not practice in the NH.
- Plan 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.

Access to Care and Transitions

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 providers.

Transitions: Hospital to Nursing Home

- MCO Role (continued):
  - Assists in compiling documentation for authorization
  - 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 assessment 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.

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Transitions: Community to Nursing Home

- MCO Role:
  - Provides NH plan liaison
  - Member of care planning team, ensure:
    - 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.

Appeals/Fair Hearings

- 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 hearings
- 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

  - 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

Patient Care after Placement

- 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
  - 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.

Authorization 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 State/MCO contract requirements
- Enrollee internal appeal, external appeal, fair hearing and complaint rights apply.

Finance and Reimbursement

Benchmark Rates

- The benchmark rate will include all aspects of the Nursing Home 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.

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 the 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.

Billing/Cash Flow

- 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

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/benefits
    - Scenario 1 – NH does cover physician benefits (in benchmark), Plan pays NH as part of the 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 not 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

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, Plan 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 alternative 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 Nursing 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

- 15 ADM-01 available online

available at http://www.health.ny.gov/health_care/medicaid/redesign/mrt_1458.htm:

- NH Policy Paper
- Frequently Asked Questions
- Today's (7/29/15) Power Point Presentation
- Questions - MRTupdates@health.ny.gov

Scenario 1 – Current Enrollee Prior to 7/1/15

Example:

1/31/ 2015

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

6/1/2015

- ✓ 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 7/1/15

Example:

7/1/2015

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

9/1/2015

- ✓ LDSS completes long term eligibility determination, enters results of determination and RE code (N1-N6) into SDOH systems
- ✓ Notices are sent to MCO and NH
- ✓ Roster is sent to MCO, including date of eligibility and NAMI
- ✓ LDSS must notify MCO of any change in NAMI

Scenario 3 – New Enrollee Post 7/1/15

Example:

7/1/2015

- ✓ Permanent placement is recommended by NH
- ✓ NH transmits LDSS-3559 to LDSS
- ✓ LDSS enters RE code 90 into SDOH systems in order to prevent auto assignment during eligibility determination

9/1/2015

- ✓ LDSS completes long term eligibility determination, enters results of determination and RE code (N-7) into SDOH systems
- ✓ Notices are sent to NH
- ✓ Consumer selects MMCP or MLTCP for enrollment within 60 days or is auto assigned to a plan contracting with the nursing home

11/1/2015

- ✓ Effective date of plan enrollment
- ✓ Roster is sent to MCO, including associated NAMI, if applicable
- ✓ LDSS must notify MCO of any change in NAMI

Scenario 3 – New Enrollee Post 7/1/15

Example:

7/1/2015

- ✓ Permanent placement is recommended by NH; NH transmits LDSS-3559 to LDSS
- ✓ LDSS enters RE code 90 into SDOH systems to prevent auto assignment during eligibility determination

9/1/2015

- ✓ LDSS completes long term eligibility determination, enters results of determination and RE code (N-7) into SDOH systems
- ✓ Notices are sent to NH
- ✓ Consumer selects MMCP or MLTCP for enrollment within 60 days or is auto assigned to a plan contracting with the nursing home

11/1/2015

- ✓ Effective date of plan enrollment
- ✓ Roster is sent to MCO, including associated NAMI, if applicable
- ✓ LDSS must notify MCO of any change in NAMI
- ✓ Once enrollment occurs, LDSS end dates N7;
- ✓ Enter RE code N1-N6 as appropriate; Transaction Date = Managed Care enrollment date.