

## Coding and Editing Requirements

### MCO Enrollment

Enrollment in an MCO is based on the following criteria:

- Residing County
- Eligible for MA, NMED, or MCRE
- Eligibility Type
- Gender
- Living Arrangement
- Medicare Coverage
- Age

Enrollment in an MCO depends upon accurate and timely entry on the MMIS RPPH screen.

For MA and NMED:

- Enrollment is person specific, not case specific
- RTRK must be coded for each person who needs to be tracked for enrollment
- Exclusion reason is entered for the current month
- New enrollment spans are entered for the next available month (unless newborn or reinstate)
- Enrollment information is entered on REFM and RPPH for each individual
- Future MCO spans may be deleted if MCO payment has not been made; last cap pay date will be 99/99
- Retroactive enrollment or disenrollment is not allowed unless an exception is approved by DHS and the MCO (please see adjustments)
- Payment to the MCO is on a monthly basis
- Enrollment cut-off is eight working days prior to the end of the month
- Enrollment after cutoff is coded for next available month

For MinnesotaCare:

- Coding is case based; RCHP screen shows enrollment information
- Enrollment for MinnesotaCare may be keyed until the last day of the month for MCO enrollment the following month
- MinnesotaCare enrollments are entered by DHS in a nightly batch process

### Initial PMAP Enrollment

Before eligibility is opened:

- Enrollment information can be keyed on RTRK
- If client already completed an enrollment form enter selected MCO and enrollment questions on bottom half of screen

Once eligibility is opened:

- Enter MCO enrollment or exclusion on RPPH
- Enrollments are keyed for the next available month meeting managed care cutoff (8 working days from the end of the month)
- Exclusions are keyed beginning the first day of the current month
- If no current enrollment/exclusion span on RPPH direct navigate to RENR
- Enter MCO contract number or exclusion code
- Transmit, MMIS navigates to RPPH and creates enrollment/exclusion span for next available month
- Review the data created on RPPH

- Transmit. MMIS will navigate to REFM
- Update REFM with the information from the Managed Health Care Enrollment Form
- Note: Do not use RENR to code newborn enrollment. Navigate to RPPH and enter enrollment span beginning the first day of the birth month. Remember to verify mom's enrollment before adding the newborn to managed care. Transmit to REFM and change the Y on the "form received" to an N. This will allow you to save the enrollment without completing this screen.

### Reenrollment

Managed care reenrollment is automated based on policy. Non-excluded clients will automatically reenroll in their MCO for the next available month when eligibility is reopened. If eligibility has been closed for more than 12 months, the client should be re-educated and allowed to choose a new MCO.

### MCO Codes

Enter a valid MCO nine-digit NPI number or exclusion code for each individual.

MCOs with a contract for service in the county of residence will be accepted by the system. If an MCO is entered and is not available in the residing county, the system will not accept the enrollment span and will place YY 'pending enrollment' span on RPPH.

The NPI Numbers for the MCOs are listed below:

<b>NPI Number</b>	<b>MCO</b>
A0658138 00	Blue Plus
A5857139 00	HealthPartners
A836618200	Hennepin Health
A1060139 00	Itasca Medical Care
A4057139 00	Medica
A1551183 00	PrimeWest Health System
A0137073 00	South Country Health Alliance
A5658136 00	UCare Minnesota
A168407400	United Healthcare

### MMIS Case Notes

MMIS Case Notes are entered by the worker regarding MCO information in order to track the following MCO changes:

- Initial MCO enrollment
- Multiple exclusion reasons
- Adjustment requests
- Changing MCOs
- Inpatient hospital information
- Managed care State fair hearing information

To enter an MMIS case note:

1. Enter MMIS in the "c" change mode
2. Place cursor under the case number
3. PF4 to display previous case notes
4. PF11 to enter your case note
5. PF3 to save and exit

MMIS Case Notes are entered by DHS staff:

- The county adjustment request has been modified or denied
- Newborn requests

- Inpatient adjustment requests
- Unable to complete adjustment request due to system problem
- Appeal pending/resolution
- Other situations as needed

### **MMIS Managed Care Panels**

Following are brief descriptions of the MMIS panels used to code managed care information. Please see MMIS Manual for more detailed information.

#### **MMIS Managed Care Panels – RCHP**

The RCHP panel is used primarily by MinnesotaCare staff. It is used to record managed care enrollment information. MinnesotaCare managed care enrollment is case based. The PMAP case default MCO can also be viewed on this screen. In July 2001 the appearance of the RCHP screen was changed to allow viewing of previous default MCOs online.

#### **MMIS Managed Care Panels – REFM**

REFM is completed when a selected MCO has been entered on RPPH. REFM records the client's clinic choice and responses to the managed care enrollment form questions which are sent to the MCOs electronically. The "Date Sent" field indicates when the information was sent to the MCO. Note: If the enrollee wants to change their clinic choice, refer them to the MCO.

#### **MMIS Managed Care Panels – RENR**

In managed care counties, RENR may be used to build an enrollment or exclusion span on RPPH when the client is not already enrolled or excluded. Changes to enrollment/exclusion information must be completed on RPPH. Direct navigation to RENR must be requested. Enter the MCO's NPI number or an exclusion reason code and transmit. MMIS will build a managed care enrollment span for the next available month, based on cut-off, or the exclusion code for the current month. The user is then taken to the RPPH screen to view and verify the enrollment or exclusion span that the system created from the information coded on RENR. Once the worker transmits from RENR they are unable to return as RENR does not store any information, it is retained on RPPH.

#### **MMIS Managed Care Panels – RPPH**

The RPPH panel is used to record managed care enrollment and exclusion. Exclusions begin the first of the current month. Enrollments must observe cut-off deadlines.

#### **MMIS Managed Care Panels – RTRK**

The tracking panel records the type of managed care education the client receives, generates notices, creates enrollment spans, and generates reports. RTRK can only be updated using the recipient path. RTRK should be updated for ALL recipients on the same case at the same time. This panel can be used to record the MCO choice and enrollment form information if keyed prior to eligibility being opened. This panel also reflects the number of processing days the recipient has been in the tracking process listed by the counter number. The educational codes are as follows:

- |                         |   |
|-------------------------|---|
| <b>M (Mailout)</b>      | a one day tracking letter will print at the county the next working day. This letter must be mailed to the recipient with an education packet informing them about their choice of MCO's and how to choose and use health plan services.  |
| <b>P (Presentation)</b> | no tracking letter will print; however, the system clock will be activated. Once the counter reaches 30, an enrollment span will be created using the default for next available month. Only use this code if you have discussed the managed care process with the recipient in office and have provided the education materials. |

- C (Phone Call)** Use this code if the recipient has obtained education materials and you have discussed enrollment options by phone.
- O (System Entered)** DHS runs a monthly tracking program to initiate the enrollment process for recipients not tracked by the county worker. A one-day letter will print at the county which must be mailed to the recipient with the packet.

### Additions to Open Cases

When adding an individual to an active MA managed care case, determine if they meet an exclusion reason. If not, enroll them in the same MCO as the rest of the family. The enrollment begin date must be effective for the next available month. Code the RPPH panel with either an exclusion reason or MCO enrollment. If an individual is added to an active MinnesotaCare managed care case, the individual will be systematically enrolled in the same MCO as other family members.

### MMIS Managed Care Edits

Following are managed care edits that may be received online if inaccurate information has been keyed in MMIS. The informational message details the managed care policy that will not allow the change. Note: This list is not all inclusive. If you receive a managed care edit and need assistance, contact a DHS managed care enrollment coordinator.

Error Message	Definition
The Begin Date must be the Beginning of the Next Available Month.	The begin date of a new enrollment span on RPPH must be the first day of the next available month. If entering span before cut-off, enter the first day of the next month. If the span is entered after cut-off, the begin date will be the next month plus one.
Cannot NAVIG- Cursor must be on a Key Fld: Contract, Prod ID OR Last-Cap DT	To PF4 to PPHP contract information, the cursor must be under the contract or product ID number.
Change Reason IN Only Allowed First Time Recipient Is Enrolled	Received if an enrollment span is already coded on RPPH as IN and another enrollment span is added with IN. Use RE code.
Change Reason of NT Can Not Be Used After 90 Days of HP Enrollment	The previous health plan enrollment span begin date is more than 90 day from the current date. The system counts 90 calendar days.
Change Reason of NT can only be used when health plan will change.	The previous contract number is the same as the added span or the enrollment span is over 90 days old.
Contract number not found.	An invalid contract number has been entered on RPPH. Enter appropriate contract number: A0658138 00 Blue Plus A5857139 00 HealthPartners A8366182 00 Hennepin Health A1060139 00 Itasca Medical Care A4057139 00 Medica A9657134 00 Metropolitan Health Plan A1551183 00 PrimeWest Health System A0137073 00 South Country Health Alliance A5658136 00 UCare Minnesota
Date Range Conflict between two or more items.	Begin and end dates overlap between multiple spans on RPPH or RLVA.
Date Range Conflict between enrollment	An exclusion span and enrollment span overlap.

and exclusion dates.	Close one span before opening another. OR If MinnesotaCare is active, contact Enrollment Coordinator or MinnesotaCare.
Disenrollment Reason does not meet policy. Contact Enrollment Coordinator.	An end date is entered on an enrollment span and the disenrollment reason entered does not follow managed care disenrollment policy.
Disenrollment Reason must be entered when PPHP has ended.	An end date is entered on the enrollment span but the disenrollment reason is blank, OR A disenrollment reason is entered without an end date on the enrollment span.
DT disenrollment reason can only be used when there is a date of death.	Disenrollment reason is DT and the recipient does not have date of death on RCIP. Workers do not need to update RPPH when a recipient has died. The system will update at capitation.
An eligibility type inclusion conflict exists.	If the recipient is on MinnesotaCare and changing to MA, contact the MMIS help desk.
End date must be equal or greater than the last day of the cap payment date.	An end date was entered on RPPH that was earlier than the last cap payment date.
Enrollment end date cannot be prior to begin date.	Begin and end dates on the RPPH enrollment span are the same. The span can be deleted if the last cap payment date is 99/99. If there is a Last Cap Payment date, contact the Enrollment Coordinator.
Entry of new PPHP span not allowed. Reopen closed PPHP span.	The enrollment span is ended for the last day of the current month and a new span is created for the first of the next month for the same MCO and product. Reopen elig and PF9.
Exclusion end date can't be prior to begin date.	The end date of the exclusion is after the begin date.
Exclusion end date must be the last day of the month.	Exclusion end date on RPPH is not the last day of the month.
First year change option can only be used once.	Recipient has already used their first year change option and another FY is entered as a change reason on RPPH.
First year change option invalid after initial year.	First date of enrollment into managed care is more than 12 months prior to the current date. Enter the appropriate change reason. FY changes must be keyed by the 11th month.
Invalid read on MCC file.	Contact Enrollment Coordinator.
Last cap payment date must be covered by a proper eligibility span.	The Last Cap Payment date on RPPH does not have a matching eligibility span on RELG.
A living arrangement inclusion conflict exists.	The contract number on RPPH does not cover the living arrangement on RLVA. Check RLVA for appropriate code, if correct, exclude recipient with proper exclusion code.
MV change reason is not allowed. Past 60 days.	Change reason MV cannot be used if the effective date of the county of residence is more than 60 days old. The system counts calendar days.
MV disenrollment reason is not allowed. Past 60 days.	The disenrollment reason MV cannot be used if the effective date of the county of residence is more than 60 days old.

No corresponding eligibility span for PPHP was found.	The enrollment span entered on RPPH does not have a matching eligibility span on RELG.
On a reinstatement, the begin date must be next month.	An enrollment span on RPPH has the same contract number as the previous month. Remove the end date from the previous enrollment span.
PCA LL is no longer excluded for managed care effective 12/31/95.	Recipients who receive PCA services can no longer be excluded from managed care. Enter an appropriate exclusion reason or an enrollment span.
PPHP span(s) are not present	Managed care enrollment spans must be entered on RPPH before REFM is updated.
(Product )(date) price err- excp/key= _____	Recipient does not fit into a rate cell for the current month plus one. Review rate cell criteria: <ul style="list-style-type: none"> <li>- Age – Medicare Status</li> <li>- County of Residence – Program</li> <li>- Eligibility Type – Spenddown Type</li> <li>- Living Arrangement</li> </ul>
Product does not allow spenddown.	Recipient has a spenddown but the product they are enrolled in does not allow a spenddown.
Product has institutional spenddown/Recipient has medical spenddown.	Recipient is enrolled in a MCO and has an open medical spenddown. Review spenddown information and exclude recipient with SS on RPPH.
Recipient liv arrange not included on product.	The recipient is enrolled in a product that does not cover this living arrangement. Review RLVA for appropriate living arrangement, if correct, exclude with proper exclusion code.
Recipient does not meet the (exclusion code) exclusion requirements.	Recipient does not meet this exclusion requirement. Review policy and determine correct exclusion code or begin managed care enrollment. <ul style="list-style-type: none"> <li>• BB Under 65 &amp; Blind or Disabled - Eligibility types BT, BX, DC, DI, DP, DT, DX, 15 &amp;16</li> <li>• QQ QMB/SLMB/QWD/QI - Major program on RELG must be QM, SL or WD with no active major program MA</li> <li>• SS Spenddown - RSPD must have a current medical spenddown span.</li> <li>• ZZ RTC/IMD - Major program must be IM OR the living arrangement on RLVA must be 47, 49,50, 52, 53, 54,78 or 57</li> </ul>
Recipient has been pending for 90 day – enroll, exclude or complete RTRK screen.	Recipient has been excluded from managed care enrollment with exclusion code YY for 90 days or more. An enrollment span or a new exclusion span must be entered on RPPH.
Recipient must be blind or disabled to use this exclusion code.	Recipient must be under age 65 and the eligibility type on RELG must be BT, BX, DC, DI, DP, DT, DX, 15, or 16. Recipients over the age of 65 must enroll in managed care unless they meet an exclusion other than disabled.  If the recipient is under age 65 & certified disabled by SSA or SMRT but is open on a different basis of eligibility they may choose to be excluded from

	managed care. Use a UU exclusion code on MMIS and enter a STAT/DISA panel on MAXIS. This use of UU may exceed 90 days.
Recipient must have TPL to have this exclusion code.	TPL information must be recorded on RPOL to use the HH exclusion.
Warning: active MinnesotaCare case PPHP exclusion not valid.	An exclusion span on RPPH overlaps MinnesotaCare eligibility span on RELG.
Warning: change in waiver obligation elig, contact county case mgr.	MMIS/RWVR reflects a change in the recipient's waiver obligation. Contact the county case manager regarding the change.
Warning: PCUR spans cannot overlap PPHP spans.	This is a warning edit. Enter past it. Previously recipients reflecting a restricted ID span could not be enrolled in managed care. No longer applicable.
Warning: price err-excp/key.	Recipient does not fit into a rate cell for current month plus two. This is a warning edit. Review rate cell criteria.
Warning: recipient has been pending for 30 days.	Warning edit indicates that the recipient has been excluded from managed care with exclusion code YY for 30 days or more.
Warning: recipient may volunteer to enroll into a health plan.	Warning edit indicates that recipient with exclusion codes AA, EE, and HH and may voluntarily enroll in managed care. These recipients should receive education materials with their options.
Warning: review YY/WW excl recip meets reenrollment criteria.	This recipient should be reenrolled in managed care or excluded with the correct exclusion code.
Warning: RTRK selected health plan is not equal to reenrollment PPHP span.	Eligibility has been reopened and the selected MCO on RTRK is not the same as the previous MCO on RPPH. The automatic reenrollment process will enter the MCO from the previous managed care span. A different MCO may be entered if a change option is available to the recipient at this time. Contact your managed care enrollment coordinator if the MCO cannot remain the same for this reenrollment.
Warning: system will reassign PPHP product to _____.	This is an informational edit informing the worker the system will create a new enrollment span due to a major program change. <b>Note:</b> Any information previously entered on REFM will be lost and needs to be reentered.

### Case Transfers

Do not update RPPH before transferring cases on SPEC/XFER in MAXIS.

If the MCO is available in the new county of residence, the enrollment span on RPPH remains open and there will be one continuous span for both counties.

If the enrollee requests a change in MCOs when moving to another county, the change is allowed due to MV. When the MCO is not available in the new county, the system will close the enrollment span on RPPH at the next capitation. The new county should begin the mail out process. In PMAP counties, enrollees are reported on the county's Potential Enrollee Report and the Capitation Error Report with the error message, "(product) (date), 001- health plan/product not available in county of

residence", every effort should be made to avoid a gap in managed care coverage. If this is not possible, fee-for-service will cover intervening months as long as there is medical eligibility.

### **Adding a Newborn to an Open MA Case**

Eligibility begins on the first day of the month of birth and continues until the end of the month of the first birthday (age 1) without regard to income or assets if the following conditions are met:

- The child is born to a woman who applied before or after the end of her pregnancy and received MA for the month of birth, and
- The child lives with the mother in Minnesota. Consider the child to live with the mother through the 60-day postpartum period even if the child remains in the hospital after the woman's discharge. If the child leaves the hospital but lives apart from both parents for more than one full calendar month, re-determine the child's eligibility using only the child's income, starting with the first full calendar month apart.

### **Note:**

If a mother legally relinquishes control of the child before the child leaves the hospital, consider the child to be out of the mother's household starting with the first full calendar month for which you can give 10-day notice after papers are signed giving custody and control of the child to an agency or person other than the mother. This could be a pre-adoptive placement or foster home placement of any duration.

All children born to a woman on MA are eligible to be added to the mother's case as an auto newborn for the month of birth, including children who are placed for adoption immediately. If the mother is enrolled in a managed care health plan during the birth month, enroll the newborn in the same health plan effective the 1st day of the month of birth, unless the newborn meets an exclusion. If a health plan change is requested allow the change for the next available month based on managed care cut-off.

Obtain the newborn child's name and birth date. For MA-only cases, do not require an addendum. Document the information in the case record. Also, do not require a name as a condition of adding a child for whom the mother has relinquished care or control.

If you are unable to contact the mother to determine if she wants continued MA for the newborn, add the child for the birth month only. Send a notice to add the child for the birth month and a notice to remove the child the following month. If the mother contacts the county later requesting continued coverage for the child, reinstate MA for the child back to the date of removal if the child has continued to live with the mother. Children added for the birth month only can be added without obtaining a name. The required information is gender and date of birth which can come from the MCO or DHS. Add the newborn as Baby boy or Baby girl adding the last name of the mother. If continued MA is later requested, update the name on Stat/Memb panel.

To add a newborn who is automatically eligible for Medical Assistance to a MAXIS case:

1. Update the STAT/HCRE panel for the newborn in the month of birth. Complete all necessary STAT panels.
2. Note: Enter an addendum date on STAT/HCRE even though policy does not require completing one. The addendum date sets the newborn's status to Pending. The status must be pending in order to approve MA eligibility.
3. Navigate to ELIG HC in the month the baby was born.
4. MAXIS should PASS the person tests for the newborn and enter ELIG TYPE 11 (Automatic Newborn) and standard X for the budget period.
5. Approve correct health care eligibility results on ELIG/H CPR.

- A. Periodic Processing will send a DAIL message at the end of the mother's 60-day postpartum period to redetermine eligibility (as long as the worker has updated STAT/PREG with the newborn DOB).
- B. Periodic Processing will send a DAIL message at the end of the automatic newborn eligibility period to remind the worker to send a review form to redetermine eligibility for the child. Note: MAXIS does not mail review forms for either of these redeterminations.

If eligibility for the newborn is added within 90 days from the birth, the newborn should be retroactively enrolled in the MCO for the birth month and all succeeding months unless a MCO change is requested.

If the newborn is added to the case after 90 days from the birth, an adjustment to pay the MCO for birth month must be requested. Add the newborn to the same MCO for the next available month based on managed care cut-off, unless a MCO change is requested. There will be a break in MCO enrollment, covered by fee-for-service, between the birth month and the next available month.

If a MCO change is requested for the child, allow the change.

If the mother was not in a MCO at the time of the child's birth, the newborn must be added to the MCO for the next available month or tracked for enrollment if no other household members are enrolled.

MinnesotaCare newborns follow the above policy, however since MCO enrollment is case based for MinnesotaCare, no change option is available unless the case has a change option available.

### **Transitional Medical Assistance / Transition Year Medical Assistance**

Enrollees who become eligible for transitional medical assistance (TMA) or transition year medical assistance (TYMA) must continue to be enrolled in a PMHCP MCO. When an enrollee is changing eligibility status due to TMA/TYMA and MCO coverage exists, no change in coding is required until the case closes. When the case closes, the system (auto-close) will enter the MCO end date on RPPH and a disenrollment notice will be sent. These cases will appear on the county Capitation Error Report.

### **State Paid Medical Assistance (Major Program NM)**

Federal law changes in 1996 have resulted in some non-citizens losing eligibility for MA with federal financial participation (FFP). To provide a safety net for these people, the 1997 Minnesota Legislature created major program "NM", which provides MA benefits paid for by state dollars.

Clients eligible for medical benefits through program "NM" must be enrolled in a PMHCP MCO. Code MCO enrollment for persons eligible under this program the same as MA enrollees.

### **Hospitalization at Time of Enrollment**

The contracts between the MCOs and the Department provide for liability for hospital stays.

Enrollment policies for enrollees who are in an inpatient status in an acute care facility (hospital) during an enrollment change are as follows:

- MA/NMED enrollees who are on fee-for-service and are in the hospital (inpatient status) on the initial effective date of PMAP, the MCO enrollment will not become effective in the MCO until the first of the month following discharge. The Department will pay claims incurred on a fee-for-service basis for that month(s). An inpatient adjustment to recover the initial month must be requested, either thru the MCO or by the county via MADJ.
- For MSHO enrollees who are hospitalized in an acute care facility on the initial effective date of coverage, the initial effective date remains the same. Hospital costs for the stay before enrollment

shall not be the responsibility of the MCO. The MCO will assume responsibility for medical services effective midnight the date of discharge.

- MinnesotaCare enrollees who are in the hospital on the date of initial MCO enrollment will be MnCare eligible and effective midnight the date of discharge from the hospital. Capitation will not be recovered from the MCO for the month of initial enrollment.
- PMHCP enrollees who are in the hospital (inpatient status) on the effective date of their enrollment into a different MCO will remain in the "old" MCO and become effective in the new MCO the first of the month after discharge from the hospital. The MCO in effect at the time of the hospital admission is liable for the client's charges through the month of discharge.
- PMAP or MSHO enrollees who are in the hospital (inpatient status) on the effective date of fee-for-service coverage (contract termination, basis of eligibility change) will remain covered by the MCO through discharge. Fee-for-service coverage will become effective upon discharge from the hospital.