

**** Note these questions and responses are specific for the CSHCS/Medicaid population which will be transitioning from Fee-for-Service to Managed Care. These responses are not applicable for the CSHCS only (Title V only) population.**

Why are we doing this?

W-1: Why do we need to do this now? Why is this changing now? How can adding one more layer of administration help to reduce cost? Is this in the best interest of our clients?

The State of Michigan has decided that the benefits in terms of health care quality and access as well as health care cost savings warrant this transition to managed care. Medicaid managed care has a track record of delivering high quality care and containing health care costs. MDCH and CSHCS looked at more than 15 years of experience and data for Medicaid beneficiaries in Medicaid health plans. This data shows that being in a managed care plan helps improve the health status of the enrollees. In addition, the rates that the MHPs will receive have been calculated to provide high quality services with cost savings. It should also be noted that many families have declined enrollment in CSHCS in order to remain in an MHP.

Benefits of enrolling in an MHP include:

- better access to all health care services
- help making arrangements for all medical care including specialty, primary, and all other covered services
- help finding a PCP for their child if they don't already have a PCP
- better access to transportation assistance
- access to outpatient mental health services

Local Health Department Funding:

F-1: How will funding for CC/CM be affected?

For FY13, funding for CC/CM will not be affected. LHDs will continue to bill MDCH for CC/CM services

F-2: What needs to be done to ensure that LHD Care Coordination is carved out from the MHP?

LHD Care Coordination will continue to be a CSHCS service provided outside of the MHP at least through FY 13.

Access to Medical Care and Treatment /Continuity of Care

A-1: Will I be able to stay with my current specialists?

Yes

A-2: What is the referral process for specialists?

The specialist referral process will be specific for each MHP. This question should be directed to the MHP.

A-3: What if all of the client's physicians are not in the MHP that s/he is enrolled?

CSHCS enrollees will be allowed to continue to see physician providers and facilities in which they have an existing relationship, regardless of whether the provider is in the MHP network. This is a contract requirement for the MHPs. Families should contact the MHP's member services department to let them know which providers the beneficiary sees.

A-4: What to do if the family can't get the referrals that they think the child needs?

Each MHP has an appeals process if the beneficiary believes the service was denied in error. MHPs are required to separately track CSHCS complaints, grievances and appeals and DCH will review these periodically. All family complaints, grievances or appeals should be immediately referred to the MHP Member Services staff following the instructions in the Member Handbook. CSHCS/Medicaid beneficiaries also may call the Beneficiary Helpline when they have questions or concerns.

A-5: Do I need a referral to see my specialist if they do not participate with my MHP?

It will be important to tell families to call their MHP in these situations. CSHCS enrollees will be allowed to continue to see physician providers and facilities in which they have an existing relationship, regardless of whether the provider is in the MHP network. This is a contract requirement for the MHPs. The MHP may choose to contract with the provider. Families should contact the MHP's member services department to let them know which providers the beneficiary sees.

A-6: Will MHP's recognize borderland providers as in-state like CSHCS?

CSHCS enrollees will be allowed to continue to see physician providers and facilities in which they have an existing relationship, regardless of whether the provider is in the MHP network. This is a contract requirement for the MHPs. Families should be advised to contact their MHP to discuss borderland providers.

A-7: What will happen re: continuity of care when the Pediatric Specialist is out of network and out of county?

CSHCS enrollees will be allowed to continue to see physician providers and facilities in which they have an existing relationship, regardless of whether the provider is in the MHP network. This is a contract requirement for the MHPs. Families should contact the MHP's member services department to let them know which providers the beneficiary sees.

A-8: I am from a very small community and there are not many HMO specialists that my CSHCS clients can go to. By making the CSHCS clients in my community it will limit who my CSHCS clients can go to. The care for our children will be jeopardized by having to choose an HMO. The only reason some of my children are enrolled in CSHCS is because they can get open Medicaid.

The transition to Medicaid Managed Care will only impact the CSHCS enrollees dually enrolled in Medicaid. MHPs will authorize out-of-network services when CSHCS beneficiaries have established relationships with physicians and facilities that are not listed in the MHP's provider network. MHPs will work to contract with specialists and other providers that see their members. MHPs have specialty networks already established outside of the county service area for members with special needs already in their plan. MHPs have experience with this and are actively seeking and negotiating contracts with CSHCS-utilized pediatric subspecialists with which they do not already contract.

A-9: What options will be available for patients whose primary provider doesn't accept the same MHP as the specialist/s?

MHPs will authorize out-of-network services when CSHCS beneficiaries have established relationships with physicians and facilities that are not listed in the MHP's provider network. MHPs will work to contract with specialists and other providers that see their members. MIEnrolls will work with the family to help them select the plan that best meets each family's needs, which may include which MHP contracts with their providers or the MHP in which other family members are enrolled. Families should contact the MHP's member services department to let them know which providers the beneficiary sees.

A-10: We have some concerns about keeping continuity of care until a child can be transitioned. This may mean that the child has to go 2 hours away once the MHP thinks they can safely transition the child to new providers instead of being able to go 45 minutes away to see a provider.

Continuity of care concerns have been prominent in every discussion regarding this transition, and the health plans have been equally concerned with assuring continuity of care. MHPs will authorize out-of-network services when CSHCS beneficiaries have established relationships with physicians and facilities that are not listed in the MHP's provider network. MHPs will work to contract with specialists and other providers that see their members. The CSHCS-specific contract language requires the MHP to consult with the family and the care team before transitioning to an in-network provider. Additionally, the MHPs are making every effort to contract with providers who are currently providing services to CSHCS enrollees. Families should contact the MHP's member services department to let them know which providers the beneficiary sees.

A-11: What will we do if the MHP for certain hospitals are not the ones we carry in rural Michigan...do people have to change their specialists?

MHPs will authorize out-of-network services when CSHCS beneficiaries have established relationships with physicians and facilities that are not listed in the MHP's provider network. MHPs will work to contract with specialists and other providers that see their members. Families should contact the MHP's member services department to let them know which providers the beneficiary sees.

A-12: Hearing that the UPHP clients are not being allowed to go out of state, will the MHPs be required to authorize out of state (OOS) care?

Yes, when appropriate.

A-13: Who decides which providers need to be in an MHP network?

MHPs establish their provider networks; however, MHPs need to demonstrate sufficient capacity within their provider network to serve their members. Additionally the MHP contract requires the network to include pediatric subspecialists, children's hospitals, pediatric regional centers, and ancillary providers that provide services to CSHCS enrollees.

A-14: What encourages specialists to be in all plans?

In order to improve coordination of care, MHPs are actively seeking to contract with CSHCS authorized providers. Many providers find contracting with health plans provides benefits in terms of prior authorization, communication and in some instances reimbursement rates.

A-15: What is the process for a second opinion if in MHP?

This is specific for each MHP.

A-16: How do families know who is in network for MHP?

The MHP provides this information to their members. Members can contact the MHP's Member Services Department.

A-17: What is process to continue with a provider not in the MHP network?

MHPs will authorize out-of-network services when CSHCS beneficiaries have established relationships with physicians and facilities that are not listed in the MHP's provider network. MHPs will work to contract with specialists and other providers that see their members. Members should work with their providers and the MHP's Member Services Department.

Local Health Department prepared Plans of Care can assist with this transition by providing current information on the client's authorized providers.

A-18: Is there an "exception from choosing" process for children needing many providers as there is with the adult transition to Medicaid folks?

There is a medical exception process for Medicaid beneficiaries in an active treatment protocol with a non-network provider at the time of enrollment. However, since MHPs are required to work with out of network providers for CSHCS enrollees, MDCH anticipates the medical exception process will be appropriate very infrequently.

Enrollment

E-1: Will those children who have private insurance in addition to Medicaid and CSHCS be exempt from having to choose a Medicaid health plan?

Private HMO/PPO insurance coverage will exclude beneficiaries from enrolling in a Medicaid health plan. When children have other types of health coverage, they are still required to join a MHP; the plan will coordinate benefits with the other insurance carrier.

All Medicaid and CSHCS beneficiaries must report to the Beneficiary Helpline or their DHS worker if they have other insurance coverage and when there is a change to that coverage. Medicaid is the payer of last resort and must coordinate benefits with other carriers. If Medicaid does not have current insurance information, beneficiaries may have problems obtaining needed services.

E-2: Are LHDs going to be receiving information/documentation from MHPs so when we receive calls regarding which one is "best", "Good" or you which do you suggest, we can give this information to our clients. How do we pick the best MHP for our location? How do I know which plan is best for my child? How do I choose an MHP?

Health Departments should not be steering or directing clients towards or away from any particular plan. Health Departments should instruct the client to call Michigan Enrolls.

Michigan Enrolls will have information to assist clients with the selection of an MHP. Clients will be provided information comparing the quality of the MHPs in their county of residence in the enrollment packet. Additionally, MIEnrolls will provide information on each MHP's provider network to assist the beneficiary in choosing the health plan that best fits with their current provider configuration. In addition, MIEnrolls can assist families that want to enroll their CSHCS child in the same MHP as other family members.

E-3: Will the families have the option to choose to dis-enroll and re-enroll from MHP's freely? Is the timeline going to be prorated up 45 days?

Members are encouraged to call their MHP's member services department if they have any problems or concerns with their plan or their providers. MHPs want to know when members have concerns or problems so they can address them. CSHCS / Medicaid beneficiaries also may call the Beneficiary Helpline when they have questions or concerns.

If, after talking with the MHP, a family decides another MHP may be a better fit for their child's care needs, the family has 90 days from the first day of their enrollment in an MHP to change to another MHP. For example, if the beneficiary's enrollment begins on May 1, the beneficiary has until July 31 to change plans. If a family changes MHPs, the enrollment in the new plan will be prospective (for the next available month). Until the new MHP enrollment takes effect, the current MHP is responsible for all covered services. Families also can change plans during their annual open enrollment period. Each family will receive a letter from Michigan ENROLLS letting them know that when their open enrollment period is.

E-4: Who will introduce CSHCS to "new" families? Ex; social workers in hospitals

Outreach and program promotion will continue to be a role of local health departments. Other mechanisms to introduce families to the program will continue to operate as well.

E-5: What is the incentive for families to join the CSHCS MHP vs regular MHP?

Families determined medically eligible for CSHCS and currently enrolled in a Medicaid Health Plan will be enrolled in CSHCS. Families will then have the additional CSHCS-only benefits.

E-6: Will MDCH CSHCS do eligibility?

CSHCS Medical Consultants will continue to determine medical eligibility for CSHCS.

E-7: Will the MHP send info for eligibility to MDCH when they find potentially eligible kids?

This happens currently and will continue.

E-8: Will kids already in MHP stay in same plan if eligible?

Yes. Families will be able to switch plans during their annual open enrollment period.

E-9: When determined eligible, what paperwork will the family receive from MDCH?

Discussions are currently taking place to determine communications for clients already enrolled in a Medicaid Health Plan and then determined eligible for CSHCS. Families will be informed of enrollment into CSHCS.

E-10: Please explain what counties have what plans as choice. Ex; if only one in county, do not have to choose, if two or more, must choose; length of time to choose MHP and what's the time frame in which plan must be chosen?

If there is only one plan available in the county, with the exception of the U.P., families will be enrolled in the available plan and will be given the opportunity to disenroll into FFS. . During the initial transition period in the fall of 2012, clients will have approximately 50 days to choose a Medicaid Health Plan. This is twice as long as the typical process. After the transition, CSHCS clients will have the same time frame to choose a plan as other MHP enrollees – up to 28 days.

E-11: Will every CSHCS client have a CEN, whether in MHP or not?

Yes

E-12: If the child is already in an MHP, and wants to join CSHCS, do they still do a CSHCS application?

A client enrolled in an MHP who becomes medically eligible for CSHCS will not need to complete a CSHCS application.

E-13: Will families receive an MHP and a CSHCS/MA card? Will I have a new card and provider list sent to me?

MHP member ID card - Yes. CSHCS / MA card (mihealth) – will be mailed to beneficiaries only when they are first determined eligible for CSHCS / MA. Provider list will be available through the MHP.

E-14: How often can a different MHP be chosen?

Families have 90 days from the effective date of their enrollment in an MHP to choose a different MHP. After this 90 day period, there is an annual open enrollment period at which time a different MHP can be selected.

E-15: Does every child that qualifies for CSHCS have to enroll in CSHCS?

Every child that is in a MHP and deemed medically eligible for CSHCS by MDCH will be enrolled in CSHCS. For CSHCS/MA beneficiaries who must enroll in an MHP, CSHCS is an added benefit.

E-16: Who do you call to get on CSHCS program now~will this stay unchanged?

Unchanged; contact the local health department or Family Phone Line.

E-17: Do I need to call my MHP to change my MHP or MI Enrolls?

The process for changing MHPs, either during open enrollment or during the first 90 days of enrollment is handled through MI Enrolls.

E-18: How do I know when I can change plans (after 90 days has passed)?

Families will receive a letter from MI Enrolls alerting them to the opportunity to change plans.

E-19: Who must choose an MHP?

All CSHCS/Medicaid beneficiaries that are not excluded from mandatory enrollment (e.g., private HMO coverage) must enroll in an MHP. Most CSHCS/Medicaid beneficiaries will need to choose an MHP. CSHCS/Medicaid beneficiaries in the U.P. that are not excluded from mandatory enrollment will be enrolled in the U.P. Health Plan. Those approved for PDN services will be excluded from enrolling in a Medicaid Health Plan, and existing voluntary populations (e.g. Native Americans, migrants, Medicare enrollees) will remain voluntary.

E-20: Can my other kids (non-CSHCS) switch now to the plan with my CSHCS enrolled child, or do they have to wait for open enrollment?

Other family members can change the MHP enrollment during their open enrollment period.

E-21: What will happen to 'CSHCS look-alikes' that are currently enrolled in a MHP that does not participate with CSHCS?

All MHPs will participate with CSHCS.

Role of Local Health Department

LHD-1: Will LHDs be assisting families with all the navigation?

LHDs are expected to coordinate with the MHPs when it comes to client care coordination and case management. This includes navigation; however accessing services through the MHP is the MHP's responsibility. If a beneficiary feels more comfortable contacting the LHD, the LHD should facilitate communication between the beneficiary and the MHP. Both entities should help the beneficiary in a coordinated manner to access all needed services.

LHD-2: What can the LHDs do to get ready?

Local Health Departments should be updating plans of care for the highest acuity clients, to assure a smooth transition into a Medicaid Health Plan. The plan of care will be invaluable toward efforts to coordinate services and benefits. Local Health Departments should anticipate increased caseloads and some evolution of roles for the 5/19 population, as we work through this transition to obtain all the benefits that managed care will bring to CSHCS/Medicaid clients.

LHD-3: For new enrollees in CSHCS, what will the role of the LHD be with regard to choosing a MHP?

LHDs should immediately refer clients to MIEnrolls to enroll in a Medicaid health plan. Michigan Enrolls will have the most current provider information to assist clients with the selection of an MHP that best meets their needs. Clients will be provided information on comparing the quality of the MHPs in their county of residence in the enrollment packet. Health Departments should not steer or direct clients towards or away from any particular plan.

Authorized Providers/Adding a Provider

Auth-1: Will MDCH CSHCS authorize providers at the start and create a CEN and then would the MHP authorize those providers when an MHP is chosen?

The MHP will be listed on the CEN as an authorized provider. Once enrolled in an MHP, the MHP's network of providers will be available for the enrollee without CSHCS authorization. In addition, MHPs will authorize out-of-network services when CSHCS beneficiaries have established relationships with physicians and facilities that are not listed in the MHP's provider network. MHPs will work to contract with specialists and other providers that see their members.

Auth-2: Who do I call to add a new provider?

Once enrolled in an MHP, CSHCS beneficiaries will be able to see in-network providers per the MHP referral policy. Families should contact the MHP's member services department to let them know which providers the beneficiary sees. Many MHPs do not require a referral in order to see a specialist. In order to see an out of network specialist, the CSHCS beneficiary will need to follow the MHP procedures for this. It will no longer be necessary to add authorized providers for the Medicaid/CSHCS clients enrolled in a MHP, although CSHCS will continue to add providers to the CSHCS database.

Auth-3: What should the LHD do if an enrollee approaches the LHD to have a provider added for CSHCS?

The LHD should work with the MHP to ensure that the new provider is in the MHP network. If not, the LHD and MHP should coordinate to find an appropriate in-network provider, unless the beneficiary has already established a relationship with the "new" provider. Then the LHD should add the provider following the current CSHCS process.

Benefits/Other Services

B-1: Will CSHCS covered services change when clients are enrolled in a Medicaid Health Plan?

No

B-2: Will the MHP cover dental care?

If dental care is not related to the qualifying CSHCS diagnosis, Medicaid covered dental services continue to be covered outside of the MHPs. CSHCS/Medicaid beneficiaries must go to a dentist that accepts Medicaid fee-for-service or for beneficiaries in the Healthy Kids Dental Program, a dentist that accepts Delta Dental.

B-3: Will MHP cover vision care?

All current Medicaid/CSHCS benefits will remain same, which includes coverage of vision services. As of 10/1/12, vision will again be a benefit for all Medicaid beneficiaries including those age 21 and older.

B-4: Who authorizes and follows up with out of state care (OOS)?

MHPs will authorize OOS for their members. CSHCS Medical Consultants will be available to assist MHPs with this determination.

B-5: How do clients access CMH services; thru MHP? How does that work? How do I access mental health services?

For individuals with mild to moderate mental illness, 20 outpatient mental health visits is a benefit available through the MHP. The beneficiary should follow the instructions in the Member Handbook for accessing these services. For individuals needing services for developmental

disability or serious mental illness, the beneficiary should contact the PIHP in their county of residence directly. In either case, the beneficiary may call the MHP member services for assistance.

B-6: Will MHPs be responsible for providing Respite Services for families? What if the services are not available?

Respite services will continue to be a CSHCS-only benefit. MHPs are expected to coordinate with CSHCS with regard to this benefit, in order to identify available services.

B-7: Will suppliers (in-state and out of state) for CF and Hemophilia be covered by MHPs? Some of them are out of state.

The covered benefits for CSHCS/Medicaid enrollees will remain the same. MHPs will have established relationships with DME and pharmacy suppliers. LHDs and families need to work with the MHP's member services department to obtain all covered services, equipment and supplies.

Benefits/Prior Authorization:

BPA-1: Sometimes when a person in a Medicaid Managed Care Plan gets enrolled in CSHCS they retroactively disenroll them from their plan which has caused issues as far as something already being prior approved by an MHP and then they take it back and have straight Medicaid yet CSHCS starts the first of the following month.

Beginning 8/1/12 as a result of this policy change, enrollment into CSHCS will not result in retroactive disenrollment from the MHP. Also as part of this policy change, retroactive enrollment in CSHCS will be possible. In addition, prior authorization policies and processes are being reviewed to minimize any disruptions in prior authorized care during this transition.

Benefits/Transportation/Travel

T-1: Will transportation be covered by MHP for regular dental and vision?

Transportation will be covered by the MHP for MHP covered benefits. If the dental care is not related to the qualifying CSHCS diagnosis, and therefore is not covered by the MHP, transportation may not be covered by the MHP for the dental visit. Transportation for CSHCS covered services which are not covered by the MHP (e.g. Title V only services and carved out benefits) can be covered by CSHCS if related to the qualifying diagnosis. Since vision is a covered benefit, MHPs will cover transportation to vision services. As of 10/1/12, vision will again be a benefit for all Medicaid beneficiaries including those age 21 and older.

T-2: Will we still be able to provide transportation if a client in MHP has a difficult time getting in touch with the case manager at the MHP or it is a last minute trip that needs to be arranged? Will the MHPs do mileage reimbursement and hotels as well?

Families should contact their MHP's member services department for help getting to transportation and travel arrangement for medical appointments. MHPs have provisions for travel approval on short notice. MHPs do cover mileage reimbursement and lodging per their policy. Beneficiaries should use the instructions in the Member Handbook for accessing transportation services.

T-3: Do the MHPs assist with all requests or only trips for non-specialist?

The MHPs are responsible for all medical transportation for their members.

T-4: Who does the client call for transportation?

MHP members should call the MHP Member Services Department for transportation assistance. Details regarding how to access all needed services are included in the Member Handbook.

T-5: How do families get mileage reimbursement now?

Transportation reimbursement will be handled through the MHPs. Questions regarding how to get reimbursement for mileage should be directed to MHP Member Services. MHP procedures are included in the MHP's Member Handbook.

T-6: Emergency Lodging...Who do I call?

MHP Member Services.

Benefits/Carve-outs

CO-1: Clients eligible for and receiving PDN, will they be in MHP?

Clients receiving PDN will be a population excluded from MHP enrollment.

CO-2: What services are "carve outs" and how does that work?

All current MHP carve outs remain in place for the CSHCS population. Additionally, factor, orphan drugs, and the DeVos Intensive Feeding Clinic will be carved out. Other CSHCS only services will also be available outside of the MHP, although the MHP is expected to assist with and coordinate these additional benefits.

Benefits/Pharmacy

BP-1: Who do I call if there are issues related to pharmacy?

The MHP member service department. The number is printed on the MHP member ID card.

BP-2: What pharmacies will be in the plan?

Michigan Enrolls can tell families which pharmacies participate with each MHP.

Benefits/DME

DME-1: Will families have to change DME suppliers (including hearing aid dealers)?

MHPs have contractual relationships with DME suppliers. MHP members need to contact the Member Services Department to talk about their current suppliers and which suppliers the MHP uses.

DME-2: Do the MHP contract with all DMEs as recently a few of these companies have pulled out of Medicaid?

Each MHP contracts with different providers. Families need to contact their MHP's member services department to talk about which DME suppliers work with each plan.

DME-3: Will my DME (supply company, including hearing aid providers) be in the plan?

Michigan Enrolls can tell families which DMEs participate with each MHP

Coordination of Benefits:

CB-1: Under Medicaid the federal government is moving forward on only having one case manager per client. If health plans are considered the client case manager is there talk about through the health plans health departments would only possibly be contracted to provide the plan of care?

A Care Coordination Subcommittee, with representatives from LHDs and MHPs, has been formed to explore issues around care coordination and to offer recommendations toward better coordination of efforts at the practice level, community level, and plan level.

CB-2: Can representatives from the MHPs host meetings to explain their programs, plans, etc.?

MDCH encourages MHPs and LHDs to meet to share information. MHPs and LHDs will be required to establish data sharing and coordination agreements.

CB-3: Who will follow Medicaid eligibility? ex; preventing a kid from falling off

An important role that should be continued by LHDs is assistance with Medicaid redetermination processes, when needed. MHPs do not have any responsibility regarding eligibility, although they are permitted to assist.

CB-4: Will families have a DHS MA worker, MHP manager and LHD care coordinator?

Potentially yes. However, enhanced coordination among the various case workers is anticipated.

CB-5: Will MHPs handle social/financial/local concerns?

It is expected that MHPs and LHDs will negotiate agreements with regard to care coordination and support.

CB-6: How will MHPs know local resources?

MHPs currently have knowledge of various local resources. It is expected that through partnership with local health departments, service to clients will be improved. MHPs and LHDs will be expected to have data sharing and coordination agreements in place to better serve families and clients.

CB-7: How will LHDs and MHPs work together?

It is expected that through partnership with local health departments, service to clients will be improved. MHPs and LHDs will be expected to have data sharing and coordination agreements in place to better serve families and clients.

CB-8: Who do I call with questions related to coverage, bills, etc.?

CSHCS/Medicaid clients, enrolled with an MHP, should call their MHP with questions related to coverage and billings.

CB-9: Will I still need to contact DHS for anything?

Families need to contact DHS with issues related to their Medicaid eligibility, including address changes and eligibility redetermination.

CB-10: Who determines the treatment plan, the provider or MHP protocols?

Medical providers will determine the medical treatment plan and as contractors of the MHP are aware of the plan's treatment protocols.

Billing Questions:

BQ-1: Who follows up on unpaid bills due to system issues

MHP members should follow-up with the MHP on billing issues.

BQ-2: Should billing questions be referred to the MHP?

Yes

Medicaid Health Plan and MHP Services

MHP-1: Since we rely on the Medicaid Provider Manual, the Medicaid Provider Specific Information (i.e. HPCPS code) look up regarding coverage and Magellan for pharmacy look up. Do the MHP's utilize these guidelines/ manuals for determination of coverage? If not, will LHD's have access to the individual MHP's guidelines/ manuals/ medication formulary to assist families?

Enrolling in an MHP does not change the services covered by either CSHCS or Medicaid. However, MHPs are allowed to use different Pharmacy Benefit Managers other than Magellan. They are also able to have different formularies as long as they encompass the same class of medications covered by Medicaid. This information is available by contacting the MHP.

The MHP will help arrange all medical care including specialty, primary, and all other services by both programs. MHPs are required to meet Medicaid FFS requirements, but can and do exceed these minimum requirements. MHPs are required to issue Certificates of Coverage (COC) to their members that detail the coverage/benefits and are also required to publish and distribute to their members, a Member Handbook. The COC must be approved by the State of Michigan Office of Insurance and Financial Regulation and the Member Handbook must be approved by the DCH Managed Care Plan Division. Members should contact their MHP's member services department for information about covered services and network providers.

In addition, agreements and data sharing arrangements are expected between MHPs and LHDs.

MHP-2: Which MHP's are planning to get on board with this??

All MHPs will participate.

Assurance/Compliance

A/C-1: What enforcement language is being put in place if health plans do not comply with CSHCS rules?

MHPs have contractual requirements for providing and reporting the provision of covered services. DCH conducts annual compliance reviews and responds to requests for assistance from providers regarding compliance. If LHDs have specific examples of MHP non-compliance with contractual or Medicaid policy requirements, the LHD should contact DCH. DCH also includes incentives for MHPs to achieve high scores for DCH priorities such as lead screening, prenatal/postpartum care and well-child preventive visits.

A/C-2: Could you please address what will be done to ensure that the health plans provide adequate transportation to and from appointments?

DCH Managed Care Plan Division closely monitors complaints regarding accessing transportation services. Beneficiaries should first contact their MHP Member Services. If they are unable to access transportation services through their MHP, they should contact the Beneficiary Help Line. DCH will immediately follow-up on these complaints. DCH also monitors complaints as part of the annual compliance review. A special review of procedures related to CSHCS members will be conducted in FY 13 and FY 14.

Issues with a specific MHP can be forwarded to the MSA Managed Care Division for a response.

A/C-3: Will distance be a factor in state oversight of the networks' panels of providers? Ex; if there is a local provider not in network and network provider is two hours away. What do providers think; how do they pick which networks; will MHPs try to involve the local providers of their members?

MHPs will authorize out-of-network services when CSHCS beneficiaries have established relationships with physicians and facilities that are not listed in the MHP's provider network. MHPs will work to contract with specialists and other providers that see their members. Families

should contact the MHP's member services department to let them know which providers the beneficiary sees.

Other

O-1: What is the difference between a Managed Health Plan (MHP) and a Health Maintenance Organization (HMO)?

A Medicaid Health Plan is a licensed HMO contracted to serve Medicaid beneficiaries. MHPs also are required to be accredited by a national organization such as NCQA.

O-2: Could parents from rural areas be invited to the parent focus groups since needs can be different?

The focus groups are now completed. There will be other opportunities for parent input into this transition process, and contact information for interested parents is being gathered.

O-3: How does one get into those subgroups or are they just CLAC members?

LHDs should contact MDCH CSHCS to discuss opportunities for additional involvement with this effort

O-4: I was thinking another group to consider are those kids on the hab waiver because CMH very rarely calls me or do the parents for anything, so do they do their own care plans and will that population stay on fee for service?

Individuals who receive services through the Habilitative Supports Waiver are not excluded from MHP enrollment. The family should coordinate with the MHP for HSW services. Additionally, the PIHP and the MHP are required to coordinate care for these beneficiaries. It is likely that care plans for this population are developed in coordination between the PIHPs and the MHPs.

O-5: Are the providers going to be made aware of this change and who is going to answer their questions.

Yes, communications are being sent to providers. MDCH issued an L-letter to all Michigan Medicaid-enrolled providers on 7/20/12. Special sessions have been scheduled with children's hospitals and pediatric regional centers.