

DRAFT FOR PUBLIC COMMENT

Department of Community Health

Project Number: 1226-CSHCS

Date: July 25, 2012

Comments Due: August 23, 2012

Proposed Effective Date: October 1, 2012

Direct Comments To: Medicaid Program Policy
Michigan Department of Community Health

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Policy Subject: Enrollment of Children's Special Health Care Services (CSHCS)/Medicaid Beneficiaries in Medicaid Health Plans (MHP)

Affected Programs: Medicaid, CSHCS

Distribution: All Providers

Summary: Effective October 1, 2012, CSHCS/Medicaid beneficiaries will become a mandatory population for purposes of MHP enrollment. Beneficiaries authorized for private duty nursing are excluded from MHP enrollment. Operational changes to the CSHCS program to accommodate MHP enrollment are included in the policy.

Purpose: Required by P.A. 63 of 2011, Section 1204

Cost Implications: Estimated \$6.4 million savings to MDCH

Potential Hearings & Appeal Issues: Previously exempt beneficiaries may appeal mandatory enrollment or auto enrollment in an MHP.

State Plan Amendment Required: Yes No
If yes, date submitted:

Public Notice Required: Yes No
Submitted date:

Tribal Notification: Yes No - Date: June 13, 2012

THIS SECTION COMPLETED BY RECEIVER

Approved

No Comments

See Comments Below

Disapproved

See Comments in Text

Signature:

Phone Number

Signature Printed:

Bureau/Administration (please print)

Date

Proposed Policy Draft

Michigan Department of Community Health Medical Services Administration

Distribution: All Providers

Issued: September 1, 2012 (Proposed)

Subject: Enrollment of Children's Special Health Care Services (CSHCS)/Medicaid Beneficiaries into Medicaid Health Plans (MHP), MHP Exclusion of Beneficiaries Authorized for Private Duty Nursing (PDN), CSHCS Program Updates

Effective: October 1, 2012 (Proposed)

Programs Affected: Medicaid, CSHCS

As required by Section 1204 of Public Act 63 of 2011, effective October 1, 2012, Medicaid beneficiaries who have full Medicaid benefits and are also eligible for CSHCS coverage (hereafter referred to in this bulletin as CSHCS/MA beneficiaries) will transition from an excluded population to a mandatory population for purposes of MHP enrollment. The MHP enrollment process begins on October 1, 2012.

MHP Enrollment for CSHCS/MA Beneficiaries

Certain categories of CSHCS/MA beneficiaries are exempt from mandatory MHP enrollment.

The following CSHCS/MA beneficiaries are *excluded* from MHP enrollment:

- CSHCS/MA beneficiaries without full Medicaid coverage (e.g., Medicaid deductible, Emergency Services Only, Qualified Medicare beneficiaries, Special Low Income Medicare beneficiaries, Additional Low Income Medicare beneficiaries, etc.)
- CSHCS/MA beneficiaries excluded for other reasons such as medical exception, incarceration, or enrollment in commercial health maintenance organizations (HMOs) or preferred provider organizations (PPOs)
- CSHCS/MA beneficiaries who meet any of the excluded criteria described in the Medicaid Provider Manual, Beneficiary Eligibility Chapter

The following CSHCS/MA beneficiaries are *voluntary* for purposes of MHP enrollment:

- CSHCS/MA beneficiaries with Native American status
- CSHCS/MA beneficiaries with active Medicare
- CSHCS/MA beneficiaries with migrant status

CSHCS/MA beneficiaries who are required or eligible to enroll in an MHP have the opportunity to choose an MHP in their county of residence. The enrollment process for CSHCS/MA beneficiaries will be conducted by the MDCH enrollment contractor using the same enrollment process currently in place for all Medicaid beneficiaries. If the beneficiary does not select an MHP, the beneficiary is automatically enrolled with an MHP in their county of residence. The beneficiary has 90 days after the MHP enrollment effective date to change their enrollment to another MHP in their county of residence. After 90 days, the beneficiary is required to remain in the MHP until the next open enrollment period.

The enrollment contractor provides information to beneficiaries, answers beneficiary questions, assists beneficiaries with enrollment into an MHP, or automatically enrolls beneficiaries into an MHP. Refer to the

Medicaid Provider Manual, Beneficiary Eligibility Chapter, for a complete description of the enrollment process and enrollment contractor responsibilities.

Providers are responsible for verifying a beneficiary's eligibility and enrollment status prior to rendering service. The CHAMPS Eligibility Inquiry transaction indicates a Benefit Plan ID of **CSHCS-MC** for a CSHCS/MA beneficiary enrolled in an MHP. Providers must bill the appropriate payer for all services rendered.

MHPs must cover all Medicaid services specified in the MHP contract and must follow Medicaid policy. MHPs are allowed to have different formularies, prior authorization requirements, and documentation requirements than Medicaid fee-for-service (FFS).

CSHCS/MA beneficiaries enrolled in an MHP, including beneficiaries age 21 and over, are exempt from MHP copayment requirements for all Medicaid covered services.

A number of different circumstances may cause a beneficiary to change enrollment status from FFS to MHP, MHP to FFS, or MHP to MHP. After a change in enrollment status, MHPs will allow CSHCS/MA beneficiaries to remain with the primary and specialty providers with whom they have an established relationship at the time of enrollment in the MHP. CSHCS/MA beneficiaries may be transitioned to a network provider as appropriate upon consultation with the family and the care team.

When a change in enrollment status occurs and approved prior authorizations are in place for equipment or services, the following rules apply:

- Inpatient Hospitalizations
 - For change of enrollment status during inpatient hospitalizations, the payer at the time of admission is responsible for payment for all services provided until the date of discharge. Services provided after discharge are the responsibility of the new payer. Refer to the Medicaid Provider Manual, Billing and Reimbursement for Institutional Providers Chapter for additional information.
 - The CSHCS split-billing exception for inpatient hospital is rescinded.
- Custom Fabricated Equipment
 - When custom-fabricated equipment (prosthetic or orthotic) is ordered for a beneficiary during a hospital stay but not delivered until discharge, and enrollment changes, the payment must be made by the party responsible for the hospital stay.
 - When custom-fabricated, -fit, or -modified equipment with an approved prior authorization has been ordered by the provider before a change of enrollment, the party that authorized the equipment is responsible for payment. This responsibility only applies if the service is delivered within 30 days of the change of enrollment status.
- All Other Services (Transplants, out-of-state care, outpatient therapies, standard or non-custom medical equipment, etc.)
 - MHPs and FFS will coordinate the transition of a beneficiary's prior authorized services in a timely manner when a change of enrollment status occurs.
 - In order to preserve continuity of care, MHPs and FFS must accept prior authorizations in place when the CSHCS/MA beneficiary has a change in enrollment status. Full reciprocity is required between the party that originally authorized the service and the new payer for the duration of the approved prior authorization. This includes accepting the approved provider, services, quantity limits, Medicaid rates and special rates, as well as other terms that have been negotiated for the beneficiary's care.
 - If the prior authorized provider is not in the MHP network, the MHP must pay the out of network provider at the prior authorized rate for the duration of the prior authorization. Providers may not bill FFS or the beneficiary for services covered by the MHP; the provider must bill the MHP.

- The servicing provider is responsible for transmitting a copy of the previously approved prior authorization to the new payer when there is a change of the beneficiary's enrollment status.
- Providers must be enrolled or willing to enroll with Medicaid to bill FFS. Providers who are unwilling to enroll with Medicaid cannot be reimbursed. Providers may not bill the MHP or the beneficiary for services covered by Medicaid FFS; the provider must bill FFS.

All services specified as excluded from the MHP contract remain excluded for CSHCS/MA beneficiaries enrolled in an MHP. Refer to the Medicaid Provider Manual, Medicaid Health Plans Chapter, for the list of services excluded from the MHP contract. Additionally, drugs used to treat coagulopathies such as hemophilia and orphan drugs used to treat rare metabolic conditions are also excluded from the MHP contract effective October 1, 2012. MHP enrollees continue to access these benefits through Medicaid FFS.

The following services continue to be covered by the CSHCS program and are not the responsibility of the MHP:

- Local Health Department care coordination
- Local Health Department case management
- Children's Multidisciplinary Specialty Clinic facility payment
- Orthodontia provided for certain CSHCS qualifying diagnoses
- Respite
- Private insurance premium payment
- Certain over-the-counter medications covered by CSHCS but not covered by Medicaid
- In-state approved intensive feeding clinic(s)

MHP Exclusion of Beneficiaries Eligible for Private Duty Nursing

Effective October 1, 2012, Medicaid beneficiaries eligible to receive private duty nursing (PDN) are excluded from MHP enrollment. Beneficiaries enrolled in an MHP and determined eligible for PDN prior to October 1, 2012, will be disenrolled from the MHP effective October 1, 2012. Beneficiaries enrolled in an MHP and determined eligible for PDN services on or after October 1, 2012, will be retroactively disenrolled from the MHP effective the first day of the month the beneficiary was determined eligible for PDN. Medicaid covered services, including private duty nursing, are covered by Medicaid FFS for these beneficiaries.

CSHCS Changes to Application Process and Coverage Effective Date

Effective October 1, 2012, the CSHCS program changes described below are in place to accommodate CSHCS/MA beneficiaries required to enroll in an MHP.

When a medical report is submitted on behalf of a Medicaid beneficiary and the CSHCS medical consultant determines that the beneficiary is medically eligible for CSHCS, the beneficiary is not required to complete the CSHCS application process for any of the following circumstances:

- The beneficiary is enrolled in an MHP,
- The beneficiary has Medicaid coverage and will be required to enroll into an MHP, or
- Other circumstances allowing for CSHCS coverage without the submission of a CSHCS application.

When a beneficiary enrolled in an MHP subsequently becomes eligible for CSHCS, the CSHCS coverage begin date is the first day of the month the medical report was submitted that determined the beneficiary met CSHCS eligibility criteria.