

**CSHCS Enrollment in MHPs  
Frequently Asked Questions**

	Category	Question	Answer
B1	Benefits	Are the MHPs responsible for full coverage for all CSHCS and Medicaid covered services	MHPs will be responsible for all Medicaid covered services covered by the contract with the exception of additional carve outs for CSHCS. MHPs will not be responsible for CSHCS-exclusive services: LHD care coordination, CMS clinic facility payment, Orthodontia provided for certain diagnoses, respite, insurance premium payment, and certain over-the-counter medications
B2	Benefits	Please define any carve outs	All carve outs currently in the contract remain the same. Additionally, factor for Hemophilia and select orphan drugs will also be carved out as well as the CSHCS-exclusive services listed above. NOTE: CSHCS individuals receiving Private Duty Nursing will continue to be an excluded population.
B3	Benefits	Will CSHCS enrollees in MHPs still have access to the Children's Special Needs fund	Yes
B4	Benefits	Will qualifying diagnoses remain the same	Yes
B5	Benefits	Is this population voluntary or mandatory	Mandatory
B6	Benefits	Is FFS an option	Only in POC counties
B7	Benefits	How will they be handled for open enrollment	CSHCS enrollees will be handled like all other enrollees in rolling open enrollment
B8	Benefits	For pharmacy related carve outs, will DCH provide information at the NDC level regarding carve out medications?	DCH will provide a list of the carved out medications with the NDC number
B9	Benefits	Please confirm if CSHCS members will be eligible for any additional benefits through the MHPs that are not currently provided to all existing MHPs members?	The MHPs will not be required to provide additional benefits; however, CSHCS will provide the benefits listed above
B10	Benefits	For carve out items such as – orthodontia, respite care etc., please clarify MHPs role in assisting members getting access to these services? Is this handled through the CSHCS department?	MHPs are required to assist the CSHCS enrollee in communicating with the CSHCS program to request these services

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B11	Benefits	DCH reported that telemedicine services are used more frequently for this population? Can DCH share which providers are providing these services? Any special requirements for providing services?	<p>Because the use of telemedicine is still in start up phase, the numbers remain small. However, CSHCS has a federal grant for the purpose of increasing access to telemedicine for children with special care needs in rural or underserved areas. Currently CSHCS partners with DeVos Children's Hospital and U of M Mott (discussions with Detroit Children's Hospital) on this effort with the following rural sites:</p> <p><u>In - place</u> Alcona Health Center, Alpena Dickinson Pediatric Clinic, Iron Mt</p> <p><u>Upcoming</u> Partners in Pediatrics, PLC. ,Saginaw Holland Pediatrics, PLC., Holland Forest Hills Pediatric Associates, PC, Grand Rapids Tawas/St. Joseph Pediatrics, Tawas City</p> <p><u>Stand-alone</u> Marquette Clinic</p> <p>MHPs have no special requirements beyond what is stated in published policy.</p>
CL1	Claims	Please define MHP claim responsibility for the MHP assigned members during conversion	DCH is developing the timeline with specific dates for when disenrollment from MHPs will cease.
CL2	Claims	Will there be a separate fee schedule rate specifically for CSHCS enrollment on the DCH website?	CSHCS does not have special rates. CSHCS rates are exactly the same as Medicaid FFS rates
CL3	Claims	Please confirm that if the CSHCS member has primary insurance and is also enrolled into MHP, the claims will be considered COB?	Correct
CMS1	CMS Clinics	Will DCH allow MHPs to authorize CMS visits? Will MHPs be required to pay in-network and out of network CMS professional claims? Is there a specific/unique place of service code reported on the claims for CMS clinic services?	Children being seen in CMS clinics must be allowed to continue receiving services at CMS clinics without prior authorization. MHPs are required to coordinate with CMS clinics regarding the services provided at the CMS clinic. Therefore, plans should be working with these providers to plan care rather than require prior authorization. MHPs must pay non-contracted providers providing services at CMS clinics at the Medicaid fee screen rate. Providers will use outpatient clinic (22) as the place of service code on the 837P for the provider billing since all CMS clinics are located in outpatient hospitals

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CMS2	CMS Clinics	Can DCH provide breakdown of CMS clinic utilization to identify high volume CMS clinics? By dollar amount? By encounter?	Data is not available at this time
CMS3	CMS Clinics	Do MHPs have to cover transportation provided to CMS clinic visits?	Yes
CMS4	CMS Clinics	If a child sees a psychologist at the CMS clinic visit, does this count towards their 20 OP mental health visit benefit?	If the psychologist bills separately for the service she provides, then the service can count toward the 20 outpatient mental health visit benefit.
CMS5	CMS Clinics	Can MHPs participate in the CMS clinic visits? MHP case managers may want to be part of the team? Will CMS clinics be required to provide a copy of the care plan to the MHP?	This will be discussed as part of the collaboration required
CMS6	CMS Clinics	How will DCH handle CMS clinics that are not contracted with the MHPs and have not signed the hospital access agreement?	MHPs are encouraged to have contracts with the providers who provide professional services in the CMS clinics. If the MHP does not have a contract with the provider, the MHP must pay the professional services at the Medicaid FFS rate. MHPs will not be responsible for the CMS facility payment
CMS7	CMS Clinics	Can DCH tell the MHPs which CMS clinics the member is enrolled in?	CSHCS is currently researching whether this information is available
CMS8	Claims	CMS Clinics that is based in the hospital or stand alone, what Type of Bill and/or Form Type will the facility claim be submitted on?	Professional Providers in CMS clinics will bill, as appropriate, on the 837P claim form. CSHCS will continue to cover the CMS facility fee. The CSHCS covered service is not claim-based billing.
CMS9	Claims	Please confirm that in the event CMS Clinics submit claims directly to the MHP for CSHCS member enrolled in the MHP, the MHP will deny the claims?	CMS clinics will not submit claims to MHPs for facilities fees. The CMS facility payment made by CSHCS is not a claim-based billing. MHPs should contact their contract manager if the plan receives a facility claim from a CMS clinic.
CMS10	Claims	When a member is being seen by multiple specialists at the CMS Clinics on the same day, will the medical doctor (MD, DO) submit encounter claim separately to the MHP? Will the non medical doctor (i.e. Nutritionist, Psychologist) submit encounter claim separately to the MHP also, and is this consider a separate payment?	Each provider of a covered Medicaid service may bill separately. The CMS clinic will not submit a claim to the MHPs for facility services. The CMS facility payment made by CSHCS includes payment for all ancillary providers who are unable to bill directly
CON1	Contract Language	When will draft contract language be available for review?	A revised draft of language was sent 05/07/2012
CON2	Contract Language	When will MHPs need to make decision regarding participation?	DCH will give the plans a deadline for decision on Wednesday May 9

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CON3	Contract Language	If MHPs decides not to participate initially, can they request participation at a later date after 10/1/2012?	At this time there are no plans to allow participation opportunities in the future
CON4	Contract Language	If MHP participates, are they required to provide services to CSHCS in all approved services areas?	Yes
COB1	Coordination of Benefits	On the Plan level, is there coordination of benefits with other insurance?	Yes, MHPs must coordinate benefits with primary insurance in the same manner for all MHP enrollees
COB2	Coordination of Benefits	Would the Plan coordinate any pharmacy co-pays or is that a non issue?	CSHCS enrollees, even adults in CSHCS, have no co-pays
CCRR1	Core Competencies Readiness Review	When will core competencies document be completed and provided to MHPs?	Core competencies were provided in April. The final version was provided on 5/7/2012
CCRR2	Core Competencies Readiness Review	When will we see tool used during readiness reviews?	DCH sent the tool to the plans on 5/7/2012
CCRR3	Core Competencies Readiness Review	When will readiness reviews occur?	May and June
CCRR4	Core Competencies Readiness Review	How much lead time with MHPs have to prepare for readiness reviews?	Plans who are interested in participating should be preparing for the readiness review now
CCRR5	Core Competencies Readiness Review	Will MHPs have to provide documentation prior to readiness review?	Yes, as specified in the core competencies
CCRR6	Core Competencies Readiness Review	How long will readiness review last?	DCH will not be visiting the plans for the readiness review. Readiness reviews are documentation based. Plans' submissions will be reviewed at DCH.
CCRR7	Core Competencies Readiness Review	When will MHPs get report on readiness review findings?	MSU Institute for Health Care Studies has agreed to turn the reviews around quickly. The goal is to have a decision within 2 weeks of plan <u>complete</u> submission of all required documentation and response to IHCS questions
CCRR8	Core Competencies Readiness Review	Will MHPs have opportunity to appeal any negative findings on the readiness review?	The need for appeals is not anticipated. IHCS will work with plans to clarify unclear documentation
CCRR9	Core Competencies Readiness Review	Will DCH be incorporating this into the annual compliance review?	No. Readiness review for CSHCS participation is completely separate from the annual compliance review. However, certain core competences are now in the contract or in the annual compliance review component
CCRR10	Core Competencies Readiness Review	Will DCH be conducting a focus study on CSHCS enrollment for FY2013 compliance reviews?	Yes
CC1	Care Coordination Continuity of Care	Will CSHCS provide care plans (like they do for CSHCS age outs/graduates) at the time of enrollment?	If the LHD has prepared a care plan, then the care plan will be available for the MHP. Not all LHDs have prepared care plans for all CSHCS beneficiaries

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CC2	Care Coordination Continuity of Care	How long do we need to allow of network services/out of state services? For specialty and primary care? When can we transition into network?	There is no set time period. The contract language requires: "enrollees should be allowed to remain with providers with whom they have an established relationship at the time of enrollment in the health plan. Contractors should work with the family and established providers to assure access to the most appropriate provider for the enrollee. Contractors are encouraged to seek contracts with providers with established relationships with CSHCS enrollees"
CC3	Care Coordination Continuity of Care	Multiple agencies are providing some form of care management/case management services, will DCH provide contact information for LHD CHSCS staff and CMS clinics for MHPs to develop relationships?	Yes
CC4	Care Coordination Continuity of Care	Will MHPs need care coordination agreements (like we do with the CMHs) for LHD and CMS clinics?	Yes
CC5	Care Coordination Continuity of Care	What type of oversight will the CSHCS department and OMA have on MHP utilization management activities? What is there role in this process?	OMA will be participating in the annual compliance reviews. Additionally, MHPs are strongly encouraged to seek the guidance of OMA physicians in making prior authorization and service decisions for CSHCS enrollees. Neither, OMA nor CSHCS will have a routine operational role in MHP utilization management activities
CC6	Care Coordination Continuity of Care	DCH mentioned possible retrospective review of MHP denials for this population. How will this be handled?	This language has been removed from the contract
CC7	Care Coordination Continuity of Care	DCH mentioned monitoring of the referral process. Most MHPs do not require authorization/referral for specialty physician services. Is DCH referring to services that require plan referral/authorization?	Contract requires MHPs to track referral processes for CSHCS enrollees so that DCH may monitor the referral/approval process for CSHCS enrollees
CC8	Care Coordination Continuity of Care	Will DCH require different timeframes for authorization decisions for this population?	No
D1	Data	Please provide rate book – claims data used to develop rates	This will be a part of the formal rate letter package
D2	Data	Please provide a break down pharmacy costs into drug categories.	This will be a part of the formal rate letter package
D3	Data	Please provide utilization/cost breakdown by service category (i.e. inpatient, physician services, etc.)	This will be a part of the formal rate letter package
D4	Data	Please provide cost and utilization data by diagnosis group by county/region.	A county study including some diagnosis information was already provided to the MHPs. No additional work is planned for this item
D5	Data	Please provide cost and utilization data by provider type by county/region.	Other than the rate book discussed above, nothing additional will be provided for this item.

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D6	Data	Please provide data on out of state utilization? By service? By provider type? By diagnosis group? By cost?	A county study including some diagnosis information was already provided to the MHPs. No additional work is planned for this item.
D7	Data	Will DCH provide breakdown of out of state services? By encounter and dollar amount? By service type? Who are key providers that MHPs will work with out of state?	A county study including some of this information was already provided to the MHPs. No additional work is planned for this item.
D8	Data	Can DCH provide updated enrollment count by county? Last report provided was from November 2011.	One of the county studies discussed above included updated member counts by county with age ranges. DCH will provide this updated monthly prior to the Operational Work Group meeting.
D9	Data	Breakdown of CSHCS utilization by SNAF providers.	Since CSHCS is not yet part of the SNAF logic, this would be too difficult to provide at this point in time
EL1	Eligibility	Will there be any changes to the MERF submission process for the MHPs for submitting a existing member for consideration for CSHCS eligibility?	For newly CSHCS-eligible individuals there will be no change to process; however, MHPs will be required to meet requirements for accuracy and completeness of medical information submitted
EL2	Eligibility	Please confirm that families will no longer have to complete an application for enrollment in CSHCS. Please confirm that the child will automatically be enrolled into CSHCS at the time of CSHCS eligibility determination? Will the enrollment in CSHCS be retroactive to date of eligibility determination?	Families will no longer need to complete an application. Once the beneficiary is determined to be medically eligible, the beneficiary will be automatically enrolled in CSHCS. The effective date of CSHCS benefit plan and movement to the CSHCS-specific capitation rate is still under discussion.
EL3	Eligibility	Please clarify the "opt out process". If there is an opt out of CSHCS for the family if the child is approved, how long does the family have to decide they do not want to be enrolled in CSHCS? What is the process for the family to communicate their desire to opt out?	There is not an opt out process for CSHCS enrollment. Once a child is determined medically eligible for CSHCS, the child is given the CSHCS benefit plan and must choose an MHP.
EL4	Eligibility	If the family decides to opt out of CSHCS, will the CSHCS eligible beneficiary who is currently enrolled in a MHP be disenrolled from the MHP and enrolled in FFS? Is this disenrollment retroactive back to date of eligibility determination?	There is not an opt out process for CSHCS enrollment
EL5	Eligibility	If the family decides not to opt out and remain in the MHP, when will the MHP receive the enhanced capitation rate? Will it be retroactive back to date of CSHCS eligibility determination? If so, what will be the process for capitation adjustments?	The effective date of CSHCS benefit plan and movement to the CSHCS-specific capitation rate is still under discussion. However, please note that there is not an opt out process for CSHCS enrollment

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EL6	Eligibility	If the state has an 'opt out' process, and the family is notified of approval and their right to 'opt out' but they want to be in the program, is there a way for them to let the state know they do not want to 'opt out' or do they just have to not respond and then they will be automatically enrolled once the allotted 'opt out' time frame has expired?	There is not an opt out process for CSHCS enrollment
EL7	Eligibility	Will there be any changes to the process for submitting MERFs within 30 days of birth for NICU babies?	There is not a change in the process
EL8	Eligibility	Will there be any changes to retro disenrollment processes for NICU babies (going back to date of birth if MERF submitted within 30 days of birth) or for non-NICU cases being disenrolled back to the beginning day of the month in which the MERF was submitted if the family chooses to opt out?	This issue is still under discussion.
EL9	Eligibility	Will all of the current diagnoses listed for potential CSHCS approval remain the same?	Yes, as of the time of implementation. CSHCS diagnoses coverage changes over time for various reasons.
EL10	Eligibility	Will there be any changes to qualifying factors such as intensity of specialty treatment or severity of condition?	None expected
EL11	Eligibility	There are many CSHCS eligible members currently enrolled in the plan, that have not completed an application to enroll, will these members automatically be enrolled into CSHCS at the implementation date of the project if the MERF was submitted within a certain timeframe (year?) If not, will the MHPs be required to submit an updated MERF to DCH for eligibility determination?	Current status in MHP will be maintained until implementation is finalized
EL12	Eligibility	For the CSHCS transition, how will DCH handle retroactive eligibility after 10/1/2012 for the outstanding cases that have been submitted to DCH and are pending CSHCS eligibility determination or have been determined CSHCS eligible, but have not completed an application to enroll (especially NICU's) as there is a significant lag time? Will DCH retro-actively term the member for months prior to implementation and then leave them in the current Plan as of 10/1/2012? Will DCH still require an application for members determined eligible prior to 10/1/12?	DCH is currently developing a timeframe during implementation when the family will no longer be required to submit an application. The CSHCS managed care benefit plan does not begin until 10/1/2012; therefore, the increased capitation payment for CSHCS enrollees will begin on 10/1/2012 for all children determine retroactively eligible in the MHP with effective dates of prior to 10/1/2012.

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EL13	Eligibility	Will MHPs be informed when CSHCS eligibility is expiring? What is redetermination process for CSHCS? Can MHPs assist in this process to ensure CSHCS eligible members have no “gaps” in eligibility?	DCH has not yet discussed a process for informing MHPs of CSHCS eligibility expiration dates but is open to discussing a process. MHPs are required to assist with the renewal process.
EL15	Eligibility	For 10-15k look alike currently enrolled in plans, but not enrolled in CSHCS, what will be process to get these members determined eligible and enrolled into CSHCS? Will DCH be hiring additional staff to process MERFs?	Discussion is ongoing regarding how DCH will respond to this issue
EL16	Eligibility	Will DCH be automating the MERF eligibility process? Will MHPs get more frequent reports of CSHCS eligibility status – to ensure appropriate capitation reconciliation?	DCH is moving toward the use of EZ link. Note that there are limitations to automating a process requiring the professional judgement of physicians.
EL17	Eligibility	Will the current age out process remain the same	Please clarify question
EN1	Enrollment Process	What will the policy be for plans that choose not to participate	Please clarify question
EN2	Enrollment Process	How will they be identified on the enrollment and financial files	At this time, DCH believes that CSHCS enrollees will have a different provider ID; therefore, plans will be able to use this ID to track the members through enrollment and payment
EN3	Enrollment Process	For non-participating plans, how will the State hold the plan harmless if there is a retro approval/disenrollment	Discussion is ongoing regarding how DCH will respond to this issue
EN4	Enrollment Process	Will MDCH be adding a flag for all CSHCS members in the 4276? Will that be in the same field as the ‘pregnant’ flag or will they create a separate field for that? Will this require a change to the 4276 file layout? Will MI Enrolls do some B2B testing?	DCH is actively exploring this option with MI Enrolls
EN5	Enrollment Process	Will MDCH be providing a flag on the 834 files (4976, 5012, and 5013) to identify the CSHCS enrollment? Will DCH send effective and term dates for CSHCS eligibility in the files? Is DCH planning on providing this information in the COB loops? If so, MHPs have concerns about data accuracy since we experienced have experience similar issues with the duals (i.e. invalid effective term/dates, confusing data, etc.) If that information is in that loop, will we receive a test files?	At this point DCH believes, CSHCS enrollees will have a different provider ID; therefore, plans will be able to use this ID to track the members through enrollment and payment.
EN6	Enrollment Process	Will the companion guide be updated?	Yes
EN7	Enrollment Process	Can we anticipate reporting of the CSHCS children via the 4276 in advance of the program effective date (10/1/2012)?	DCH will explore this option with MI Enrolls
EN8	Enrollment Process	Will DCH allow more time to match member with a PCP at the time of enrollment (instead of 30 day timeframe)?	No

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EN9	Enrollment Process	Can MHPs include information about CSHCS eligibility in member communications/materials to promote the program benefits?	Yes
GA1	Grievance & Appeals	Will the guidelines and Turn Around Times for Grievances be the same as the existing process for Medicaid members?	Yes
GA2	Grievance & Appeals	Will members be able to appeal Non-covered benefit denials as well as other pre-service denials?	Yes, same as for all MHP enrollees
GA3	Grievance & Appeals	Will there be any changes in the Appeal process and guidelines?	No, DCH will require MHPs to track grievance and appeals for CSHCS enrollees separately for at least the first year
GA4	Grievance & Appeals	How will the requests for Administrative Hearings be communicated and processed?	Same as for all other MHP enrollees
GA5	Grievance & Appeals	Is there such a process as "For Cause Disenrollments" for CSHCS?	Yes, same as for all MHP enrollees
Q1	Quality	Will there be any different Encounter /Data Quality reporting requirements	Same as for all other MHP enrollees CSHCS-specific quality measures may be developed in future
OSS1	Out of State Services	Will MHPs be allowed to transition members back into state for on-going services?	This is no different than out of network services. The contract language requires: "enrollees should be allowed to remain with providers with whom they have an established relationship at the time of enrollment in the health plan. Contractors should work with the family and established providers to assure access to the most appropriate provider for the enrollee. Contractors are encouraged to seek contracts with providers with established relationships with CSHCS enrollees"
OSS2	Out of State Services	What is the lodging and travel expenses related to out of state services? Please confirm MHPs are required to provide lodging/travel and meals for members and one guardian if child is a minor. What is the actual number of members receiving services out of state?	MHPs must provide lodging/travel, including meals, for CSHCS enrollees. MHPs must also provide lodging/travel and meals for one guardian if the member is a minor, is an adult with a legal guardian or has need of assistance in traveling. Data on out of state services has been provided
OSS3	Out of State Services	What type of services are provided out of state?	Services that are not available in-state or have begun out-of-state and needs to be maintained with original provider (or in-state providers are unwilling to take beneficiary as a patient in the middle of a treatment plan. A county study including some of this information was already provided to the MHPs. No additional work is planned for this item.

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OSS4	Out of State Services	Will DCH notify the out of state providers about the enrollment change into MHPs?	Out-of-state providers are required to be enrolled with MI Medicaid and are to check beneficiary eligibility and enrollment prior to services as with any other provider. As MI Medicaid enrolled providers, these providers also receive Medicaid policy bulletins announcing this change.
OSS5	Out of State Services	Can DCH develop a L letter to encourage out of state providers to accept Michigan Medicaid rates?	Published policy exists and a policy bulletin with additional information is being drafted.
OSS6	Out of State Services	Which providers refer out of state most often? Will DCH work with the MHPs to reduce number of out of state referrals (when services are available in state)?	DCH is already working to reduce out of state referrals and will continue to do so.
PN1	Provider Network	What will the network standards be?	DCH has added the following language for network standards to the contract: The Contractors network must include pediatric subspecialists, children's hospitals, pediatric regional centers, and ancillary providers that provide services to CSHCS enrollees.
PN2	Provider Network	What is the State doing to educate pediatric subspecialists about the change?	DCH is developing communications and a communication plan for beneficiaries and providers. The Communication Subgroup Committee will report to the group at the Operations Work Group meetings.
PN3	Provider Network	Will MHPs be required to contract with new provider types?	No
PN4	Provider Network	Population appears to have high cost/utilization for DME and Home Healthcare. Will DCH share list of providers currently providing services to CSHCS members by county? This will help plan to enhance provider networks and limit out of network services?	Yes, DCH will provide a list of DME providers utilized most often for CSHCS beneficiaries. The high cost/utilization for home health is likely related to PDN. CSHCS enrollees receiving PDN will continue to be an excluded population.
PN5	Provider Network	If MHPs have preferred provider arrangements with DME, lab, or HHC, can MHPs require members get services through these providers?	This is a complicated issue which is still under discussion. DCH expects that plans will not disrupt the coordinated care provided at comprehensive treatment sites. For example, plans may not require a family to take their child from an outpatient hospital to a special laboratory to have blood drawn and analyzed.
PN6	Provider Network	How did the 3/21/12 meeting with the Pediatric and Children's Hospitals go? Any issues or concerns that MHPs need to be aware of?	A summary of this meeting was provided at the March Bi-Monthly operations meeting
PN7	Provider Network	Will DCH provide list of high volume primary care sites providing services to CSHCS members? Again this information will help MHPs ensure adequacy of provider networks?	This can be provided although the unusual role that specialists have in providing primary care to this population might be a study problem

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PN8	Provider Network	Will DCH share CSHCS approved provider listing?	DCH has already sent the MHPs a list of current CSHCS-authorized providers.
PN9	Provider Network	DCH wants members to have PCP? Will Michigan ENROLLs be reporting PCP selection in enrollment files?	CSHCS enrollees must have a PCP; this is one of the major benefits of transitioning this population to managed care. When the member chooses a PCP at time of enrollment, the PCP choice will be on the 4276 daily file the same as all other MHP enrollees
PN10	Provider Network	What role will LHDs play in PCP selection? What does the Health Plan do if we cannot make contact with the enrollee/family to choose a PCP?	Because of the community-based nature of LHDs, LHDs may have access to more current contact information than DCH. LHDs will assist the MHPs in contacting the family to make a PCP selection.
PN11	Provider Network	Impact of non-par services for CSHCS members on OFIR in-network service requirements. Any update from OFIR?	DCH is still working with OFIR on this issue
PN12	Provider Network	Will provider access standards be different for this population?	No. However, MHPs should track access for this population separately for at least the first year
R1	Rates	How is DCH coordinating with OFIR regarding out of network payment	DCH is still in discussions with OFIR regarding consideration of SNAF as "In-Network."
R2	Rates	If CHSC members have primary commercial insurance, do we still get the higher capitation rate	Any CSHCS members with another primary comprehensive HMO or PPO commercial insurance carrier will not be enrolled with an MHP. MHPs will get CSHCS capitation rate for members with non-HMO or PPO and standard adjustment rates will apply.
R3	Rates	Please describe what happens if they are retroactively approved as it relates to capitation payment – will rates be adjusted retroactively to the certification date	It is likely that rates will be adjusted retroactively to the CSHCS approval date for individuals that are new to the MHPs. For current MHP members that qualify for CSHCS enrollment, that higher utilization data is already part of the MHP rate analysis. Therefore, a downward adjustment to the MHP ABAD and TANF rates will probably be necessary when those CSHCS "hidden" members are transferred to the CSHCS rate cell. This question raises a number of technical issues which are still being analyzed.
R4	Rates	When will a data book be published	Data was sent 5/7/2012.
R5	Rates	When will rates be published	The goal is to submit rates to CMS by July 1 for an effective date of October 1
R6	Rates	Please provide more detail re the State's stop/loss proposal	The detail is included in the draft rate exhibit.
R7	Rates	Please define financial reporting requirements	No change is expected here
R8	Rates	Will the CSHCS rates have a bonus withhold	Yes

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R9	Rates	What are the implications for the add-on components of the rates? E.g., SNAF	CSHCS fee-for-service experience in the Physician Adjuster Payment program will be analyzed so that the SNAF component of the MHP capitation rate can be enhanced (i.e. the funds will shift from FFS to managed care).
R10	Rates	Will there be rate differentials for acuity and regions. (risk adjustments)	There will be rate differentials by region and there will be acuity risk adjustments every six months at the MHP level as we do now for the ABAD members.
R11	Rates	Do we receive a cap payment on identified CSHCS diagnosis or do the members still have to be found eligible by an MDCH medical director	Must be found eligible due to chronicity, severity and the need for a pediatric (except for adults) sub-specialist
R12	Rates	When will the rates be available? What will timeframe be for comment period on rates? At the last Operations Meeting, DCH reported there would be a rate conference call scheduled? When will this be scheduled?	Draft rates were made available in mid-April. Plans requested a data book which was provided on 5/7/2012 along with revised draft rates. MHPs will be given time to review the draft rates and make an informed decision regarding participation for this population.
R13	Rates	MHPs will need to evaluate the CSHCS rates to make to evaluate participation. Will DCH provide MHPs with a "rate book" that provides same information (claims data, etc.) that Milliman used for rate development	Milliman will provide this in the formal rate letter package.
R14	Rates	How will risk adjustment process work?	It will work the same way the ABAD risk adjustment process works. Although it is not clear yet whether CDPS or a different system will be used, the CSHCS members will be "rebased" once a year with the new MHP rebased risk score being applied in October of each year. Each MHP's CSHCS member mix will be reanalyzed in February-March and a new risk factor will be implemented in April of each year.
R15	Rates	DCH stated that they will be sharing multiple options for risk sharing levels in the rate development process. Will all plans be required to accept same option or can plans select individually?	All plans will be required to accept the same option.
R16	Rates	Sounds like travel and lodging is higher than typical Medicaid member – is this additional cost included in the rates?	This issue has been discussed with Milliman, and the draft rates shared in mid-April accommodate these higher non-emergency transportation costs. The Department provided a combination of FFS data, ABAD encounter data and other relevant data to adequately address these additional costs.