CSHCS Operations Update

Customer Support Section (CSS)

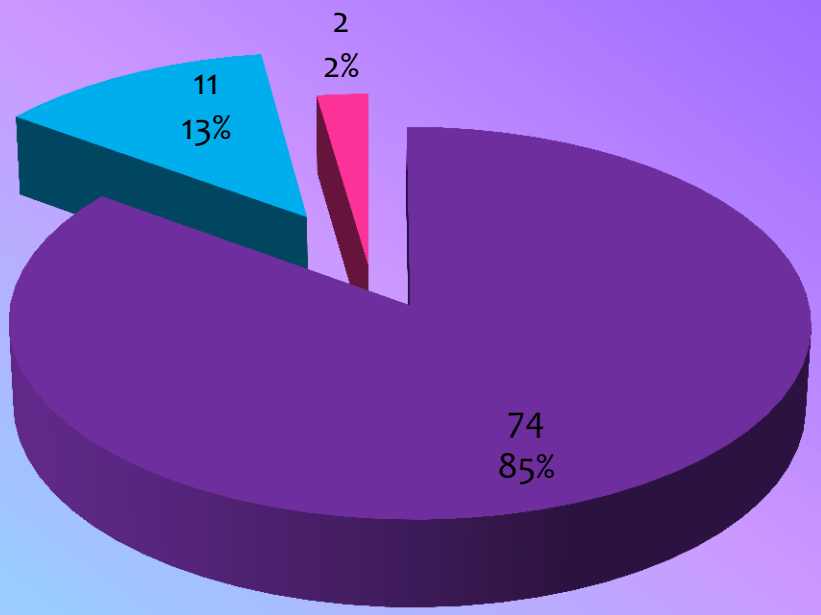
....where it all begins....

PROCEDURAL CHANGES SINCE SPRING 2013

* Newly eligible Clients with MIChild are not required to complete an Application for enrollment
* Enrollment begin date for new clients who have full Medicaid or MIChild is the first of the month of the qualifying event, up to 6 months from the month the approved medical was received
* All clients: Coverage begins on the first day of the month AND ends on the last day of the month, unless aging out
* LHDs have access to the CHAMPS CLIENT VIEW link

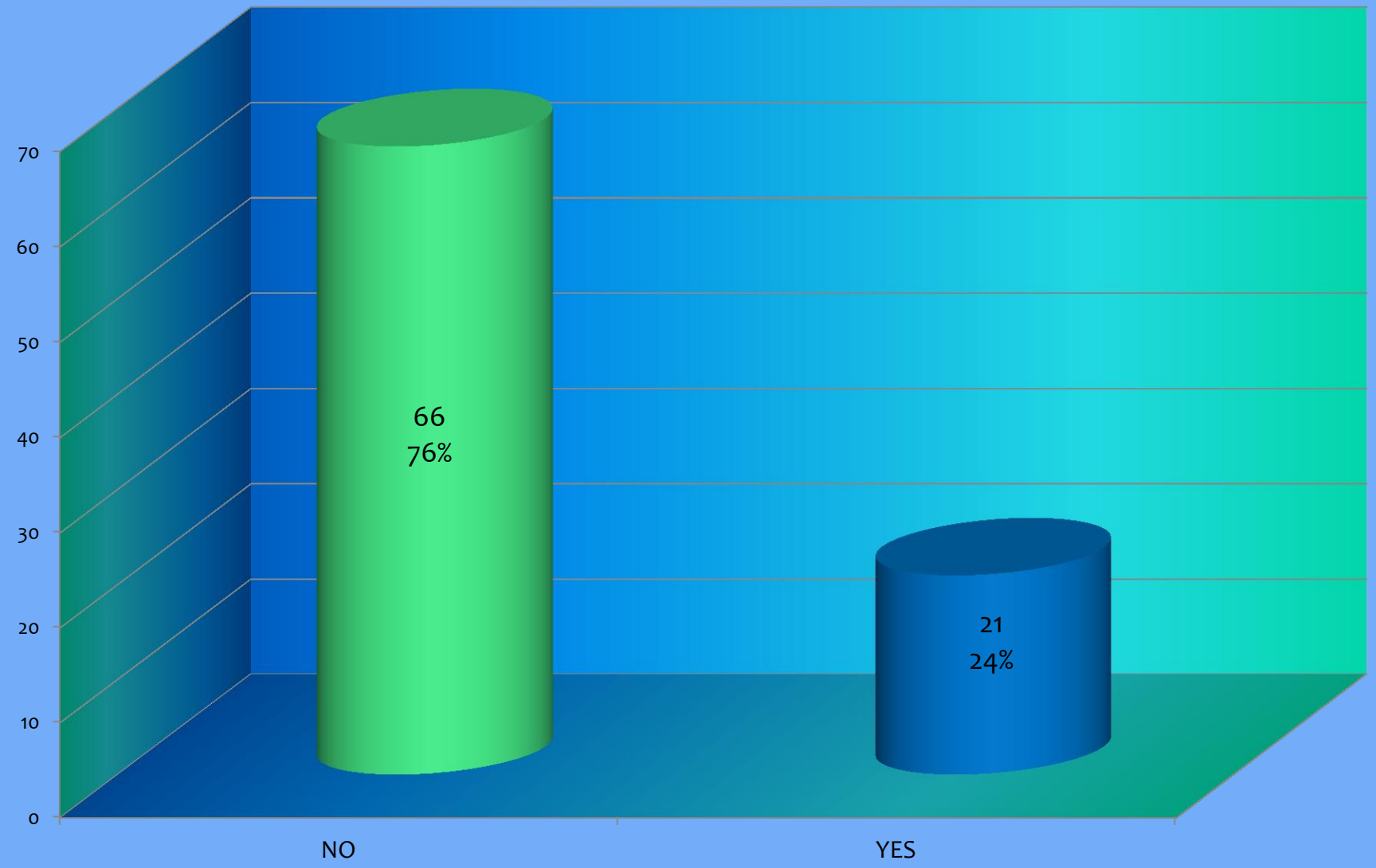
Has access to the CHAMPS Client View link been helpful for viewing beneficiary information?

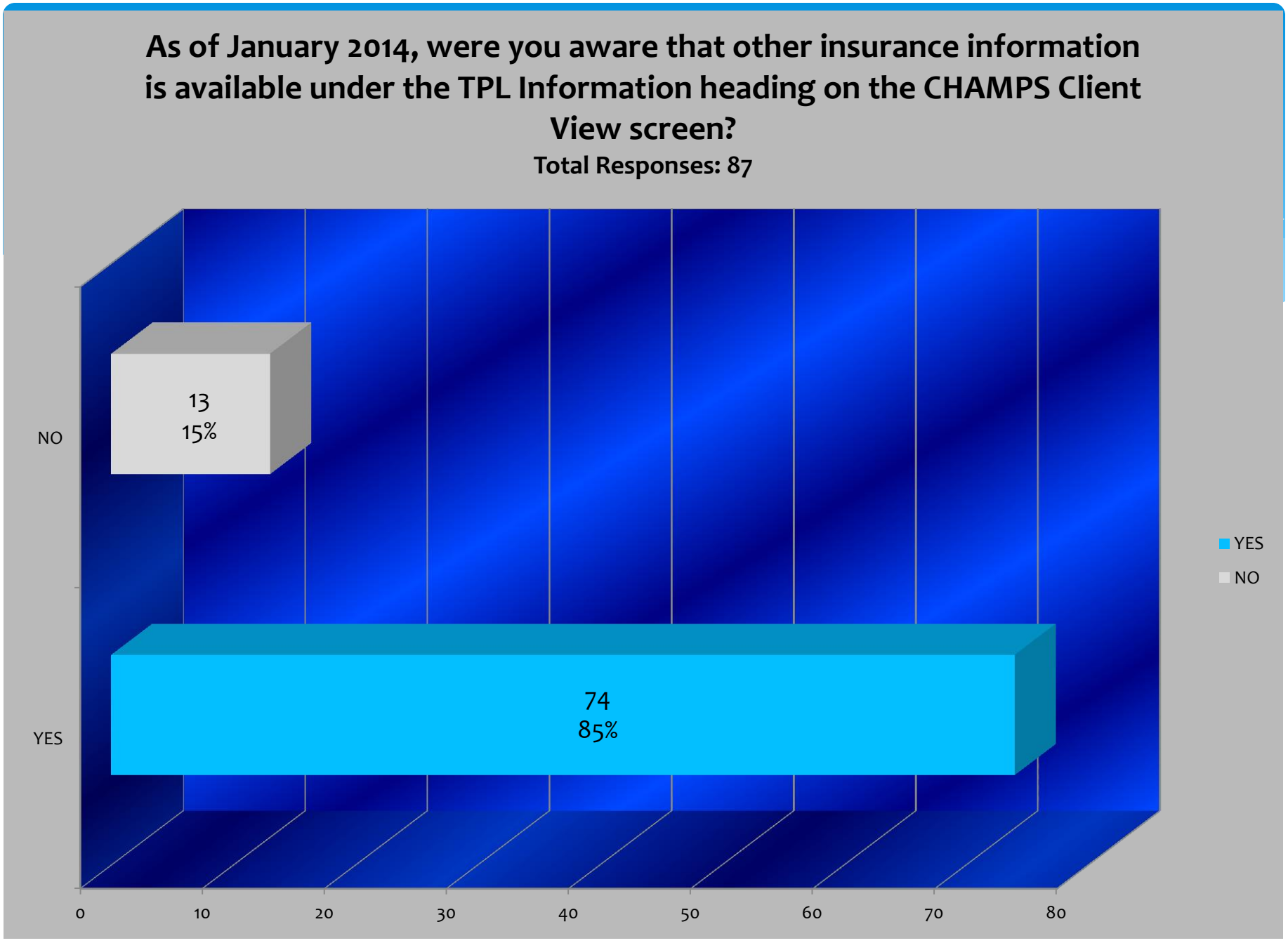
Total Responses: 87



Would you prefer to eliminate the CHAMPS Client View link in order to view clients that reside in other counties?

Total Responses: 87




As of January 2014, were you aware that other insurance information is available under the TPL Information heading on the CHAMPS Client View screen?
Total Responses: 87
NO
YES
13
15%
74
85%
0
10
20
30
40
50
60
70
80
YES
NO

TOPICS

* NEW CLIENT CSHCS Begin Date
* Payment Agreement
* Adding Providers
* CSHCS-only services
* Medicaid Carve Out services
* MIChild and Healthy Michigan Plan
* Dental Services
* Medical Report Processing
* Miscellaneous Reminders
* LHD Reports

NEW CLIENT CSHCS BEGIN DATE

* Effective Immediately, for all new clients:
* The CSHCS begin date is the first day of the month of the client's qualifying event, retroactive up to six (6) months from the date the Michigan Department of Community Health (MDCH) receives **all necessary documentation that results in a final determination of CSHCS eligibility.**
  * Full MA or MIC – approved medical report
  * CSHCS-only – Application and IRPA

NEW CLIENT CSHCS BEGIN DATE

* When Application information is missing:
  * CSS sends a letter requesting the missing information
  * Family has 30 days to submit the information in order to preserve the initial effective date of coverage
  * If the information is not submitted within 30 days, the effective date of coverage will be retroactive up to six months from the date CSS receives the required information

NEW CLIENT CSHCS BEGIN DATE

* Families no longer have to ask for retro coverage
* Retro coverage does not guarantee that providers of services already rendered will accept CSHCS payment
* CSHCS does not reimburse families directly for payments made to providers

BACKDATING INITIAL COVERAGE

* **MYTH BUSTERS!**
  * CSHCS will always backdate initial coverage up to one year as long as the family requests in writing (not true)

Maximum 6 months from Application received date

  * If private insurance denies coverage, CSHCS will backdate up to one year from the month the Application with IRPA is received (myth)

Maximum 6 months from Application received date

  * Providers always refer potentially eligible families to CSHCS

Local PR activities still critical !!

BACKDATING RENEWAL COVERAGE – NO CHANGE

* When the information required for renewal of CSHCS coverage is submitted within one (1) year of the date CSHCS coverage ended and the client remains eligible for CSHCS, the CSHCS coverage may be renewed a maximum of two (2) months retroactively from the month renewal information is received.

PAYMENT AGREEMENT REMINDERS

* Use the Financial Worksheet (MSA-0742) to project income for the IRPA if there has been a dramatic change in income since last Federal 1040
* Use the Payment Agreement Amendment form (MSA-0927) when there is a change in family size, income, etc. during the contract period
  * Amendment applies to current payment agreement only

PAYMENT AGREEMENT

* **THANKS, MYTH BUSTERS! YOU'VE DONE A GREAT JOB!**
  * If we don't use CSHCS coverage, the payment agreement will be cancelled (untrue)
  * If we don't pay for the first month, coverage will automatically terminate and the payment agreement will be cancelled (BUSTED)
  * I sent in my IRPA but thought coverage would not be renewed until I gave the OK (BUSTED)

ADDING PROVIDERS

* Why do we authorize providers on the Client Eligibility Notice (CEN)?
  1. **Identify the client's 'system of care' (sub-specialists)**
     * Applies to all CSHCS clients
     * Assure client has access to appropriate care
  2. **Claims processing (CHAMPS)**
     * Applies to CSHCS-only clients.
     * Not necessary for clients with full Medicaid or MIC unless related to CSHCS-only services paid through the CHAMPS system (e.g. orthodontia)

ADDING PROVIDERS FOR HEALTH PLAN MEMBERS

* Specialist(s) and hospital related to Initial or subsequent qualifying diagnosis
* CSHCS-only Services
* Date of Service prior to Health Plan enrollment
* CSHCS does not add providers for:
  * Medicaid services that are 'carved out' of the Health Plan
  * Medicaid services which the Health Plan provides in a different way than Medicaid fee-for-service

CSHCS-only Services (not covered by MA or MIC)

* Certain dental services. Go to: www.Michigan.gov/medicaidproviders > Billing and Reimbursement > Provider Specific Information
* Intensive Feeding Clinic at Helen DeVos Children's Hospital
* CMS Clinic facility fee
* Respite
* Insurance Premium Payment benefit
* LHD Care Coordination and Case Management
* Transportation Assistance for MIChild members

Medicaid Carve Out Services

* Medicaid-covered Services that are not the responsibility of the Health Plan
  * See Policy Bulletins MSA 12-46, MSA 13-46, and the Medicaid Provider Manual, Medicaid Health Plans Chapter for the list of carved out services
  * Drugs in the categories listed on the MHP carve-out list found at https://michigan.fhsc.com/ >> Providers >> Drug Information

MIChild

* No fee-for-service option for MIChild; Dental health plan
* The MIChild benefit package is slightly different from Medicaid. Examples:
  * PDN is covered
  * Travel/transportation assistance is not a benefit
* Obtaining other insurance which is an HMO or PPO does not exclude a client from the Health Plan

HEALTHY MICHIGAN PLAN (HMP)

* Coverage is similar to full Medicaid
* Clients with HMP do not need to complete a CSHCS Enrollment Application
* May have private insurance in addition to HMP
* CSHCS enrollees who have HMP are excluded from Health Plan enrollment

Dental Services

* Clients with full Medicaid receive covered dental services through Healthy Kids Dental or Medicaid fee-for-service, depending on the county of residence
* MIChild members choose one of the MIChild Dental Plans, depending on the county of residence
* HMP/CSHCS enrollees use HMP ffs for covered dental services. (For HMP Health Plan members, dental care is the responsibility of the Health Plan.)

Medical Report Processing

* **New Client or Coverage Lapsed Greater than 1 year**
  * Medical Record created in CSHCS system (Medical tab)
  * County Technician determines if review by Consultant needed (if not, report forwarded to LHD as FYI medical)
  * Routed to Medical Consultant via EZLink
  * CSHCS Medical Record updated with Consultant decision
  * Letter created and report with decision forwarded to LHD via EZLink, copy to MHP
  * Target processing time: 15 work days

Medical Report Processing

- **Active Coverage or Coverage Lapsed less than 1 year**
  - Medical Record created in CSHCS system (Medical tab)
  - Reviewed by County Analyst to determine if review by Consultant needed (if not, report forwarded to LHD as FYI medical)
  - Route to Medical Consultant via EZLink

Medical Report Processing

* **Active Coverage or Coverage Lapsed less than 1 year**
* If renewal decision,
  * Review Details in CSHCS system (Enrollment tab) updated with Consultant decision
  * Report forwarded to LHD with consultant decision. Copy to MHP.
  * Coverage renewed at next Auto renewal process or manually.
  * Close out letter with appeal rights if eligibility denied.

Medical Report Processing

* **Active Coverage or Coverage Lapsed less than 1 year**
* If request for additional diagnosis,
  * Medical Record in CSHCS system (Medical tab) updated with Consultant decision
  * Report forwarded to LHD with consultant decision, Copy to MHP
  * Diagnosis added to current CSHCS enrollment
  * Denial letter with due process rights, if eligibility denied

Medical Report Processing

* **Active Coverage or Coverage Lapsed less than 1 year**
* If request to add provider/cover service,
  * Report forwarded to LHD with consultant decision
  * Provider added to current CSHCS enrollment, if approved
  * Denial letter, if appropriate

Medical Report Processing

- 'FYI Medical' means Consultant did not review report
- LHDs use EZLink 'Reply' functionality to request:
  - Add provider
  - Denial letter, if needed
  - Review by Medical Consultant, include your rationale
- FYI medicals are not sent to the Health Plan

Miscellaneous

* Address Changes – We assume you verified with family
* Please advise CSS when you find that a client has obtained MA, HMP or MIC. Multiple IDs are on the rise.
* MiBridges application process MA eligibility effective the first day of the application month, even when family requests retro coverage on the application. MA begin date will be updated in Bridges as long as the DHS case worker notices the backdate request when the application is assigned to the local DHS office.

FUTURE LHD REPORTS

* Diagnosis Usage Report – LHD Access
* Client Expenditure Report

EZLink Alternative

* Document Management Portal (DMP)
* Providers Access the DMP via CHAMPS
* DMP is currently available as an alternative to EZLink for providers to submit documentation for Claim Attachments, Consents and Predictive Modeling
* Documents stored in FileNet

Children's Special Health Care Services

QUESTIONS ?