MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Bulletin Number: MSA 12-46

Distribution: All Providers

Issued: August 31, 2012

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

Effective: October 1, 2012

Programs Affected: Medicaid, Children's Special Health Care Services

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

Under Medicaid policy, 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

After October 1, 2012, Medicaid beneficiaries who become eligible for CSHCS who are enrolled in an MHP will no longer be retroactively disenrolled from the MHP. 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 or MHP to FFS. 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 an appropriate network provider upon consultation and arrangement 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, pharmacy, etc.)
    - 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 for the first 30 days following the enrollment change. Full reciprocity is required between the party that originally authorized the service and the new payer for the first 30 days following the enrollment change. 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 first 30 days following the enrollment change. 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 in 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. MHPs are not required to provide transportation for services excluded from the MHP contract. Additionally, in-state approved intensive feeding clinic(s) and 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. A list of these medications is available on the Magellan Medicaid Administration website at https://michigan.fhsc.com. MHP enrollees will 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

MHP Exclusion of Beneficiaries Authorized for Private Duty Nursing Services by Fee-for-Service

Effective October 1, 2012, Medicaid beneficiaries authorized for private duty nursing (PDN) services are excluded from MHP enrollment. Beneficiaries enrolled in an MHP and authorized for PDN services prior to October 1, 2012, will be disenrolled from the MHP effective October 1, 2012. Beneficiaries enrolled in an MHP and authorized 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 authorized 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 as per Medicaid policy.

When a medical report is submitted to CSHCS on behalf of a beneficiary with full Medicaid coverage and the CSHCS medical consultant determines that the beneficiary is medically eligible for CSHCS, the beneficiary is automatically enrolled in CSHCS (without completing the CSHCS application).

The CSHCS coverage begin date for beneficiaries enrolled in an MHP is dependent upon the date of the event that qualifies the beneficiary for CSHCS. The CSHCS begin date is the first day of the month of this qualifying event (up to six months from the date MDCH received the medical report). The enrollee will not be retroactively disenrolled from the MHP. Individuals currently enrolled in the health plan whose qualifying event pre-dates August 1, 2012, will be enrolled with CSHCS effective April 1, 2013.

Manual Maintenance

Retain this bulletin until the information has been incorporated into the Michigan Medicaid Provider Manual.

Questions

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Community Health, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mailed to ProviderSupport@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, and phone number so you may be contacted if necessary. Providers may phone toll-free 1-800-292-2550.

Approved

Stephen Fitton, Director
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