Michigan Department of Community Health
Program Policy
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Michigan Department of Community Health
MDCH
Rick Snyder, Governor
James K. Haveman, Director

September 2012

<Provider Name>
<Provider Address1>
<Provider Address2>
<Provider City> <state> <zipcode5-zip4>

Dear Provider:

The Michigan Department of Community Health (MDCH) recently issued policy in bulletin MSA 12-46 announcing the change in enrollment status of beneficiaries that have eligibility for both Medicaid and Children's Special Health Care Services (hereafter referred to as CSHCS/MA beneficiaries). Effective October 1, 2012, CSHCS/MA beneficiaries will be required to enroll into a Medicaid Health Plan (MHP) in their county.

Continuity of Care with Primary Care, Specialty Care, and Hospital Providers

In order to ensure a smooth transition of CSHCS/MA beneficiaries into managed care, MDCH is requiring the MHPs to allow CSHCS/MA beneficiaries to continue to see an established primary care, specialty or hospital provider, even if this established provider is out-of-network, as described in this paragraph. Out-of-network providers serving CSHCS/MA beneficiaries are encouraged to contract with the MHPs. However, even if the established out-of-network provider does not contract with the MHP, the provider must work with the MHP on the patient's care coordination, prior authorization request and medical management activities. If the out-of-network provider does not coordinate with the MHP's case management team for the care of the beneficiary on such issues as prior authorization and medical management, the MHP may move the CSHCS/MA beneficiary to a network provider. If an out-of-network established provider chooses not to contract with the MHP, the MHP may bring the CSHCS/MA beneficiary into network through transition to an appropriate network provider upon consultation and arrangement with the family and the care team. Additionally, MHPs will pay out-of-network providers at the Medicaid rate as was done under Fee-For-Service (FFS) CSHCS.

Prior Authorizations

To minimize the potential for access to care issues during the transition into an MHP, MDCH also requires the MHPs to maintain prior authorizations approved by FFS Medicaid for CSHCS/MA beneficiaries for the time period summarized below. As explained in bulletin MSA 12-46:

- MHPs must accept FFS prior authorizations in place for the first month following the CSHCS/MA beneficiary's enrollment in the MHP. 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 Medicaid rate or special prior authorized rate, as applicable, for the first month following the CSHCS/MA beneficiary's enrollment in the MHP. 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 MHP to facilitate payment. For the first month following the CSHCS/MA beneficiary's enrollment in the MHP, the service provider should attach a copy of the previously approved FFS prior authorization to the MHP billing invoice. After the first 30 days, the provider must contact the MHP to obtain prior authorization.

Verify Eligibility and Enrollment Status Before Providing Services

Long-standing Medicaid policy requires providers to verify a beneficiary's eligibility and enrollment status ***prior*** to providing services, with the exception of emergency services prior to stabilization. A complete description of how to verify beneficiary eligibility and enrollment is provided in the Medicaid Provider Manual, Beneficiary Eligibility Chapter. Providers may not bill FFS or the beneficiary for services covered by the MHP if the MHP denies a claim for the provider's failure to obtain prior authorization.

MHP Excluded Services

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, in-state approved intensive feeding clinics 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. CSHCS/MA beneficiaries will continue to access these benefits through Medicaid FFS.

Beneficiaries Excluded from MHP Enrollment

Beneficiary communications and enrollment plans for these beneficiaries are in process. Providers can assist in the smooth transition of CSHCS/MA beneficiaries into managed care by informing their patients about the MHPs with which they contract. Be aware, however, there are some factors that exclude CSHCS/MA beneficiaries from enrolling in an MHP such as private HMO coverage (OI 89) and those beneficiaries approved for Private Duty Nursing (PDN) services. Refer to the Medicaid Provider Manual, Beneficiary Eligibility Chapter, for the list of all exclusions from mandatory enrollment.

Thank you for continuing to provide care and support to Michigan's most vulnerable citizens. If you have any questions you may contact Provider Inquiry at 1-800-292-2550 or providersupport@michigan.gov.

Sincerely,

Stephen Fitton, Director
Medical Services Administration