MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
CHILDREN'S SPECIAL HEALTH CARE SERVICES MANAGED CARE ENROLLMENT

(FY 2014 Appropriation Bill – Public Act 59 of 2013)

October 1, 2013

Sec. 1204. By October 1 of the current fiscal year, the department shall report to the senate and house appropriations committees on community health and the senate and house fiscal agencies on its plan for enrolling Medicaid eligible children's special health care services recipients in the Medicaid health plans. The report shall include information on which Medicaid health plans are participating, the methods used to assure continuity of care and continuity of ongoing relationships with providers, and projected savings from the implementation of the proposal.

Rick Snyder, Governor
James K. Haveman, Director

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
SECTION 1204- Public Act 59 of 2013

Bureau of Family, Maternal, and Child Health

Children's Special Health Care Services (CSHCS) strives to enable individuals with special health care needs to have improved health outcomes and an enhanced quality of life through the appropriate use of the CSHCS system of care. For September, 2013, 32,986 individuals were enrolled in CSHCS. Of these, 22,681 were dually eligible for Medicaid and CSHCS, and 17,866 of these dually eligible were enrolled in a health plan.

CSHCS works to:

- Assist individuals with special health care needs in accessing the broadest possible range of appropriate medical care, health education and supports.
- Assure delivery of these services and supports in an accessible, family centered, culturally competent, community-based and coordinated manner.
- Promote and incorporate parent/professional collaboration in all aspects of the program.
- Remove barriers that prevent individuals with special health care needs from achieving these goals.

The benefits of transitioning individuals dually eligible for Medicaid and CSHCS into managed care include:

- Improved access to and an organized approach for primary care
- Addition of health plan case management services and medical care coordination
- Enhanced quality monitoring which will lead to quality improvement
- Enhanced access to outpatient mental health services
- Increased access to non-emergency transportation services

A collaborative workgroup formed and worked for two years to plan for and transition individuals dually eligible for Medicaid and CSHCS from Medicaid fee-for-service to managed care. The effort included staff from various areas of the Department of Community Health's Medical Services Administration and Public Health Administration as well as staff from the Department of Human Services. The team also included staff from external organizations such as the Michigan State University Institute for Healthcare Studies, and Maximus (Medicaid's enrollment broker). Additionally, monthly meetings have been held throughout the past two years with health plans and throughout the past eighteen months with local health departments as part of the transition planning efforts. Subcommittees have also formed regarding information technology systems, care coordination, communications, and data. Numerous meetings have also been held with representatives from Michigan's children's hospitals and pediatric regional centers. The transition planning has taken thousands of hours and the transition successfully went live on October 1, 2012. As of September 1, 2013, 17,866 individuals were dually enrolled in CSHCS and a health plan.

A. Information on which health plans are participating

The health plan's eligibility to participate in the enrollment of CSHCS beneficiaries who also have Medicaid is predicated upon their ability to meet the required set of CSHCS core competencies approved by the Department. These core competencies were developed by the Department in conjunction with representatives from the Michigan State University Institute for Health Care Studies. The core competencies address access standards, network adequacy, referral processing, performance monitoring, grievance/appeals, prior authorization, family involvement,

and overall health plan performance. All health plans that meet the core competencies are required to participate. The Michigan State University Institute for Healthcare Studies reviewed the documentation submitted by the health plans to assess compliance with the core competencies.

The following twelve health plans documented compliance with the core competencies and are participating. – Blue Cross Complete, CoventryCares of Michigan, HealthPlus Partners, Inc, McLaren Health Plan, Meridian Health Plan of Michigan, Midwest Health Plan, Molina Healthcare of Michigan, Physicians Health Plan Family Care, Priority Health Government Programs, Inc, Total Health Care, UnitedHealthCare Community Plan, Upper Peninsula Health Plan.

B. The methods used to assure continuity of care and continuity of ongoing relationships with providers

In addition to the core competencies which address access standards and network adequacy, the Department added contractual requirements to the health plan contracts for CSHCS enrollees to ensure access to care, continuity of care, and continuity of ongoing relationships with providers. The health plans are contractually obligated to:

- Maintain continuity of care for primary and specialty care
- Accept prior authorizations in place prior to enrollment for providers in and out of network
- Maintain additional network adequacy and availability requirements for providing services to CSHCS enrollees
- Maintain grievance and appeals process specific to CSHCS enrollees
- Monitor and report performance against defined measures for CSHCS enrollees
- Implement special requirements for selection of primary care physician
- Provide a higher payment for Family Centered Medical Homes
- Establish a care coordination agreement with local health departments

The workgroups that were convened to plan for the transition of the eligible CSHCS population into health plans will continue to convene to assess continuity of care and continuity of ongoing relationships with providers. Mechanisms have been established to receive feedback from families, providers, local health departments, and health plans through established workgroups and advisory committees.

C. Projected savings from the implementation of the proposal

In development of the CSHCS managed care rates, the actuary applied adjustments to fee for service data based upon savings expected in a managed care environment. An internal impact analysis will be completed upon availability of post transition data.