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State/Territory Name: Michigan

State Plan Amendment (SPA) #: MI-22-0024-CHIP

This file contains the following documents in the order listed:

- 1) Approval Letter
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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, MD 21244-1850



Children and Adults Health Programs Group

September 8, 2022

Farah Hanley
Chief Deputy for Health
Michigan Department of Health and Human Services
400 S. Pine
Lansing, MI 48913

Dear Ms. Hanley:

Your title XXI Children's Health Insurance Program (CHIP) state plan amendment (SPA), MI-22-0024-CHIP, submitted on June 28, 2022, has been approved. The SPA has an effective date of May 1, 2022.

SPA MI-22-0024-CHIP modifies the lead abatement Health Services Initiative (HSI) portion of the CHIP state plan to allow for the removal of any galvanized steel plumbing components connected to service lines that contain lead hazards. Additionally, this SPA updates the reference value used to prioritize lead abatement services for children. The new reference value is an elevated blood lead level (EBLL) that is greater than the most current Centers for Disease Control and Prevention blood lead reference value. The HSI also revises the clearance lead levels used to compare clearance testing results after lead abatement work has been completed to be consistent with the most current levels established by the Department of Housing and Urban Development and the Environmental Protection Agency.

This approval is based on Section 2105(a)(1)(D)(ii) of the Social Security Act (the Act) and 42 CFR §§457.10 and 457.618, which authorize use of title XXI administrative funding for expenditures for HSIs under the plan for improving the health of children, including targeted low-income children and other low-income children. Consistent with section 2105(c)(6)(B) of the Act and 42 CFR §457.626, title XXI funds used to support an HSI cannot supplant Medicaid or other sources of federal funding.

The state shall ensure that the remaining title XXI administrative funding, within the state's 10 percent limit, is sufficient to continue the proper administration of the CHIP program. If such funds become less than sufficient, the state agrees to redirect title XXI funds from the support of this HSI to the administration of the CHIP program. The state shall report annually to CMS the expenditures funded by the HSI for each federal fiscal year.

Page 2 - Ms. Farah Hanley

Your title XXI project officer is Ms. Joyce Jordan. She is available to answer questions concerning this amendment and other CHIP-related issues. Her contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop: S2-01-16
7500 Security Boulevard
Baltimore, MD 21244-1850
Telephone: (410) 786-3413
E-mail: Joyce.Jordan@cms.hhs.gov

If you have any questions, please contact Meg Barry, Director, Division of State Coverage Programs, at (410) 786-1536. We look forward to continuing to work with you and your staff.

Sincerely,
/Signed by Amy
Lutzky/

Amy Lutzky
Deputy Director

**MODEL APPLICATION TEMPLATE FOR
STATE CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT
STATE CHILDREN'S HEALTH INSURANCE PROGRAM**

Preamble

Section 4901 of the Balanced Budget Act of 1997 (BBA) amended the Social Security Act (the Act) by adding a new title XXI, the State Children's Health Insurance Program (SCHIP). Title XXI provides funds to states to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner. To be eligible for funds under this program, states must submit a state plan, which must be approved by the Secretary. A state may choose to amend its approved state plan in whole or in part at any time through the submittal of a plan amendment.

This model application template outlines the information that must be included in the state child health plan, and any subsequent amendments. It has been designed to reflect the requirements as they exist in current regulations, found at 42 CFR part 457. These requirements are necessary for state plans and amendments under Title XXI.

The Department of Health and Human Services will continue to work collaboratively with states and other interested parties to provide specific guidance in key areas like applicant and enrollee protections, collection of baseline data, and methods for preventing substitution of Federal funds for existing state and private funds. As such guidance becomes available; we will work to distribute it in a timely fashion to provide assistance as states submit their state plans and amendments.

Form CMS-R-211

Effective Date: May 1, 2022

Approval Date: September 8, 2022

**MODEL APPLICATION TEMPLATE FOR
STATE CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT
STATE CHILDREN'S HEALTH INSURANCE PROGRAM**

(Required under 4901 of the Balanced Budget Act of 1997 (New section 2101(b)))

State/Territory: Michigan
(Name of State/Territory)

As a condition for receipt of Federal funds under Title XXI of the Social Security Act, (42 CFR, 457.40(b))

(Signature of Governor, or designee, of State/Territory, Date Signed)

submits the following State Child Health Plan for the State Children's Health Insurance Program and hereby agrees to administer the program in accordance with the provisions of the approved State Child Health Plan, the requirements of Title XXI and XIX of the Act (as appropriate) and all applicable Federal regulations and other official issuances of the Department.

The following state officials are responsible for program administration and financial oversight (42 CFR 457.40(c)):

Name: Logan Dreasky	Position/Title: Manager, Eligibility Policy Section
Name:	Position/Title:
Name:	Position/Title:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0707. The time required to complete this information collection is estimated to average 160 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, N2-14-26, Baltimore, Maryland 21244.

Effective Date: May 1, 2022

Approval Date: September 8, 2022

Section 1. General Description and Purpose of the State Child Health Plans and State Child Health Plan Requirements (Section 2101)

1.1 The state will use funds provided under Title XXI primarily for (Check appropriate box) (42 CFR 457.70):

1.1.1 Obtaining coverage that meets the requirements for a separate child health program (Section 2103); **OR**

1.1.2. Providing expanded benefits under the State's Medicaid plan (Title XIX); **OR**

1.1.3. A combination of both of the above.

1.2 Please provide an assurance that expenditures for child health assistance will not be claimed prior to the time that the State has legislative authority to operate the State plan or plan amendment as approved by CMS. (42 CFR 457.40(d))

Michigan received federal approval to implement MICHild effective May 1, 1998. All claimed expenditures were after May 1, 1998.

1.3 Please provide an assurance that the state complies with all applicable civil rights requirements, including title VI of the Civil Rights Act of 1964, title II of the Americans with Disabilities Act of 1990, section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, 45 CFR part 80, part 84, and part 91, and 28 CFR part 35. (42CFR 457.130)

Michigan complies with the above by including the following statements on the application:

Michigan Department of Health and Human Services (MDHHS) will not discriminate against any individual or group because of race, sex, religion, age, national origins, marital status, disability or political beliefs.”

“If you need help with this application, call toll free **1-888/988-6300**
Spanish: If you need help with this application, call toll free **1-888/988-6300**
Arabic: If you need help with this application call toll free **1-888/988-6300**”

“If you need help with reading or writing to complete this application, under the Americans with Disabilities Act, you are invited to make your needs known by calling **1-888/988-6300** or your local FIA office.”

Model Application Template for the State Children's Health Insurance Program

“You have the right to appeal a decision made by the MDHHS. You will be notified of your rights if your application is denied for any reason.”

1.4

Please provide the effective (date costs begin to be incurred) and implementation (date services begin to be provided) dates for this plan or plan amendment (42 CFR 457.65):

Date of Plan Submitted:	December 29, 1997
Date Plan Approved:	April 7, 1998
State Plan Effective Date:	May 1, 1998
Date Amendment #1 Submitted:	April 16, 1998
Date Amendment #1 Effective:	May 1, 1998
Date Amendment #2 Submitted:	December 21, 1998
Date Amendment #2 Effective:	January 1, 1999
Date Amendment #3 Submitted:	May 28, 1999
Date Amendment #3 Effective:	June 28, 1999
Date Amendment #4 Submitted:	May 30, 2000
Date Amendment #4 Effective:	July 1, 2000
Date Amendment #5 Submitted:	August 13, 2001
Date Amendment #5 Effective:	July 1, 2001
Date Amendment #6 Submitted:	December 20, 2003
Date Amendment #6 Effective:	July 1, 2002
Date Amendment #7 Submitted:	January 9, 2003
Date Amendment #7 Effective:	December 1, 2002
Date Amendment #8 Submitted:	June 1, 2005
Date Amendment #8 Effective:	November 1, 2005
Date Amendment #9 Submitted:	January 16, 2007
Date Amendment #9 Effective:	October 1, 2006
Date Amendment #10 Submitted:	March 8, 2007
Date Amendment #10 Effective:	April 1, 2007
Date Amendment #11 Submitted:	March 30, 2010
Date Amendment #11 Effective:	January 1, 2010

Effective Date: May 1, 2022

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Date Amendment #12 Submitted:	August 28, 2010
Date Amendment #12 Effective:	October 1, 2010
Date Amendment #13 Submitted:	September 28, 2011
Date Amendment #13 Effective:	October 1, 2010
Date Amendment #14 Submitted:	February 21, 2013
Date Amendment #14 Effective:	April 1, 2013
Date Amendment #15 Submitted:	October 4, 2013
Date Amendment #15 Withdrawn:	October 14, 2013
Date Amendment #16 Submitted:	March 21, 2014
Date Amendment #16 Effective:	July 1, 2014
Date Amendment #MI-15-0001-CHIP Submitted:	March 31, 2015
Date Amendment #MI-15-0001-CHIP Withdrawn:	June 4, 2015
Date Amendment #MI-15-0002-CHIP Submitted:	December 17, 2015
Date Amendment #MI-15-0002-CHIP Effective:	January 1, 2016
Date Amendment #MI-16-0017-CHIP Submitted:	November 3, 2016
Date Amendment #MI-16-0017-CHIP Effective:	January 1, 2017
Date Amendment #MI-17-0018-CHIP Submitted:	September 7, 2017
Date Amendment #MI-17-0018-CHIP Effective:	January 1, 2017
Date Amendment #MI-18-0019-CHIP Submitted:	August 8, 2018
Date Amendment #MI-18-0019-CHIP Effective:	October 2, 2017
Date Amendment #MI-19-0020-CHIP Submitted:	May 23, 2019
Date Amendment #MI-19-0020-CHIP Effective for lead abatement HSI:	January 1, 2019
Date Amendment #MI-19-0020-CHIP Effective for Poison Control HSI:	August 1, 2019
Date Amendment #MI-20-0021-CHIP Submitted:	September 30, 2020
Date Amendment #MI-20-0021-CHIP Effective:	March 1, 2020
Disaster Relief SPA Not Yet Approved	
Date Amendment #MI-20-0022-CHIP Submitted:	September 30, 2020
Date Amendment #MI-20-0022-CHIP Effective:	October 1, 2020
Date Amendment #MI-22-0024-CHIP Submitted:	June 28, 2022
Date Amendment #MI-22-0024-CHIP Effective:	May 1, 2022

Effective Date: May 1, 2022

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Superseding Eligibility Pages of Modified Adjusted Gross Income (MAGI) CHIP State Plan Material
State: Michigan

Transmittal Number	SPA Group	PDF #	Description	Superseded Plan Section(s)
MI-13-0001 Date Submitted: 12/20/13 Approval Date: 10/09/14 Effective/Implementation Date: January 1, 2014	MAGI Eligibility & Methods	CS7	Eligibility – Targeted Low Income Children	Supersedes the current sections 4.1.1, 4.1.2 and 4.1.3
		CS9	Eligibility – Coverage from Conception to Birth	Supersedes the current sections 4.1.1, 4.1.2 and 4.1.3
		CS15	MAGI-Based Income Methodologies	Incorporated within a separate subsection under section 4.3
MI-13-0002 Date Submitted: 12/20/13 Approval Date: 12/22/14 Effective/Implementation Date: January 1, 2014	XXI Medicaid Expansion	CS3	Eligibility for Medicaid Expansion Program	Supersedes the current Medicaid expansion section 4.0
MI-13-0003 Date Submitted: 12/20/13 Approval Date: 03/17/14 Effective/Implementation Date: January 1, 2014	Establish 2101(f) Group	CS14	Children Ineligible for Medicaid as a Result of the Elimination of Income Disregards	Incorporated within a separate subsection under section 4.1
MI-13-0004 Date Submitted: 12/20/13 Approval Date:	Eligibility Processing	CS24	MAGI-Based Eligibility Process	Supersedes the current items in sections 4.3 and 4.4 related to application processing,

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Transmittal Number	SPA Group	PDF #	Description	Superseded Plan Section(s)
03/11/14 Effective/Implementation Date: October 1, 2013				eligibility screening and enrollment, and renewals
MI-13-0005 Date Submitted: 12/20/13 Approval Date: 12/17/15 Effective/Implementation Date: January 1, 2014 Effective/Implementation Date for CS20 only: January 24, 2014	Non-Financial Eligibility	CS17 CS18 CS19 CS20 CS21	Non-Financial Eligibility – Residency Non-Financial Eligibility – Citizenship Non-Financial Eligibility – Social Security Number Non-Financial Eligibility – Substitution of Coverage Non-Financial Eligibility – Non-Payment of Premiums	Supersedes the current section 4.1.5 Supersedes the current section 4.1.0 Supersedes the current section 4.1.9 Supersedes the current section 4.4.4 Supersedes the current Cost Sharing and Payment section 8.7
MI-15-0003 Date Submitted: 12/17/15 Approval Date: 03/08/16 Effective/Implementation Date: January 1, 2016	XXI Medicaid Expansion	CS3	Eligibility for Medicaid Expansion Program	Supersedes the current Medicaid expansion section 4.0 and MI-13-0002
MI-15-0004	Non-Financial Eligibility	CS21	Non-Financial Eligibility –	Supersedes the current Cost Sharing

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Transmittal Number	SPA Group	PDF #	Description	Superseded Plan Section(s)
Date Submitted: 12/17/15 Approval Date: 03/08/16 Effective/Implementation Date: January 1, 2016			Non-Payment of Premiums	and Payment section 8.7

Section 2. General Background and Description of State Approach to Child Health Coverage and Coordination (Section 2102 (a)(1)-(3)) and (Section 2105)(c)(7)(A)-(B))

2.1. Describe the extent to which, and manner in which, children in the state including targeted low-income children and other classes of children, by income level and other relevant factors, such as race and ethnicity and geographic location, currently have creditable health coverage (as defined in 42 CFR 457.10). To the extent feasible, make a distinction between creditable coverage under public health insurance programs and public-private partnerships (See Section 10 for annual report requirements). (42 CFR 457.80(a))

State Response: Much attention has been given to the problem of the lack of health insurance coverage for the unborn child in low-income families –whose incomes are at or below 195 percent of the Federal Poverty Level and who are uninsured. This is the baseline figure used by Michigan as the target for Medicaid or Maternity Outpatient Medical Services (MOMS) enrollment.

2.2. Describe the current state efforts to provide or obtain creditable health coverage for uncovered children by addressing: (Section 2102)(a)(2) (42CFR 457.80(b))

2.2.1. The steps the state is currently taking to identify and enroll all unborn children who are eligible to participate in public health insurance programs (i.e. Medicaid and state-only child health insurance):

State Response: Michigan currently has several programs focused on identifying potentially eligible Medicaid clients and assisting them to complete enrollment forms to become Medicaid recipients. All local health departments in the state have at least two sources of funding specifically for outreach to families and children not currently enrolled in Medicaid and for provision of assistance in applying for Medicaid eligibility.

Medicaid provides funding to all forty-two local health departments so they can identify pregnant women whose unborn child is not currently enrolled in Medicaid, assist them in completing enrollment materials, and in selecting and obtaining access to health care providers

serving Medicaid eligible pregnant women and the unborn child. The health departments also have a Prenatal Care Enrollment and Coordination Program which provides outreach to facilitate access to prenatal care through the Healthy Kids Program, and assistance in obtaining access to a prenatal care provider. This program also provides families with assistance in completing Medicaid enrollment forms for children, which are then forwarded to Medicaid for determination of eligibility. Services provided through this program include assistance in completion of the Medicaid application gathering all required verifications, negotiating the Medicaid system, obtaining health care providers, responding to managed care problems/concerns, and obtaining access to other support programs.

Several other programs provide outreach for special populations as identified below.

- Maternal Support Services (MSS): Pregnant women and teens that are potentially Medicaid-eligible are assisted in obtaining Medicaid enrollment by providers throughout the state. As with the ISS program, both public and private agencies are providers. This program also provides services to non-Medicaid-eligible women and teens with additional state funding made available for this purpose.
- Maternal and Infant Health Advocacy Services Program (MIHAS): This program provides outreach to pregnant women who are not currently receiving prenatal care, assists them in dealing with situations which may keep them from remaining in prenatal care, and supports and reinforces the health education messages delivered by health care providers. MIHAS services are delivered by a team of paraprofessional advocates and a supervisor specifically trained to deal with the psychosocial problems of high-risk, low-income pregnant women. Paraprofessional advocates must be indigenous to the community and have been on Medicaid.
- Special Supplemental Nutrition Program for Women, Infants and Children (WIC): WIC screens and refers clients to other appropriate health and social services, including Medicaid, food stamps, prenatal care, immunizations, smoking cessation programs, and substance abuse programs. Referral of WIC clients for Medicaid enrollment is a required outreach activity in this program. Nearly half of the infants born in Michigan are served by the WIC Program, making this an important source of outreach for Medicaid enrollment.

2.2.2. The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in health insurance programs that involve a public-private partnership:

State Response: Prenatal Care Enrollment and Coordination Program provides outreach to facilitate access to prenatal care and assistance in obtaining access to a prenatal care provider. Michigan is working with *Covering Kids*, a national public/private partnership, by providing

staffing and materials to promote education and outreach at health-related conferences. The Michigan initiative is called *Covering Michigan's Kids*.

NOTE: In the revised "Template for Child Health Plan under title XXI of the Social Security Act Children's Health Insurance Program," section 2.2 is designed specifically for states to request to use the funds available under the 10 percent limit on administrative expenditures to implement a health services initiative.

The revised section 2.2 reads as follows:

2.2. Health Services Initiatives - Describe if the State will use the health services initiative option as allowed at 42 CFR 457.10. If so, describe what services or programs the State is proposing to cover with administrative funds, including the cost of each program, and how it is currently funded (if applicable), and also update the budget accordingly. (Section 2105(a)(1)(D)(ii)); (42 CFR 457.10)

As permitted under section 2105(a)(1)(D)(ii) of the Social Security Act and federal regulations at 42 CFR 457.10, the State of Michigan is doing a health services initiative that will use CHIP funds, within the federal administrative expenditures cap allowed for states, to support the Michigan Poison Control Center (MPCC) at Wayne State University. Effective August 1, 2019, the MPCC administration will transition from Children's Hospital of Michigan to Wayne State University. Separate payments will be made to each entity based on the periods of administration. The MPCC provides emergency telephone treatment advice, referral assistance, and information to manage exposures to poisonous and hazardous substances. The MPCC answers poisoning emergency calls from the general public as well as health care providers needing assistance 24 hours a day, 365 days each year at no charge to the caller.

The MPCC provides numerous services including:

- 24-hour emergency and information hotline services
- follow-up calls regarding continuing care in poison exposure cases
- health and safety professional education
- state and national data collection providing epidemiologic public health surveillance
- access to emergency information as an integral part of local, state and national emergency preparedness
- responses for natural and manmade disasters
- acting as a clearinghouse for scarce resources and antidotes
- providing guidance in the treatment of hazardous incidents to the public
- providing interpretative assistance of forensic data for law enforcement and medical examiners
- assisting other federal and state agencies in risk-assessment for potentially toxic exposures

Certified Specialists in Poison Information and medical or clinical toxicologists are available

Model Application Template for the State Children's Health Insurance Program

24 hours a day, 365 days a year to manage cases. The service is provided via a toll-free telephone number to every community throughout Michigan, including under-served, low income, and indigent populations. Services are available by use of an interpreter in over 150 languages and via telecommunications devices for the deaf and hearing impaired (TTY).

The MPCC provides public education programs directed towards pediatric accidental poisoning as well as targeted "at-risk" populations. Educational materials and teaching curricula are distributed throughout the state, free of charge to the public. Materials are also available in Spanish and Arabic. The MPCC participates in a variety of community injury prevention including health fairs. The MPCC also provides a robust professional educational program designed to train medical and safety professionals in the identification and treatment of poisoning and hazardous exposures including pre-hospital and first-responder training.

The MPCC receives approximately 64,000 calls annually involving individuals exposed to poisons or hazardous substances. Sixty percent of all poisoning exposure calls received involve children under age 19. For CHIP eligible children, over 33 percent of the total calls relate to poisoning exposures of children in families whose annual household incomes is \$51,500 or less (200% FPL for a family of 4 in 2019). In addition to calls regarding exposures, the MPCC receives over 10,000 calls each year from callers requesting information about poison prevention, effective use of chemicals, drug identification, substance abuse and other medical questions. These calls are considered preventive.

MPCC intervention resulted in over 71 percent of the unintentional exposure calls (in children under age 19) being handled in the home so the children did not have to use an emergency department or need a 911 call and response. For those children whose exposure necessitated hospital evaluation and treatment, MPCC intervention contributed substantially to reduced resource utilization and decreased length of stay with significant cost savings to the community.

The state assures that the Michigan Poison Control Center (MPCC) at Wayne State University will not supplant or match CHIP federal funds with other federal funds, nor allow other federal funds to supplant or match CHIP federal funds.

As permitted under section 2105(a)(1)(D)(ii) of the Social Security Act and federal regulations at 42 CFR 457.10, the State of Michigan is doing a health services initiative that will use CHIP funds, within the federal administrative expenditures cap allowed for states, to support expanded lead abatement activities in the impacted areas of Flint, Michigan and other areas within the State of Michigan, as further described herein. Federal assistance is necessary to minimize and further prevent any long-term adverse health effects associated with lead exposure, both in Flint and across Michigan. This targeted and time-limited health services initiative would complement other federal, state and local efforts to abate lead hazards from the homes and improve the health of Medicaid and CHIP eligible individuals.

Effective Date: May 1, 2022

Approval Date: September 8, 2022

Lead Abatement Defined

As alluded to in Michigan’s February 14, 2016 application for the now approved Section 1115 Demonstration, the State is seeking federal funding pursuant to Section 2105(a)(1)(D)(ii) of the Social Security Act for the enhancement and expansion of its current lead abatement program through the use of a CHIP health services initiative. As part of this expansion, the State would provide coordinated and targeted lead abatement services to eligible properties in the impacted area to mitigate all lead risks to the extent possible up to the point of family and/or property owner disengagement. Abatement services are defined as the removal of lead hazards, including:

- The permanent removal, or enclosure, or encapsulation of lead based paint and lead dust hazards from an eligible residence.
- The removal and replacement of surfaces or fixtures within the eligible residence.
- The removal or covering of soil lead hazards up to the eligible residence property line.
- Minimal rehab to the extent that this work helps to extend the life of the lead abatement work done consistent with HUD guidelines (located at https://www.hud.gov/offices/lead/library/lead/PGI-2008-02_Doing_Minimal_Rehab.pdf) and any subsequent amendments to the HUD guidelines, and
- All preparation, lab sampling analysis, clean up, disposal, and pre and post-abatement paint, dust, soil and clearance testing activities associated with such measures including pre and post-water sampling.

Eligible properties include owner-occupied, rental, and residential structures that an eligible individual inhabits or visits regularly (e.g. home of a family member, relative, or other informal child care where a child often visits). A rental property funding scale for those with ownership stake in more than 1 rental property may be established to reduce the CHIP HSI federal and state program spending on the related projects and maximize the number of homes in which the program provides abatement assistance and to ensure that the program is able to enroll high cost projects in the program equitably among property owners. Project cost must be approved by Regional Field Consultant to align with estimate and Lead Services Section Manager. There is currently no maximum funding cap placed on rental unit projects however, rental property owners may be asked to provide match to the project as follows:

Number of Units Owned by RPO, in addition to enrolled unit (s)	Maximum Assistance Provided PER UNIT, by LSHP- Based on number of units enrolled		
	Single Family Unit	2-4 Units Adjoined	≥5 units Adjoined
1	100%		
2-4	95%	85%	75%
≥5	80%	70%	60%

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Once work has started on an eligible property, all eligible surfaces and fixtures will be abated to the extent possible up to the point of family and/or property owner disengagement. A client engagement protocol is being implemented by the state to maximize participation. Eligible surfaces for abatement activities include all structural components identified during an environmental investigation or the lead inspection/risk assessment as hazards including but not limited to: all window components, door and door frames, stairs, interior walls and ceilings, painted cabinets, interior railings, painted floors, exterior porches, exterior painted siding, exterior windows and trim, exterior trim boards, exterior painted siding, trim and doors on garages and other structures, and soil. Eligible fixtures includes all interior plumbing components with the general exception of the interior water meter, which will be addressed in accordance with each community's coordinated plan. In Flint, this also includes the exterior lead and galvanized steel service lines that supply drinking water to the home, which shall be completed concurrently or prior to abatement of interior plumbing fixtures funded through this initiative. Outside of Flint, the State will recommend replacement of faucets that have not been replaced prior to 2014 regardless of water sample result and fixture and/or complete lead and galvanized steel service line replacement if water sampling results are above the acceptable level. The State will also recommend the replacement of any galvanized steel plumbing components downstream of a lead in water exceedance. A home shall not be deemed abated if water results indicate the presence of lead in the water supply line over the acceptable level.

The state assures that no partial service line replacements will be conducted under this health services initiative. Service line replacement must be "complete," meaning that both the public and private portions of the service line will be replaced. The state will supplement, not supplant, other federal, state, and local funds allocated for the removal of service lines.

For the purposes of this request, abatement does not include any of the following:

- Work that does not reduce a lead hazard.
- Work not performed by a certified lead abatement professional and/or a licensed plumber
- Work that is not the responsibility of the property owner or landlord outside the confines of the property lines, with the exception of the public portion of service lines in Flint and on a case by case basis in other communities following the guidelines put forth in this health services initiative.
- Work on dwellings that have not been determined at application to have an eligible Medicaid or CHIP individual, under the age of 19, or pregnant women residing or frequently visiting the structure.

Provision of Abatement Services

For this health services initiative, abatement activities would only be permissible for federal funds if the services are delivered to properties that have been determined at application to have a Medicaid or CHIP-eligible individual, under the age of 19, or pregnant woman residing or visiting regularly.

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Services may be rendered to the physical structure and include the surrounding land up to the property line, and would be coordinated with any service line removal that occurs outside of the property line. Federal funds can be used to support family relocation costs for up to 10 days if needed consistent with HUD guidelines and any subsequent amendments to the HUD guidelines. This limit on relocation day support can be extended on a case by case basis. This SPA will be in effect for five years from the effective date or until all homes included in the scope of this SPA have been abated for lead.

The State will ensure that eligible properties in the impacted areas of Flint, Michigan receive priority status. Upon approval of this health services initiative, outreach will begin to identify eligible properties and engage affected beneficiaries in Flint. The State will concurrently begin identifying other high-risk communities within Michigan that will be targeted for health services initiative-approved abatement activities. Target communities will be selected based on the following criteria:

- Number/percentage of population under age 6 with an elevated blood lead level that is greater than the most current CDC Blood Lead Reference Value;
- Percentage of population that is low-income;
- Number/percentage of pre-1978 and pre-1940 housing stock; and
- Other social determinant factors (e.g. unemployment rate, number/percentage of children receiving state assistance and housing conditions).
- Medicaid or CHIP-eligible beneficiaries that have a blood lead level that is greater than the most current CDC Blood Lead Reference Value in non-target areas will also be eligible for abatement activities.

In Flint, abatement services on eligible properties must be coordinated with the ongoing state and local water service line efforts. Interior plumbing and fixture abatement will be done only after service line replacement, if required under this health service initiative, has been completed. In Flint, interior plumbing and fixture abatement may occur prior to service line replacement if the city of Flint is handling the replacement of the service line. In such circumstances, after the replacement of the service line is complete, a whole house flushing procedure that will include allowing the water to flush through the plumbing, removing and cleaning aerators or replacing them if necessary, and testing of water samples to ensure no recontamination of the interior plumbing and fixtures must be performed.

Prior to starting work on homes in additional target areas, the State will notify CMS 60 days prior to work beginning in those communities. Additionally, the State will work with each community to develop a coordinated plan to guide these lead abatement activities. Services performed must be part of a comprehensive plan that ensures abatement activities of the eligible individual's residence align with the affected infrastructure needs (if applicable).

Individuals performing abatement services must be properly certified by the state. Only a person certified by MDHHS as a lead abatement supervisor or lead abatement worker may perform lead abatement activities in accordance with state law. A supervisor is defined as an individual who has been trained by an accredited training program and certified by MDHHS to supervise and conduct lead abatement services and to prepare occupant protection plans and abatement reports. A lead

abatement supervisor is required for each lead abatement job, and must be present at the job site while all abatement work is being done. This requirement includes set up and clean up time. The lead abatement supervisor must ensure that all abatement work is done within the limits of federal, state, and local laws.

A lead abatement worker is an individual who has been trained to perform abatements by an accredited training program and who is certified by MDHHS to perform lead abatement. Professionals certified by MDHHS are issued a card containing the person's picture, name, certification number, and expiration date. All certified professionals must work for a MDHHS certified lead abatement company. The abatement company and its employees must use abatement methods approved by the U.S. Department of Housing and Urban Development (HUD) and/or the U.S. Environmental Protection Agency (EPA) and in accordance with state laws and regulations.

The department may certify entities who meet the professional requirements for lead and galvanized steel service line removal and have been contracted to do such work under an approved coordinated plan.

For the purposes of this health services initiative, MDHHS requests funding to supplement the training of individuals in lead abatement in accordance with Michigan Compiled Law 333.5461 – 333.5468. Individual training for certification/licensure must occur through an accredited training program specific to lead. These funds will ensure that access to appropriate levels of lead professionals are available to mitigate lead risks in a timely manner.

Lastly, MDHHS requests funding to supplement the administrative functions necessary to successfully implement this CHIP health services initiative. The funding received for this request will supplement but not supplant other federal funding sources for lead abatement or the training/credentialing process of inspectors.

Post-Abatement Activities

MDHHS recognizes that abatement activities would only be eligible for federal assistance when performance of these activities can be demonstrated to be effective in abating all identified lead hazards and extending the life of the related abatement activities. State and federal laws dictate that a clearance test must be performed after any lead abatement work is finished to verify the work area is safe enough for the eligible resident(s) to return. On the inside of a house or apartment the dust is tested to confirm that abatement work has not created lead dust hazards that can poison young children, other occupants, or pets living in the building as defined in state law. Water sampling will also be conducted to confirm that respective plumbing component replacement has successfully reduced lead levels in the drinking water of affected homes.

Only a certified lead inspector or risk assessor, who is independent of the abatement company, may perform clearance testing after abatement work is completed. A certified inspector is defined as an individual who has been trained by an accredited training program and certified by MDHHS to conduct inspections and take samples for the presence of lead in paint, dust and soil for the purpose

of abatement clearance testing. A certified risk assessor is defined as an individual who has been trained by an accredited training program and certified by MDHHS to conduct inspections and risk assessments and to take samples for the presence of lead in paint, dust and soil for the purpose of abatement clearance testing.

During the clearance testing, an interior visual inspection is done to see if the identified lead hazards have been abated. These professionals also inspect for the presence of any visible dust or paint chips. If any problems are found the abatement supervisor must resolve all of them before the clearance testing may continue. After the visual inspection passes, the lead inspector or risk assessor must take dust wipe samples that are sent to a lab for analysis. Clearance dust samples must be taken from the floors, windowsills, and window troughs in the rooms where work was done. At least one sample must be taken from outside the work area if containment was used and from each unique passage way. If no containment was used, then dust wipe samples may be taken in any room. A floor and a window in at least four rooms must be sampled. The samples must be tested for lead by an EPA approved lab. After exterior paint abatement work is completed, an Inspector or Risk Assessor must perform a visual inspection of the outdoor work area ensure that the lead hazards were properly addressed. The lead inspector or lead risk assessor will then look for any paint chips on the ground including the foundation of the house, garage, or below any exterior surface abated. If paint chips are present, the abatement company must remove the chips and debris from the site and properly dispose of them before the clearance can be finished. No dust wipe clearance testing is required for abatement on the exterior of a house or rental property.

Water sampling protocols will follow prescribed methodology required in the EPA Lead and Copper rule.

Metrics/Reporting Requirements

The state believes that this health services initiative will abate identified lead hazards from the homes and improve the health of Medicaid and CHIP eligible individuals, both in Flint and throughout Michigan. Providing for enhancement and expansion of the lead hazard removal program will reduce the potential for ongoing exposure or re-exposure to lead hazards for the eligible population and future populations. A publicly-available housing registry of these ameliorated properties will be maintained by the state.

Key Metrics the state will track and report to CMS monthly or at another approved interval include:

- Number of houses identified with high levels of lead hazards in each of the targeted area(s)
- The number of homes in each of the targeted areas scheduled for lead hazard abatement.
- The number of homes in each of the targeted areas in which lead hazard abatement has occurred.

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- Number of houses abated for pregnant women.
- Number of houses abated for CHIP or Medicaid children under the age of 19.
- Record of actual services provided in each house.
- Clearance testing results.
- Percentage of children receiving blood lead testing under EPSDT statewide and in the areas targeted by this health services initiative.
- Percentage of children with elevated blood lead levels statewide and in the areas by this health services initiative.

Other metrics may be added at the agreement of the state and CMS during implementation of the HSI.

The results of the clearance testing will be maintained by the state. These testing results will have numbers with units of measurement; the units are different for dust and soil. MDHHS will apply the most current EPA and HUD clearance lead levels.

The state assures that this health services initiative will not supplant or match CHIP federal funds with other federal funds, nor allow other federal funds to supplant or match CHIP federal funds.

- 2.3. Describe the procedures the state uses to accomplish coordination of SCHIP with other public and private health insurance programs, sources of health benefits coverage for children, and relevant child health programs, such as title V, that provide health care services for low-income children to increase the number of children with creditable health coverage. *(Previously 4.4.5.)*
(Section 2102)(a)(3) and 2102(c)(2) and 2102(b)(3)(E)) (42CFR 457.80(c))

Section 3. Methods of Delivery and Utilization Controls (Section 2102)(a)(4))

~ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan**, and continue on to Section 4.

Guidance: In Section 3.1, describe all delivery methods the State will use to provide services to enrollees, including: (1) contracts with managed care organizations (MCO), prepaid inpatient health plans (PIHP), prepaid ambulatory health plans (PAHP), primary care case management entities (PCCM entities), and primary care case managers (PCCM); (2) contracts with indemnity health insurance plans; (3) fee-for-service (FFS) paid by

the State to health care providers; and (4) any other arrangements for health care delivery. The State should describe any variations based upon geography and by population (including the conception to birth population). States must submit the managed care contract(s) to CMS' Regional Office for review.

3.1. Delivery Systems (Section 2102(a)(4)) (42 CFR 457.490; Part 457, Subpart L)

3.1.1 Choice of Delivery System

3.1.1.1 Does the State use a managed care delivery system for its CHIP populations? Managed care entities include MCOs, PIHPs, PAHPs, PCCM entities and PCCMs as defined in 42 CFR 457.10. Please check the box and answer the questions below that apply to your State.

- No, the State does not use a managed care delivery system for any CHIP populations.
- Yes, the State uses a managed care delivery system for all CHIP populations.
- Yes, the State uses a managed care delivery system; however, only some of the CHIP population is included in the managed care delivery system and some of the CHIP population is included in a fee-for-service system.

If the State uses a managed care delivery system for only some of its CHIP populations and a fee-for-service system for some of its CHIP populations, please describe which populations are, and which are not, included in the State's managed care delivery system for CHIP. States will be asked to specify which managed care entities are used by the State in its managed care delivery system below in Section 3.1.2.

Guidance: Utilization control systems are those administrative mechanisms that are designed to ensure that enrollees receiving health care services under the State plan receive only appropriate and medically necessary health care consistent with the benefit package.

Examples of utilization control systems include, but are not limited to: requirements for referrals to specialty care; requirements that clinicians use clinical practice guidelines; or demand management systems (e.g., use of an 800 number for after-hours and urgent care). In addition, the State should describe its plans for review, coordination, and implementation of utilization controls, addressing both procedures and State developed standards for review, in order to assure that necessary care is delivered in a cost-effective and efficient manner. (42 CFR 457.490(b))

If the State does not use a managed care delivery system for any or some of its CHIP populations, describe the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Include a description of:

- The methods for assuring delivery of the insurance products and delivery of health care services covered by such products to the enrollees, including any variations. (Section 2102(a)(4); 42 CFR 457.490(a))
- The utilization control systems designed to ensure that enrollees receiving health care services under the State plan receive only appropriate and medically necessary health care consistent with the benefit package described in the approved State plan. (Section 2102(a)(4); 42 CFR 457.490(b))

Guidance: Only States that use a managed care delivery system for all or some CHIP populations need to answer the remaining questions under Section 3 (starting with 3.1.1.2). If the State uses a managed care delivery system for only some of its CHIP population, the State's responses to the following questions will only apply to those populations.

State Response: Medical services for the unborn child will be provided on a fee-for-service basis.

All pregnancy-related services must be determined to be medically necessary. Medical service coverage for unborn children is limited to the following prenatal and pregnancy-related services:

- Prenatal Care
- Maternal Support Services (MSS)
- Note: Pre-pregnancy family services and supplies are not covered for unborn children,
- Labor and delivery: Professional services fee, including live birth, miscarriage, ectopic pregnancy, and stillborn.
- Radiology and ultrasound
- Childbirth education
- Laboratory
- Pharmaceuticals and prescription vitamins
- Inpatient Hospital for Delivery Only
- Outpatient Hospital
- Note: Outpatient deliveries are not covered.

MDHHS, which includes public health, mental health and Medicaid, is committed to the development and implementation of community-based collaborative efforts to assist the pregnant woman and her unborn child Multipurpose Collaborative Bodies have been established throughout the state and are charged with community-based

planning and service provision. These collaborative bodies include public and private agencies and organizations focused on prenatal care for all unborn children.

The program developed under Title XXI will utilize the current networks described above to publicize the availability of prenatal coordinate activities that include assisting pregnant women and the unborn child and utilize various transportation, interpreter and other support services to enhance access to health care providers.

- 3.2. Describe the utilization controls under the child health assistance provided under the plan for targeted low-income children. Describe the systems designed to ensure that enrollees receiving health care services under the state plan receive only appropriate and medically necessary health care consistent with the benefit package described in the approved state plan. (Section 2102)(a)(4) (42CFR 457.490(b))

State Response: The State anticipates a capitation methodology of payment. The State will use its actuarial contractor to establish appropriate rates.

With a risk-based model, the state's oversight focus will be concentrated on ensuring that needed, quality services are received rather than focusing on issues attendant to service over-use. If the medical services reimbursement mechanism is non risk-based, the State will be equally sensitive to possibilities of service over-use and concerns of accessibility and quality of services received.

Utilization controls/reviews are detailed extensively after Section 7.1 after the heading "State Oversight and Monitoring."

Federally Qualified Health Center (FQHC) and Rural Health Center (RHC)

Section 503 of CHIPRA amends section 2107(e) (l) of the Act to make section 1902(bb) of the Act applicable to CHIP in the same manner as it applies to Medicaid. Section 1902(bb) governs payment for Federally Qualified Health Centers (FQHC's) and Rural Health Clinics (RHC's).

FQHC's and RHC's will be reimbursed based on the Medicaid Prospective Payment System (PPS). PPS was enacted into law under section 702 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000. Under the PPS, FQHC's and RHC's will be reimbursed on a per visit basis. The per visit payment is the Medicaid State plan PPS rate, effective for services provided on or after October 1, 2009. Reasonable costs are defined as the per visit amount approved by Medicare as adjusted to reflect the cost of providing services to CHIP beneficiaries that are not covered by Medicare – i.e. dental services, on-site laboratory and x-ray, non-emergency transportation, and outreach.

Section 4. Eligibility Standards and Methodology. (Section 2102(b))

*Policy narrative is superseded by forms listed in roster 1.4

Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 5.

4.1. The following standards may be used to determine eligibility of targeted low-income children for child health assistance under the plan. Please note whether any of the following standards are used and check all that apply. If applicable, describe the criteria that will be used to apply the standard. (Section 2102)(b)(1)(A)) (42CFR 457.305(a) and 457.320(a))

4.1.1. X Geographic area served by the Plan: Statewide

4.1.2- Age: conception through birth

4.1.3. X Income: at or below 195% percent of the federal poverty level For children from conception through birth, the adjusted gross income is 0 to 195% of the federal poverty level (FPL).

4.1.4 X Resources (including any standards relating to spend downs and disposition of resources): No resource test

4.1.5. X Residency (so long as residency requirement is not based on length of time in state) : Must be a resident of Michigan or be in Michigan to seek employment.

4.1.6. ~ Disability Status (so long as any standard relating to disability status does not restrict eligibility): None

4.1.7. X Access to or coverage under other health coverage

State Response: Comprehensive employer-based coverage by other creditable health insurance will preclude enrollment in this program

4.1.8. X Duration of eligibility:

State Response: Eligibility continues from the date of application through two months post partum-

4.1.9 Other standards (identify and describe): Applicants are required to provide a Social Security Number or they must have applied for SSN. Not required of others.

4.2. The state assures that it has made the following findings with respect to the eligibility standards in its plan: (Section 2102)(b)(1)(B)) (42CFR 457.320(b))

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- 4.2.1. X These standards do not discriminate on the basis of diagnosis.
 - 4.2.2. X Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income.
 - 4.2.3. X These standards do not deny eligibility based on a child having a pre-existing medical condition.
- 4.3. Describe the methods of establishing eligibility and continuing enrollment.
(Section 2102)(b)(2)) (42CFR 457.350)

State Response: The following process will be used to determine eligibility and continued enrollment:

▮
ENROLLMENT PROCESS

- receive completed applications and any required verifications,
- determine initial eligibility-based on information presented,

▮
BEGIN DATE OF ENROLLMENT

Eligibility begins on the first day of the month of application with retroactive coverage to the date of pregnancy up to 3 months prior to the applications date..

ELIGIBILITY CRITERIA

In order to be eligible for coverage for the unborn child

- The unborn child must be a resident of Michigan,
- Must reside in a family with an adjusted gross income of less than or equal to 195 percent of poverty No asset test is used. The income will be verified by self-declaration.
- The pregnant woman of the unborn child must have no comprehensive employer-based insurance coverage. Coverage through the CSHCS program and the Indian Health Services is not to be considered as other insurance for eligibility purposes.

QUALITY ASSURANCE/MONITORING

- 4.3.1 Describe the state's policies governing enrollment caps and waiting lists (if any). (Section 2106(b)(7)) (42CFR 457.305(b))
X Check here if this section does not apply to your state.

- 4.4. Describe the procedures that assure that:

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- 4.4.1. Through the screening procedures used at intake and follow-up eligibility determination, including any periodic re-determination, that only targeted low-income children who are ineligible for Medicaid or not covered under a group health plan or health insurance coverage (including access to a state health benefits plan) are furnished child health assistance under the state child health plan. (Sections 2102(b)(3)(A) and 2110(b)(2)(B)) (42 CFR 457.310(b) (42CFR 457.350(a)(1)) 457.80(c)(3))

State Response: The State will perform post-eligibility audits of the applications to assure compliance with eligibility and enrollment policies. In addition, part of the quality assurance methodology will be planned reports on the following:

- list of enrollees by county (this will be compared to the Medicaid population to assure the enrollee is not receiving both Medicaid and non-Medicaid CHIP (Maternity Outpatient Medical Services (MOMS))
- number of applications received
- number of denials of applications with the reasons for denial
- corrective actions, regarding program compliance (e.g., presumptive eligibility)

Application reviews will include assurance that any required verifications have been used, time frames have been met, and appropriate referrals have been made.

- 4.4.2. The Medicaid application and enrollment process is initiated and facilitated for children found through the screening to be potentially eligible for medical assistance under the state Medicaid plan under Title XIX. (Section 2102(b)(3)(B)) (42CFR 457.350(a)(2))

State Response: Department staff will determine if the child is Medicaid

If the Department determines the unborn child to be Medicaid eligible, the unborn child will NOT be enrolled in the MOMS. If the Department determines the unborn child to be ineligible for Medicaid they will have eligibility determined for MOMS.

- 4.4.3. The State is taking steps to assist in the enrollment in SCHIP of children determined ineligible for Medicaid. (Sections 2102(a)(1) and (2) and 2102(c)(2)) (42CFR 431.636(b)(4))

If the Department determines the unborn child to be Medicaid ineligible, the application will be reviewed at that time to determine eligibility in MOMS

- 4.4.4 The insurance provided under the state child health plan does not substitute for

coverage under group health plans. Check the appropriate box. (Section 2102)(b)(3)(C)) (42CFR 457.805) (42 CFR 457.810(a)-(c))

4.4.4.1. Coverage provided to children in families at or below 195 % FPL: describe the methods of monitoring substitution.

State Response: The application form will include a request for information regarding other insurance coverage. Pregnant women who have creditable employer based health coverage which provides prenatal services to the unborn child will not be enrolled in MOMS.

4.4.4.2. Coverage provided to children in families over 200% and up to 250% FPL: describe how substitution is monitored and identify specific strategies to limit substitution if levels become unacceptable.

4.4.4.3. Coverage provided to children in families above 250% FPL: describe how substitution is monitored and identify specific strategies in place to prevent substitution.

4.4.4.4. If the state provides coverage under a premium assistance program, describe:

The minimum period without coverage under a group health plan, including any allowable exceptions to the waiting period.

The minimum employer contribution.

The cost-effectiveness determination.

4.4.5 Child health assistance is provided to targeted low-income children in the state who are American Indian and Alaska Native. (Section 2102)(b)(3)(D)) (42 CFR 457.125(a))

State Response: Outreach efforts will include the Indian Health Centers and other agencies providing services to Native Americans.

The application form also indicates the American Indian ethnicity in its demographic information requested. Submitting this information is voluntary. Targeted outreach may be initiated if necessary-

Section 5. Outreach (Section 2102(c))

Describe the procedures used by the state to accomplish:

Section 6. Coverage Requirements for Children's Health Insurance (Section 2103)

Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 7.

6.1. The state elects to provide the following forms of coverage to children:
(Check all that apply.) (42CFR 457.410(a))

6.1.1 Benchmark coverage; (Section 2103(a)(1) and 42 CFR 457.420)

6.1.1.1. FEHBP-equivalent coverage; (Section 2103(b)(1))
(If checked, attach copy of the plan.)

6.1.1.2. State employee coverage; (Section 2103(b)(2)) (If checked, identify the plan and attach a copy of the benefits description.)

6.1.1.3. HMO with largest insured commercial enrollment (Section 2103(b)(3)) (If checked, identify the plan and attach a copy of the benefits description.)

6.1.2. Benchmark-equivalent coverage; (Section 2103(a)(2) and 42 CFR 457.430) Specify the coverage, including the amount, scope and duration of each service, as well as any exclusions or limitations. Please attach a signed actuarial report that meets the requirements specified in 42 CFR 457.431. **See instructions.**

6.1.3. Existing Comprehensive State-Based Coverage; (Section 2103(a)(3) and 42 CFR 457.440) [Only applicable to New York; Florida; Pennsylvania] Please attach a description of the benefits package, administration, date of enactment. If existing comprehensive state-based coverage is modified, please provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of 8/5/97 or one of the benchmark plans. Describe the fiscal year 1996 state expenditures for existing comprehensive state-based coverage.

6.1.4. Secretary-Approved Coverage. (Section 2103(a)(4)) (42 CFR 457.450)

6.1.4.1. Coverage the same as Medicaid State plan

6.1.4.2. Comprehensive coverage for children under a Medicaid Section 1115 demonstration project

6.1.4.3. Coverage that either includes the full EPSDT benefit or

that the state has extended to the entire Medicaid population

- 6.1.4.4. Coverage that includes benchmark coverage plus additional coverage
- 6.1.4.5. Coverage that is the same as defined by existing comprehensive state-based coverage
- 6.1.4.6. Coverage under a group health plan that is substantially equivalent to or greater than benchmark coverage through a benefit by benefit comparison (Please provide a sample of how the comparison will be done)
- 6.1.4.7. Other (Describe) Coverage to unborn children

Medical services for the unborn child will be provided on a fee-for-service basis.

All pregnancy-related services must be determined to be medically necessary. Medical service coverage for unborn children is limited to the following prenatal and pregnancy-related services:

- Prenatal Care
- Maternal Support Services (MSS)
- Note: Pre-pregnancy family services and supplies are not covered for unborn children,
- Labor and delivery: Professional services fee, including live birth, miscarriage, ectopic pregnancy, and stillborn.
- Radiology and ultrasound
- Childbirth education
- Laboratory
- Pharmaceuticals and prescription vitamins
- Inpatient Hospital for Delivery Only
- Outpatient Hospital
- Note: Outpatient deliveries are not covered.

6.2. The state elects to provide the following forms of coverage to children: (Check all that apply. If an item is checked, describe the coverage with respect to the amount, duration and scope of services covered, as well as any exclusions or limitations) (Section 2110(a)) (42CFR 457.490)

- 6.2.1. Inpatient services (Section 2110(a)(1))
- 6.2.2 . Outpatient services (Section 2110(a)(2))
- 6.2.3— Physician services (Section 2110(a)(3))
- 6.2.4. Surgical services (Section 2110(a)(4))
- 6.2.5. Clinic services (including health center services) and other ambulatory health care services. (Section 2110(a)(5))
- 6.2.6. Prescription drugs (Section 2110(a)(6))

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- 6.2.7. ~ Over-the-counter medications (Section 2110(a)(7))
- 6.2.8 Laboratory and radiological services (Section 2110(a)(8))
- 6.2.9. X Prenatal care and pre-pregnancy family services and supplies (Section 2110(a)(9))
- 6.2.10 Inpatient mental health services, other than services described in 6.2.18., but including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services (Section 2110(a)(10))
- 6.2.11. Outpatient mental health services, other than services described in 6.2.19, but including services furnished in a state-operated mental hospital and including community-based services (Section 2110(a)(11))
- 6.2.12. ——— Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices) (Section 2110(a)(12))
- 6.2.13. Disposable medical supplies (Section 2110(a)(13))
- 6.2.14. ~ Home and community-based health care services (See instructions) (Section 2110(a)(14))
- 6.2.15. Nursing care services (See instructions) (Section 2110(a)(15))
- 6.2.16. ——— Abortion only if necessary to save the life of the mother (Section 2110(a)(16))
- 6.2.17 Dental services (Section 2110(a)(17))
- 6.2.18 Inpatient substance abuse treatment services and residential substance abuse treatment services (Section 2110(a)(18))
- 6.2.19 Outpatient substance abuse treatment services (Section 2110(a)(19))
- 6.2.20. Case management services (Section 2110(a)(20))
- 6.2.21 Care coordination services (Section 2110(a)(21))
- 6.2.22. Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders (Section 2110(a)(22))
- 6.2.23. Hospice care (Section 2110(a)(23))
- 6.2.24. Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (See instructions) (Section 2110(a)(24))
- 6.2.25. ~ Premiums for private health care insurance coverage (Section 2110(a)(25))
- 6.2.26. Medical transportation (Section 2110(a)(26))
- 6.2.27. ~ Enabling services (such as transportation, translation, and outreach services) (See instructions) (Section 2110(a)(27))
- 6.2.28. ~ Any other health care services or items specified by the Secretary and not included under this section (Section 2110(a)(28))

6.2-BH Behavioral Health Coverage Section 2103(c)(5) requires that states provide coverage to prevent, diagnose, and treat a broad range of mental health and substance use disorders in a culturally and linguistically appropriate manner for all CHIP enrollees, including pregnant women and unborn children. In general, service limitations are based on medical necessity unless otherwise noted.

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Guidance: Please attach a copy of the state's periodicity schedule. For pregnancy-related coverage, please describe the recommendations being followed for those services.

6.2.1- BH Periodicity Schedule The state has adopted the following periodicity schedule for behavioral health screenings and assessments. Please specify any differences between any covered CHIP populations:

- State-developed schedule
- American Academy of Pediatrics/ Bright Futures
- Other Nationally recognized periodicity schedule (please specify: United States Public Preventive Services Task Force- recommended for preventive services, including pregnant individuals)
- Other (please describe:)

6.3- BH Covered Benefits Please check off the behavioral health services that are provided to the state's CHIP populations, and provide a description of the amount, duration, and scope of each benefit. For each benefit, please also indicate whether the benefit is available for mental health and/or substance use disorders. If there are differences in benefits based on the population or type of condition being treated, please specify those differences.

If EPSDT is provided, as described at Section 6.2.22 and 6.2.22.1, the state should only check off the applicable benefits. It does not have to provide additional information regarding the amount, duration, and scope of each covered behavioral health benefit.

Guidance: Please include a description of the services provided in addition to the behavioral health screenings and assessments described in the assurance below at 6.3.1.1-BH.

Service limitation: the state assures that any limits on the amount, duration, and/or scope of services of the below services can be exceeded if medically necessary.

6.3.1- BH Behavioral health screenings and assessments. (Section 2103(c)(6)(A))

6.3.1.1- BH The state assures that all developmental and behavioral health recommendations outlined in the AAP Bright Futures periodicity schedule and United States Public Preventive Services Task Force (USPSTF) recommendations graded as A and B are covered as a part of the CHIP benefit package, as appropriate for the covered populations.

Guidance: Examples of facilitation efforts include requiring managed care organizations and their networks to use such tools in primary care practice, providing education, training, and technical resources, and covering the costs of administering or purchasing the tools.

6.3.1.2- BH The state assures that it will implement a strategy to facilitate the use of age-appropriate validated behavioral health screening tools in primary care settings. Please describe how the state will facilitate the use of validated screening tools.

Facilitation strategy: The state of Michigan has policies and procedures that are outlined in its Medicaid Provider Manual regarding the use of standardized, age-appropriate, and validated behavioral health screening tools in the primary care setting. The Medicaid program also communicates with enrolled providers through provider L-letters to educate, inform, and/or clarify issues related to MDHHS policies and procedures. The state also has a dedicated website for Medicaid enrolled providers that includes policy information and resources.

6.3.2- BH Outpatient services (Sections 2110(a)(11) and 2110(a)(19))

Guidance: Psychosocial treatment includes services such as psychotherapy, group therapy, family therapy and other types of counseling services.

6.3.2.1- BH Psychosocial treatment

Provided for: Mental Health Substance Use Disorder

Psychotherapy services description: Treatment activity designed to reduce maladaptive behaviors, maximize behavioral self-control, or restore normalized psychological functioning, reality orientation, remotivation, and emotional adjustment, thus enabling improved functioning and more appropriate interpersonal and social relationships. Evidence-based practices such as integrated dual disorder treatment for co-occurring disorders (IDDT/COD) and dialectical behavior therapy (DBT) are included in this coverage. Family Therapy is therapy for a beneficiary and family member(s), or other person(s) significant to the beneficiary, for the purpose of improving the beneficiary/family function. SUD Outpatient treatment is a non-residential treatment service with clinicians educated/trained in providing professionally directed alcohol and other drug (AOD) treatment or a community-based location with appropriately educated/trained staff. Individual, family or group treatment services may be provided individually or in combination. SUD treatment must be individualized based on the needs of the beneficiary in order to support sustained recovery.

Limits: Service limitations are based on medical necessity.

6.3.2.2- BH Tobacco cessation
Provided for: Substance Use Disorder

Tobacco cessation services description: The state covers tobacco cessation prevention education and treatment. Counseling services for tobacco cessation are covered. All FDA approved medications for smoking cessation are covered.

Additional services: Michigan Department of Health and Human Services Public Health Administration has a Smoking Cessation section that includes a tobacco quit line, connection to free or low-cost services and support for all Michigan residents.

Limits: Service limitations are based on medical necessity.

Guidance: In order to provide a benefit package consistent with section 2103(c)(5) of the Act, MAT benefits are required for the treatment of opioid use disorders. However, if the state provides MAT for other SUD conditions, please include a description of those benefits below at section 6.3.2.3- BH.

6.3.2.3- BH Medication Assisted Treatment
Provided for: Substance Use Disorder

6.3.2.3.1- BH Opioid Use Disorder

Service description: opioid-dependent beneficiaries may be provided chemotherapy using methadone, buprenorphine and naltrexone as an adjunct to a treatment service. Covered services for Methadone and pharmacological supports and laboratory services, as required by DPT/CSAT regulations and the Administrative Rules for Substance Use Disorder Service Programs in Michigan. Decisions to admit an individual for methadone maintenance must be based on medical necessity criteria, satisfy the level of care determination using the six dimensions of the ASAM Criteria, and have an initial diagnostic impression of opioid dependency for at least one year based on current DSM criteria.

Pharmacy related services for OUD: Michigan covers all FDA approved drugs for MAT. These drugs are included on the Preferred Drug List and there are no prior authorization requirements on these medications. Tablet and film medications have daily prescribing limits consistent with the FDA approved labeling.

Coverage of MAT also includes counseling and psychotherapy services.

Additional services: The Opioid Health Home Program Pilot program is

limited to eligible geographic area sites. The goals of the program are to ensure seamless transition of care and to connect eligible beneficiaries with needed clinical and social services. This benefit enhances patient outcomes and quality of care, while simultaneously shifting people from emergency departments and hospitals to a primary care setting. Program services include: comprehensive physical and behavioral health care, comprehensive case management, care coordination and health promotion, comprehensive transitional care, patient and family support (including authorized representatives), referral to community and social support services, and use of health information technology to link services.

Limits: Service duration limits depend on ASAM Level and medical necessity.

6.3.2.3.2- BH Alcohol Use Disorder

Service description: Psychosocial treatment services are made available through county Community Mental Health Services and AUD programs including MAT services when needed.

Pharmacy services: all FDA approved medications for AUD are covered.

Limits: Service duration limits depend on ASAM Level and medical necessity.

6.3.2.3.3- BH Other

6.3.2.4- BH Peer Support
Provided for: Mental Health Substance Use Disorder

Peer support services description: Peers are self-identified consumers in recovery from, serious mental illness, serious emotional disturbance, substance use disorders, and/or lived experience with intellectual and developmental disabilities; or a parent/adult with personal experience on-going or in the past of a child or family member with similar mental illness, intellectual and developmental disabilities, and/or substance use; and have experience and perspectives with navigating human service systems and supports. Peer-delivered or peer-operated support services are programs and services that provide individuals with opportunities to learn and share coping

skills and strategies, move into more active assistance and away from passive roles, and to build and/or enhance self-esteem and self-confidence. Included programs: Drop-in centers, peer specialists, peer recovery coach, youth-peer support, peer support navigator, parent support partners, and peer with I/DD mentoring. SUD Peer Recover and Recovery Support and promote recovery and prevent relapse through supportive services that result in the knowledge and skills necessary for an individual's recovery. Peer recovery programs are designed and delivered primarily by individuals in recovery (Recovery Coach) and offer social, emotional, and/or educational supportive services to help prevent relapse and promote recovery.

Limits: Service limitations are based on medical necessity.

6.3.2.5- BH Caregiver Support
Provided for: Mental Health Substance Use Disorder

Caregiver support services description: Family-focused services provided to family of persons with serious mental illness, serious emotional disturbance, or developmental disability for the purpose of assisting the family in relating to and caring for a relative with one of these disabilities. Services target the family members who are caring for and/or living with an individual receiving mental health services. These services include education and training, counseling and peer support, Family Psycho-Education and Parent-to-Parent Support.

Limits: Service limitations are based on medical necessity.

6.3.2.6- BH Respite Care
Provided for: Mental Health Substance Use Disorder

Respite care services description: respite care services are intended to assist in maintaining a goal of living in a natural community home. Respite care services are provided on a short-term, intermittent basis to relieve the beneficiary's family or other primary caregiver(s) from daily stress and care demands during times when they are providing unpaid care.

Limits: Service limitations are based on medical necessity.

6.3.2.7- BH Intensive in-home services
Provided for: Mental Health Substance Use Disorder

Intensive in-home services description: Mental health home-based services programs are designed to provide intensive services to beneficiaries and their families with multiple service needs who require access to an array of mental health services. The primary goals of these programs are to support families in meeting developmental

needs, to support and preserve families, to reunite families who have been separated, and to provide effective treatment and community supports to address risks that may increase the likelihood of a child being placed outside the home. Treatment is based on beneficiary needs, with the focus on the family unit. The service style must support a family-driven and beneficiary-guided approach, emphasizing strength-based, culturally relevant interventions, parent/youth and professional teamwork, and connection with community resources and supports. Services are available for mental health diagnosis with co-occurring SUD.

Limits: Service limitations are based on medical necessity.

6.3.2.8- BH Intensive outpatient

Provided for: Mental Health Substance Use Disorder

Intensive outpatient services description: For mental health conditions, with or without co-occurring SUD, Assertive Community Treatment (ACT) is a therapeutic set of intensive clinical, medical and psychosocial services provided by a mobile multi-disciplinary treatment team that includes case/care management, psychiatric services, counseling/psychotherapy, housing support, Substance Use Disorders treatment, and employment and rehabilitative services provided in the beneficiary's home or community. ACT is an individually tailored combination of services and supports that may vary in intensity over time and is based on individual need. ACT includes availability of multiple daily contacts and 24-hour, 7-days- per-week crisis availability provided by the multi-disciplinary ACT team.

Intensive outpatient services are available for SUD-only conditions which includes individual assessment, individual treatment planning, individual therapy, group therapy, family therapy, crisis intervention, referral/linking/coordinating/management of services, peer recovery and recovery support, compliance monitoring, early intervention, detoxification/withdrawal monitoring, pharmacological supports and substance abuse treatment services. Level of care is determined by ASAM criteria.

Limits: Program limitations are based on medical necessity.

6.3.2.9- BH Psychosocial rehabilitation

Provided for: Mental Health Substance Use Disorder

Psychosocial rehabilitation services description: A Clubhouse is a community-based program organized to support individuals living with mental illness. Clubhouse programs are appropriate for adults with a serious mental illness who wish to participate in a structured community with staff and peers and who desire to work on the goal areas reflected in the Core Psychiatric Rehabilitation Components. Clubhouses are vibrant, dynamic communities where meaningful work opportunities drive the need for member participation, thereby creating an environment where

empowerment, relationship-building, skill development and related competencies are gained. Services are available for mental health diagnosis with co-occurring SUD.

Limits: Service limitations are based on medical necessity.

Guidance: If the state considers day treatment and partial hospitalization to be the same benefit, please indicate that in the benefit description. If there are differences between these benefits, such as the staffing or intensity of the setting, please specify those in the description of the benefit's amount, duration, and scope.

6.3.3- BH Day Treatment

Provided for: Mental Health Substance Use Disorder

Day treatment services description: Mental health and developmental disabilities day program sites are defined as places other than the beneficiary's/family's home, nursing facility, or a specialized residential setting where an array of mental health or developmental disability services and supports are provided to assist the beneficiary in achieving goals of independence, integrated employment and/or community inclusion, as specified in his individual plan of services.

For SUD-only conditions, the state provides equivalent services through intensive outpatient services and is described in 6.3.2.8.

Limits: Services limitations are based on medical necessity.

6.3.3.1- BH Partial Hospitalization

Provided for: Mental Health Substance Use Disorder

Partial hospitalization services description: Partial hospitalization services may be used to treat a person with mental illness who requires intensive, highly coordinated, multi-modal ambulatory care with active psychiatric supervision. Treatment, services and supports are provided for six or more hours per day, five days a week. The use of partial hospitalization as a setting of care presumes that the beneficiary does not currently need treatment in a 24-hour protective environment. Coverage is dependent upon individual need for ongoing intensive active treatment and active psychiatric supervision services based on the medically necessary level of care.

Partial hospitalization services are available for SUD-only conditions.

6.3.4- BH Inpatient services, including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services (Sections 2110(a)(10) and 2110(a)(18))

Provided for: Mental Health Substance Use Disorder

Inpatient services description: Treatment within an inpatient psychiatric setting is directed at stabilization of incapacitating signs or symptoms, amelioration of severely disabling functional impairments, arrestment of potentially life-threatening self/other harm inclinations, management of adverse biologic reactions to treatment and/or regulation of complicated medication situations. Inpatient psychiatric care may be used to treat a person with mental illness who requires care in a 24-hour medically structured and supervised facility. The Severity of Illness/Intensity of Service clinical criteria for admission are based upon the assumption that the beneficiary is displaying signs and symptoms of a serious psychiatric disorder, demonstrating functional impairments, and manifesting a level of clinical instability (risk) that, either individually or collectively, are of such severity that treatment in an alternative setting would be unsafe or ineffective. Coverage is dependent upon active treatment being provided at the medically necessary level of care. The continuing stay recertification process is designed to assess the efficacy of the treatment regime in addressing these concerns, and to determine whether the inpatient setting remains the most appropriate, least restrictive, level of care for treatment of the beneficiary's problems and dysfunctions.

Inpatient services are available for SUD-only conditions.

Guidance: If applicable, please clarify any differences within the residential treatment benefit (e.g. intensity of services, provider types, or settings in which the residential treatment services are provided).

6.3.4.1- BH Residential Treatment

Provided for: Mental Health Substance Use Disorder

Residential treatment services description: Residential Treatment is defined as intensive therapeutic service which includes overnight stay and planned therapeutic, rehabilitative, or didactic counseling to address cognitive and behavioral impairments for the purpose of enabling the beneficiary to participate and benefit from less intensive treatment. A program director is responsible for the overall management of the clinical program, and treatment is provided by appropriate credentialed professional staff, including substance abuse specialists. Residential treatment must be staffed 24-hours-per-day. The clinical program must be provided under the supervision of Substance Abuse Treatment Specialists.

Limits: Service limitations are based on medical necessity.

6.3.4.2- BH Detoxification

Provided for: Substance Use Disorder

Detoxification services description: Acute medical detoxification services are covered

when medically necessary. Sub-acute detoxification is defined as supervised care for the purpose of managing the effects of withdrawal from alcohol and/or other drugs as part of a planned sequence of addiction treatment. Detoxification is limited to the stabilization of the medical effects of the withdrawal and to the referral to necessary ongoing treatment and/or support services. Sub-acute detoxification is part of a continuum of care for substance use disorders and does not constitute the end goal in the treatment process. The detoxification process consists of three essential components: evaluation, stabilization, and fostering client readiness for, and entry into, treatment. Detoxification can take place in both residential and outpatient settings, and at various levels of intensity within these settings. Client placement to setting and to level of intensity must be based on ASAM Criteria and individualized determination of client need. Sub-acute detoxification settings and levels of intensity correspond to the LOC determination based on the ASAM Criteria. This service is limited to stabilization of the medical effects of the withdrawal, and referral to necessary ongoing treatment and/or support services. This service, when clinically indicated, is an alternative to acute medical care provided by licensed health care professionals in a hospital setting.

Guidance: Crisis intervention and stabilization could include services such as mobile crisis, or short term residential or other facility-based services in order to avoid inpatient hospitalization.

6.3.5- BH Emergency services

Provided for: Mental Health Substance Use Disorder

Emergency services description: Emergency services are covered including the screening and stabilization of a psychiatric emergency and does not require prior authorization.

Emergency services are available for SUD-only conditions.

6.3.5.1- BH Crisis Intervention and Stabilization

Provided for: Mental Health Substance Use Disorder

Crisis intervention and stabilization services description: Crisis Intervention are unscheduled activities conducted for the purpose of resolving a crisis situation requiring immediate attention. Activities include crisis response, crisis line, assessment, referral, and direct therapy. The standard for whether a crisis exists is a "prudent layperson" standard. That means that a prudent layperson would be able to determine from the beneficiary's symptoms that crisis services are necessary. Intensive crisis stabilization services are structured treatment and support activities provided by a multidisciplinary team and designed to provide a short-term alternative to inpatient psychiatric services. Services may be used to avert a psychiatric admission

or to shorten the length of an inpatient stay when clinically indicated. Intensive crisis stabilization services are structured treatment and support activities provided by a mobile intensive crisis stabilization team that are designed to promptly address a crisis situation in order to avert a psychiatric admission or other out of home placement or to maintain a child or youth in their home or present living arrangement who has recently returned from a psychiatric hospitalization or other out of home placement. These services must be available to children or youth with serious emotional disturbance (SED) and/or intellectual/developmental disabilities (I/DD), including autism, or co-occurring SED and substance use disorder (SUD).

6.3.6- BH Continuing care services

Provided for: Mental Health Substance Use Disorder

Continuing care services description: Referral/Linking/Coordinating/Management of SUD Services: Service purpose is in ensuring follow through with identified providers, providing additional support in the community if primary services are to be provided in an office setting, addressing other needs identified as part of the assessment and/or establishing the beneficiary with another provider and/or level of care. This service may be provided individually or in conjunction with other services based on the needs of the beneficiary (frequently referred to as substance use disorder case management). Services of compliance monitoring identifying abstinence or relapse when it is a part of the treatment plan or an identified part of the treatment program and intervention services aimed at addressing problems/issues that may arise during SUD treatment and could result in the beneficiary requiring a higher level of care if intervention is not provided.

For SUD-only conditions, the state provides equivalent services through peer support as described in 6.3.2.4.

6.3.7- BH Care Coordination

Provided for: Mental Health Substance Use Disorder

Care coordination services description: Supports and service coordination for women with mental health or co-occurring sud conditions, which includes a designated coordinator/case worker to assist with planning and/or facilitating planning using person-centered principles, developing an individual plan of service using the person-centered planning process, linking to, coordinating with, follow-up of, advocacy with, and/or monitoring of Specialty Services and Supports and other community services/supports. Brokering of providers of services/supports, assistance with access to entitlements and/or legal representation, coordination with health care providers.

For SUD-only conditions, the state provides identical care coordination services

through the case management benefit described in 6.3.8-bh; however, the funding source for women with SUD-only conditions is through a SAMHSA Substance Abuse Block Grant.

Limits: Service limitations are based on medical necessity.

6.3.7.1- BH Intensive wraparound
Provided for: Mental Health Substance Use Disorder

Intensive wraparound services description: Wraparound utilizes a Child and Family Team, with team members determined by the family often representing multiple agencies and informal supports. The collaborative team planning process that focuses on the unique strengths, values and preferences of the beneficiary and family and is developed in partnership with other community agencies. The Child and Family Team creates a highly individualized planning and a Wraparound plan with the beneficiary and family that consists of mental health specialty treatment, services and supports covered by the Medicaid mental health state plan, waivers, and other community services and supports. The Wraparound plan may also consist of other non-mental health services and supports that are secured from, and funded by, other agencies in the community. The Wraparound plan is the result of a collaborative team planning process. This planning process tends to work most effectively with beneficiaries and their families who, due to safety and other risk factors, require services from multiple systems and informal supports.

6.3.7.2- BH Care transition services
Provided for: Mental Health Substance Use Disorder

Care transition services description: These services occur through Targeted Case Management, support services and wraparound services, which all can be used to address an individual's transition to a community setting. Case-Management services will be made available for up to 180 consecutive days of a covered stay in a medical institution, which can be exceeded dependent upon medical necessity.

6.3.8- BH Case Management
Provided for: Mental Health Substance Use Disorder

Case management services description: For women with mental health or co-occurring SUD conditions, targeted case management services are services furnished to assist individuals in gaining access to needed medical, social, educational, care transition and other services. Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social, or other services. Development (and periodic revision) of a specific person-centered care plan

that is based on the information collected through the assessment that specifies the goals and actions to address service needs, linking/coordination of services, monitoring and follow-up of services, and reassessment of the beneficiary's status and need.

For those receiving SUD services only, case management as described above, is covered by a SAMHSA Substance Abuse Block Grant.

Limits: Service limitation are based on medical necessity.

6.3.9- BH Other

Provided for: Mental Health Substance Use Disorder

The state of Michigan has two Health Home SPAs, the Opioid Health Home (OHH) and the Behavioral Health Home (BHH). These are services authorized under Section 1945 of the US Social Security Act that provide intensive care management, family/social support, care transitions, etc., in an integrated care setting in select Prepaid Inpatient Health Plan Regions. Beneficiaries in select regions qualify if they meet diagnostic criteria—for BHH, this is a select Serious Mental Illness/Serious Emotional Disturbance; for OHH, this is an Opioid Use Disorder. The relevant SPAs are #20-1500 (BHH) and #20-1501 (OHH).

6.4- BH Assessment Tools

6.4.1- BH Please specify or describe all of the tool(s) required by the state and/or each managed care entity:

- ASAM Criteria (American Society Addiction Medicine)
 - Mental Health Substance Use Disorders
- InterQual
 - Mental Health Substance Use Disorders
- MCG Care Guidelines
 - Mental Health Substance Use Disorders
- CALOCUS/LOCUS (Child and Adolescent Level of Care Utilization System)
 - Mental Health Substance Use Disorders
- CASII (Child and Adolescent Service Intensity Instrument)
 - Mental Health Substance Use Disorders
- CANS (Child and Adolescent Needs and Strengths)

Model Application Template for the State Children’s Health Insurance Program

- Mental Health Substance Use Disorders
- State-specific criteria (e.g. state law or policies) (please describe)
 - Mental Health Substance Use Disorders
- Plan-specific criteria (please describe)
 - Mental Health Substance Use Disorders
- Other (please describe)
 - Mental Health Substance Use Disorders

Other Valid Instruments may include any of the following specific to each individual’s condition: Devereux Early Childhood Assessment (DECA), Child and Adolescent Functional Assessment Scale (CAFAS®) or the Preschool and Early Childhood Functional Assessment Scale (PECFAS®), Global Assessment of Functioning (GAF) Supports Intensity Scale (SIS)-A, SIS-C, the Global Appraisal of Individual Needs Initial (GAIN-I). The PIHPs network will utilize standardized instruments to assist in identifying level of need (i.e. LOCUS, SIS, ASAM, Gain-IO), administer other face to face assessments related to the individual’s functional abilities (i.e. Essentials For Living/ELF, Functional Behavioral Assessment/FBA, other adaptive behavior/global functioning scales, etc.), and identify services and supports required to reach the expected outcomes of community inclusion and participation.

The state updates its Medicaid provider manual on a quarterly basis. Medicaid provider bulletins and L-letters are utilized as needed. L-letters are informational letters that are distributed to Medicaid enrolled providers on an as needed basis. Examples of when bulletins and L-letters are used include new or changes to existing policy, updates to evidence-based guidelines, changes to validated screening/assessment tools, or to provide information about public health emergencies such as disease outbreaks. Medicaid enrolled providers can subscribe to receive all Medicaid program updates or program specific updates via email from the Michigan Department of Health and Human Services.

- No specific criteria or tools are required
 - Mental Health Substance Use Disorders

Guidance: Examples of facilitation efforts include requiring managed care organizations and their networks to use such tools to determine possible treatments or plans of care, providing education, training, and technical resources, and covering the costs of administering or purchasing the assessment tools.

6.4.2- BH Please describe the state’s strategy to facilitate the use of validated assessment tools for the treatment of behavioral health conditions.

State strategy to facilitate the use of validated assessment tools for the treatment of behavioral

health conditions: The state Medicaid agency exercises administrative discretion in the administration and supervision of the State plan benefits and issues policies, rules and regulations related to the State plan benefit assessment tools. These assessment tools are included in our managed care contract and required by all of Michigan's Prepaid Inpatient Health Plans. The State plan eligibility criteria, enrollment, and eligibility determination must include evidence of any instrument(s)/validated tools used to make this determination as described in Medicaid policy, contract, and are reviewed periodically by the state/PIHP and external quality review (EQR) vendors. The state updates its Medicaid provider manual on a quarterly basis. Medicaid provider bulletins and L-letters are utilized as needed. L-letters are informational letters that are distributed to Medicaid enrolled providers on an as needed basis. Examples of when bulletins and L-letters are used include new or changes to existing policy, updates to evidence-based guidelines, changes to validated screening/assessment tools, or to provide information about public health emergencies such as disease outbreaks. Medicaid enrolled providers can subscribe to receive all Medicaid program updates or program specific updates via email from the Michigan Department of Health and Human Services.

The state's Behavioral Health and Developmental Disabilities Administration (BHDDA) plans and implements required provider training for new mandatory validated tools. BHDDA provides a letter of training notification to executive directors of prepaid inpatient health plans (PIHPS) and substance abuse prevention and treatment directors. The notification provides training timelines and requests that each PIHP designate a representative that works with a BHDDA staff person to implement the training process.

6.2.5- BH Covered Benefits The State assures the following related to the provision of behavioral health benefits in CHIP:

- All behavioral health benefits are provided in a culturally and linguistically appropriate manner consistent with the requirements of section 2103(c)(6), regardless of delivery system.

- The state will provide all behavioral health benefits consistent with 42 CFR 457.495 to ensure there are procedures in place to access covered services as well as appropriate and timely treatment and monitoring of children with chronic, complex or serious conditions.

6.2- MHPAEA Section 2103(c)(6)(A) of the Social Security Act requires that, to the extent that it provides both medical/surgical benefits and mental health or substance use disorder benefits, a State child health plan ensures that financial requirements and treatment limitations applicable to mental health and substance use disorder benefits comply with the mental health parity requirements of section 2705(a) of the Public Health Service Act in the same manner that such requirements apply to a group health plan. If the state child health plan provides for delivery of services through a managed care arrangement, this requirement applies to both the state and managed care plans. These requirements are also applicable to any additional benefits provided voluntarily to the child health plan population by managed care entities and will be considered as part of CMS's contract review process at 42 CFR 457.1201(l).

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6.2.1- MHPAEA Before completing a parity analysis, the State must determine whether each covered benefit is a medical/surgical, mental health, or substance use disorder benefit based on a standard that is consistent with state and federal law and generally recognized independent standards of medical practice. (42 CFR 457.496(f)(1)(i))

6.2.1.1- MHPAEA Please choose the standard(s) the state uses to determine whether a covered benefit is a medical/surgical benefit, mental health benefit, or substance use disorder benefit. The most current version of the standard elected must be used. If different standards are used for different benefit types, please specify the benefit type(s) to which each standard is applied. If "Other" is selected, please provide a description of that standard.

- International Classification of Disease (ICD)
- Diagnostic and Statistical Manual of Mental Disorders (DSM)
- State guidelines (Describe: _____)
- Other (Describe: _____)

6.2.1.2- MHPAEA Does the State provide mental health and/or substance use disorder benefits?

- Yes
- No

Guidance: If the State does not provide any mental health or substance use disorder benefits, the mental health parity requirements do not apply ((42 CFR 457.496(f)(1)). Continue on to Section 6.3.

6.3 The state assures that, with respect to pre-existing medical conditions, one of the following two statements applies to its plan: (42CFR 457.480)

- 6.3.1. X The state shall not permit the imposition of any pre-existing medical condition exclusion for covered services (Section 2102(b)(1)(B)(ii)); **OR**
- 6.3.2. ~ The state contracts with a group health plan or group health insurance coverage, or contracts with a group health plan to provide family coverage under a waiver (see Section 6.4.2. of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA (Section 2103(f)). Please describe: *Previously 8.6*

6.4 **Additional Purchase Options.** If the state wishes to provide services under the plan through cost effective alternatives or the purchase of family coverage, it must request the appropriate option. To be approved, the state must address the following: (Section 2105(c)(2) and(3)) (42 CFR 457.1005 and 457.1010)

- 6.4.1. **Cost Effective Coverage.** Payment may be made to a state in excess of the 10% limitation on use of funds for payments for: 1) other child health assistance for targeted low-income children; 2) expenditures for health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children); 3) expenditures for outreach activities as provided in section 2102(c)(1) under the plan; and 4) other reasonable costs incurred by the state to administer the plan, if it demonstrates the following (42CFR 457.1005(a)):
- 6.4.1.1. Coverage provided to targeted low-income children through such expenditures must meet the coverage requirements above; **Describe the coverage provided by the alternative delivery system. The state may cross reference section 6.2.1 - 6.2.28. (Section 2105(c)(2)(B)(i)) (42CFR 457.1005(b))**
 - 6.4.1.2. The cost of such coverage must not be greater, on an average per child basis, than the cost of coverage that would otherwise be provided for the coverage described above.; **Describe the cost of such coverage on an average per child basis. (Section 2105(c)(2)(B)(ii)) (42CFR 457.1005(b))**
 - 6.4.1.3. The coverage must be provided through the use of a community-based health delivery system, such as through contracts with health centers receiving funds under section 330 of the Public Health Service Act or with hospitals such as those that receive disproportionate share payment adjustments under section 1886(c)(5)(F) or 1923 of the Social Security Act. **Describe the community based delivery system. (Section 2105(c)(2)(B)(iii)) (42CFR 457.1005(a))**

- 6.4.2. ~ **Purchase of Family Coverage.** Describe the plan to purchase family coverage. Payment may be made to a state for the purpose of family coverage under a group health plan or health insurance coverage that includes coverage of targeted low-income children, if it demonstrates the following: (Section 2105(c)(3)) (42CFR 457.1010)
- 6.4.2.1. Purchase of family coverage is cost-effective relative to the amounts that the state would have paid to obtain comparable coverage only of the targeted low-income children involved; and **(Describe the associated costs for purchasing the family coverage relative to the coverage for the low income children.)** (Section 2105(c)(3)(A)) (42CFR 457.1010(a))
- 6.4.2.2. The state assures that the family coverage would not otherwise substitute for health insurance coverage that would be provided to such children but for the purchase of family coverage. (Section 2105(c)(3)(B)) (42CFR 457.1010(b))
- 6.4.2.3. The state assures that the coverage for the family otherwise meets title XXI requirements. (42CFR 457.1010(c))

Section 7. Quality and Appropriateness of Care

~ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 8.**

- 7.1. Describe the methods (including external and internal monitoring) used to assure the quality and appropriateness of care, particularly with respect to well-baby care, well-child care, and immunizations provided under the plan. (2102(a)(7)(A)) (42CFR 457.495(a))

Will the state utilize any of the following tools to assure quality?
(Check all that apply and describe the activities for any categories utilized.)

- 7.1.1. Quality standards
- 7.1.2. Performance measurement
- 7.1.3. Information strategies
- 7.1.4. Quality improvement strategies

State Response: The State plans to assure the quality and appropriateness of care, particularly with respect to prenatal care and labor and delivery of the unborn child. **Health Maintenance Organizations (Public Act 1978, No. 368 or Michigan Compiled Laws 333.21001)**

- 7.2. Describe the methods used, including monitoring, to assure: (2102(a)(7)(B)) (42CFR 457.495)

- 7.2.1 Access to well-baby care, well-child care, well-adolescent care and childhood and adolescent immunizations. (Section 2102(a)(7)) (42CFR 457.495(a))
- 7.2.2 Access to covered services, including emergency services as defined in 42 CFR §457.10. (Section 2102(a)(7)) 42CFR 457.495(b)
- 7.2.3 Appropriate and timely procedures to monitor and treat enrollees with chronic, complex, or serious medical conditions, including access to an adequate number of visits to specialists experienced in treating the specific medical condition and access to out-of-network providers when the network is not adequate for the enrollee's medical condition. (Section 2102(a)(7)) (42CFR 457.495(c))

State Response:

Section 8. Cost Sharing and Payment (Section 2103(e))

~ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 9.**

8.1. Is cost-sharing imposed on any of the children covered under the plan? (42CFR 457.505)

8.1.1. YES

8.1.2. NO, skip to question 8.8.

8.2. Describe the amount of cost-sharing, any sliding scale based on income, the group or groups of enrollees that may be subject to the charge and the service for which the charge is imposed or time period for the charge, as appropriate. (Section 2103(e)(1)(A)) (42CFR 457.505(a), 457.510(b) &(c), 457.515(a)&(c))

8.2.1. Premiums:

8.2.2. Deductibles:

State Response: Michigan will assess no deductibles.

8.2.3. Coinsurance or co-payments:

8.2.4. Other: None

8.3. Describe how the public will be notified, including the public schedule, of this cost-sharing (including the cumulative maximum) and changes to these amounts and any

differences based on income. (Section 2103(e)(1)(B)) (42CFR 457.505(b))

- 8.4. The state assures that it has made the following findings with respect to the cost sharing in its plan: (Section 2103(e))
- 8.4.1- Cost-sharing does not favor children from higher income families over lower income families. (Section 2103(e)(1)(B)) (42CFR 457.530)
 - 8.4.2— No cost-sharing applies to well-baby and well-child care, including age-appropriate immunizations. (Section 2103(e)(2)) (42CFR 457.520)
 - 8.4.3 No additional cost-sharing applies to the costs of emergency medical services delivered outside the network. (Section 2103(e)(1)(A)) (42CFR 457.515(f))
- 8.5. Describe how the state will ensure that the annual aggregate cost-sharing for a family does not exceed 5 percent of such family's income for the length of the child's eligibility period in the State. Include a description of the procedures that do not primarily rely on a refund given by the state for overpayment by an enrollee: (Section 2103(e)(3)(B)) (42CFR 457.560(b) and 457.505(e))
- 8.6 Describe the procedures the state will use to ensure American Indian (as defined by the Indian Health Care Improvement Act of 1976) and Alaska Native children will be excluded from cost-sharing. (Section 2103(b)(3)(D)) (42CFR 457.535)
- 8.7 Please provide a description of the consequences for an enrollee or applicant who does not pay a charge. (42CFR 457.570 and 457.505(c))
- 8.7.1 Please provide an assurance that the following disenrollment protections are being applied to all enrollees:
- 8.8 The state assures that it has made the following findings with respect to the payment aspects of its plan: (Section 2103(e))
- 8.8.1. No Federal funds will be used toward state matching requirements. (Section 2105(c)(4)) (42CFR 457.220)
 - 8.8.2. No cost-sharing (including premiums, deductibles, co-pays, coinsurance and all other types) will be used toward state matching requirements. (Section 2105(c)(5)) (42CFR 457.224) (Previously 8.4.5)
 - 8.8.3. No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under the this title. (Section 2105(c)(6)(A)) (42CFR 457.626(a)(1))
 - 8.8.4. Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of

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June 1, 1997. (Section 2105(d)(1)) (42CFR 457.622(b)(5))

- 8.8.5. No funds provided under this title or coverage funded by this title will include coverage of abortion except if necessary to save the life of the mother. (Section 2105)(c)(7)(B)) (42CFR 457.475)
- 8.8.6. No funds provided under this title will be used to pay for any abortion or to assist in the purchase, in whole or in part, for coverage that includes abortion (except as described above). (Section 2105)(c)(7)(A)) (42CFR 457.475)

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Section 9. Strategic Objectives and Performance Goals and Plan Administration (Section 2107)

- 9.1. Describe strategic objectives for increasing the extent of creditable health coverage among targeted low-income children and other low-income children: (Section 2107(a)(2)) (42CFR 457.710(b))
- 9.2. Specify one or more performance goals for each strategic objective identified: (Section 2107(a)(3)) (42CFR 457.710(c))

State Response:

- Goal 1. Continue to enroll the uninsured, low income pregnant women and their unborn child in Michigan in either the Medicaid program or MOMS, as appropriate.
- Goal 2. Obtain accurate, usable HEDIS or HEDIS-like reports from providers and monitor the following outcomes with emphasis on:
Prenatal Care for the unborn child
- Goal 3. Local agencies and programs will contact pregnant women and advise them of the prenatal care available to their unborn child through Medicaid and MOMS..
- Goal 4. Provide an application and enrollment process which is easy to understand and use.
- Goal 5. Obtain the participation of community-based organizations in outreach and education activities.

- 9.3. Describe how performance under the plan will be measured through objective, independently verifiable means and compared against performance goals in order to determine the state's performance, taking into account suggested performance indicators as specified below or other indicators the state develops: (Section 2107(a)(4)(A),(B)) (42CFR 457.710(d))

Check the applicable suggested performance measurements listed below that the state plans to use: (Section 2107(a)(4))

- 9.3.1. The increase in the percentage of Medicaid-eligible children enrolled in Medicaid.
- 9.3.2. The reduction in the percentage of uninsured children.
- 9.3.3. The increase in the percentage of children with a usual source of care.
- 9.3.4. The extent to which outcome measures show progress on one or more of the health problems identified by the state.
- 9.3.5. HEDIS Measurement Set relevant to children and adolescents younger than 19.

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- 9.3.6. Other child appropriate measurement set. List or describe the set used.
- 9.3.7. If not utilizing the entire HEDIS Measurement Set, specify which measures will be collected, such as:
- 9.3.7.1. Immunizations
 - 9.3.7.2. Well child care
 - 9.3.7.3. Adolescent well visits
 - 9.3.7.4. Satisfaction with care
 - 9.3.7.5. Mental health
 - 9.3.7.6. Dental care
 - 9.3.7.7. Other, please list:
- 9.3.8. Performance measures for special targeted populations.
- 9.4. The state assures it will collect all data, maintain records and furnish reports to the Secretary at the times and in the standardized format that the Secretary requires. (Section 2107(b)(1)) (42CFR 457.720)
- 9.5. The state assures it will comply with the annual assessment and evaluation required under Section 10. Briefly describe the state's plan for these annual assessments and reports. (Section 2107(b)(2)) (42CFR 457.750)

State Response: The Michigan Department of Health and Human Services will perform the annual assessments and evaluations required in Section 2108 (a). The annual report will include an assessment of the *MiChild* Plan and its progress toward meeting its strategic objectives and performance goals.

Beginning March 31, 2000, the State will submit an annual evaluation that includes the following elements as specified in Section 2108 (b).

The State will submit a description and analysis of the effectiveness of the elements of the State plan, including:

Demographics: The demographic characteristics of the unborn children assisted under the State plan will be identified

1. Quality: The quality of health coverage provided including the types of benefits provided. The State will measure quality as described in Section 7.1 and 7.2. Effectiveness will be determined by the extent to which strategic objective performance goals are met.

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Service area: The State offers coverage on a statewide basis.

The Department of Health and Human Services will analyze changes and trends in the State that affect the provision of accessible, affordable, quality health insurance and health care to the unborn child

- 9.6. The state assures it will provide the Secretary with access to any records or information relating to the plan for purposes of review of audit. (Section 2107(b)(3)) (42CFR 457.720)
- 9.7. The state assures that, in developing performance measures, it will modify those measures to meet national requirements when such requirements are developed. (42CFR 457.710(e))
- 9.8. The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX: (Section 2107(e)) (42CFR 457.135)
- 9.8.1. Section 1902(a)(4)(C) (relating to conflict of interest standards)
- 9.8.2. Paragraphs (2), (16) and (17) of Section 1903(i) (relating to limitations on payment)
- 9.8.3. Section 1903(w) (relating to limitations on provider donations and taxes)
- 9.8.4. Section 1132 (relating to periods within which claims must be filed)
- 9.9. Describe the process used by the state to accomplish involvement of the public in the design and implementation of the plan and the method for insuring ongoing public involvement. (Section 2107(e)) (42CFR 457.120(a) and (b))
- 9.9.1 Describe the process used by the state to ensure interaction with Indian Tribes and organizations in the state on the development and implementation of the procedures required in 42 CFR 457.125. (Section 2107(e)) (42CFR 457.120(c))

State Response

- 9.9.2 For an amendment relating to eligibility or benefits (including cost sharing and enrollment procedures), please describe how and when prior public notice was provided as required in 457.65(b) through (d).

State Response

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9.10. Provide a one year projected budget. A suggested financial form for the budget is attached. The budget must describe: (Section 2107(d)) (42CFR 457.140)

- Planned use of funds, including --
 - Projected amount to be spent on health services;
 - Projected amount to be spent on administrative costs, such as outreach, child health initiatives, and evaluation; and
 - Assumptions on which the budget is based, including cost per child and expected enrollment.
- Projected sources of non-Federal plan expenditures, including any requirements for cost-sharing by enrollees.

MiChild Budget Assumptions

Budget Neutrality. The assumption is that the program will remain budget neutral.

Payments to Benefit Contractors. Premiums for health, vision, and dental coverage are estimated to be \$90 per month. Enrollment in *MiChild* during FY 15 reached 44,508 children by midyear. Average monthly enrollment for FY 15 was 42,460 children. For FY 2016 and beyond, the state hopes to achieve enrollment of 90 percent of the total number of eligible children. Average monthly enrollment in *the MiChild* /Medicaid expansion is estimated to be 40,000 children for FY 2016 and beyond. The program will provide Medicaid services to children using managed care and fee for service.

Mental Health and Substance Abuse Services. Mental health and substance abuse services are Medicaid covered services. All services are provided in accordance with Medicaid

Administrative Oversight. Administration of the program will be conducted by the Single State Agency with regard to eligibility determination and implementation of Medicaid policy. The Single State Agency will employ an outside contractor to collect monthly premium payments for this program. The contractor will notify Agency of any delay in premium payment or failure to pay a premium. The contractor will also perform enrollments (now voluntary and auto-assignments) into health plans, provide education regarding services, perform mailings which now also include MIHealth cards.

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This reporting period: Federal Fiscal Year 2022. This is a combination budget.

COST OF APPROVED SCHIP PLAN

COST OF APPROVED CHIP PLAN

	2022 Baseline	2022 with SPA 22-0024
Insurance Payments		
Managed Care	255,549,959	255,549,959
Fee for Service	59,503,152	59,503,152
Total Benefit Costs	315,053,111	315,053,111
(Offsetting beneficiary cost sharing payments)	-	-
Net Benefit Costs	315,053,111	315,053,111

Administration Costs

Personnel		
General Administration	3,979,387	3,979,387
Contractors/Brokers (e.g., enrollment contractors)	63,437	63,437
Claims Processing		
Outreach/Marketing costs		
Other (e.g., indirect costs)		
Health Services Initiatives	21,622,900	21,622,900
Total Administration Costs	25,665,724	25,665,724
10% Administrative Cap (net benefit costs divided by 9)	35,005,901	35,005,901

Federal Title XXI Share	273,188,362	273,188,362
State Share	67,530,473	67,530,473

TOTAL COSTS OF APPROVED CHIP PLAN	340,718,835	340,718,835
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Non-Federal source of funding: State Appropriations (General Fund)

Note that in future years, the intent is to maximize the use of funds available under the administrative cap to the extent possible to support lead abatement efforts as outlined in the Health Services Initiative Section.

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Section 10. Annual Reports and Evaluations (Section 2108)

10.1. Annual Reports. The state assures that it will assess the operation of the state plan under this Title in each fiscal year, including: (Section 2108(a)(1),(2)) (42CFR 457.750)

10.1.1. The progress made in reducing the number of uncovered low-income children and report to the Secretary by January 1 following the end of the fiscal year on the result of the assessment,

10.2. The state assures it will comply with future reporting requirements as they are developed. (42CFR 457.710(e))

10.3. The state assures that it will comply with all applicable Federal laws and regulations, including but not limited to Federal grant requirements and Federal reporting requirements.

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Section 11. Program Integrity (Section 2101(a))

Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue to Section 12.

11.1 The state assures that services are provided in an effective and efficient manner through free and open competition or through basing rates on other public and private rates that are actuarially sound. (Section 2101(a)) (42CFR 457.940(b))

State Response

11.2. The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX: (Section 2107(e)) (42CFR 457.935(b)) *The items below were moved from section 9.8. (Previously items 9.8.6. - 9.8.9)*

11.2.1. 42 CFR Part 455 Subpart B (relating to disclosure of information by providers and fiscal agents)

11.2.2. Section 1124 (relating to disclosure of ownership and related information)

11.2.3. Section 1126 (relating to disclosure of information about certain convicted individuals)

11.2.4. Section 1128A (relating to civil monetary penalties)

11.2.5. Section 1128B (relating to criminal penalties for certain additional charges)

11.2.6. Section 1128E (relating to the National health care fraud and abuse data collection program)

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Section 12. Applicant and enrollee protections (Sections 2101(a))

- Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan.**

Eligibility and Enrollment Matters

12.1 Please describe the review process for **eligibility and enrollment** matters that complies with 42 CFR 457.1120.

State Response: Eligibility and Enrollment issues are addressed in detail in Section 4.

The Department maintains a website where the public may either download and print an application to submit, or may elect to file the electronic application available at this web site. Submitting an electronic application yields an immediate decision and is the most efficient means of expediting an application. If a person does not have online access, they may be assisted at a local health department in having the information entered for them.

The state provides opportunities and imposes standards for review of eligibility and enrollment decisions in accordance with 42 CFR 457.1120 – 42 CFR 457.1180.

Each applicant/enrollee is provided with the necessary request forms allowing them to challenge decisions regarding:

- 1) The denial of eligibility
- 2) Failure to make a timely determination of eligibility
- 3) Suspension or termination of enrollment

The review request forms are sent to the applicant/enrollee at the same time as the notification of the denial/termination decisions. The review request forms include directions for completing the review request form, the mailing address for submitting the review request and a toll-free phone number for assistance in completing the review request form.

The State ensures that the applicant/enrollees in the medical programs receive impartial reviews of all matters pertaining to eligibility/enrollment by referring requests for reviews of the action taken to persons not directly involved in the matter under review. Representatives of the Department of Health and Human Services conduct the formal review of the actions. Neither department representative has been directly involved in the disputed action/decision under review. The Quality Assurance Analyst with the Department of Health and Human Services reviews the action taken determines if actions were in compliance with the stated policy. The analyst then presents their findings to the Department of Health and Human Services Hearings Officer. The hearings officer determines if the denial/termination should be upheld or overturned based on the findings of the analyst. The applicant/enrollee is then notified of the decision.

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In matters of Medicaid eligibility/enrollment, terminations of Medicaid are suspended if the request for review is received prior to the termination date. The applicant/enrollee continues to receive Medicaid until the decision is rendered by the Administrative Law Judge. There is no cost sharing involved with the Medicaid programs.

Enrollees/applicants are given timely written notice of any denial/termination of eligibility. The notification includes the reason for the determination, an explanation of the applicant's rights to review of the decision, the standard and expedited time frames for requesting a review. The applicant/enrollee is also advised of their right to review a decision and provided with instruction on how to request a review and how to continue current eligibility while the review is pending along with a contact phone number (including a number for individuals with hearing and speech difficulties) to request assistance in completing the review request. A review may be expedited if there is a stated immediate need for health services.

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