OMB #: 0938-0707
Exp. Date:

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

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.

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. X 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 expenditure 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:

"Neither the DCH nor the FIA will 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."

"You have the right to appeal a decision made by the DCH or FIA. 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

Date Amendment #12 Submitted:	August 28, 2010
Date Amendment #12 Effective:	October 1, 2010

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 low-income children. Recent efforts to address this problem include various expansions of the Medicaid program and the creation of Title XXI of the Social Security Act. Consistent with Title XXI, Michigan's *MIChild* program will provide comprehensive health care coverage to all children under age 19 who reside in families whose incomes are at or below 200 percent of the Federal Poverty Level and who are uninsured. In 1998, the Urban Institute estimated that there are 106,000 such children in Michigan. This is the baseline figure used by Michigan as the target for Medicaid or *MIChild* 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 uncovered 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 families with potentially eligible children who are not currently enrolled in Medicaid, assist them in completing enrollment materials, and also assist families in selecting and obtaining access to health care providers serving Medicaid clients. Local health departments utilize a variety of outreach methods including direct mail and telephone contact with families having potentially eligible children, community-based health fairs where preliminary income determination for Medicaid is provided, one-on-one contact with families who seek child health services from the local health department, and a variety of other methods to identify families with potentially eligible children. All local health departments provide transportation arrangements, interpreters for non-English speaking clients, and a variety of in-person, mail and telephone contacts as part of

their outreach services.

The other program currently available in all local health departments is the 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 shortened MIChild/Healthy Kids enrollment form, 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.

1. Adolescent Health Program/School-Based and School-Linked Health Centers: Teens receiving care in one of the state-funded Teen Health Centers and/or Alternative Models are encouraged to enroll in Medicaid, depending on eligibility, and assisted in the process of enrolling.

2. Early On/Part C of the Individuals with Disabilities Education Act: Since Part C funding represents the last federal dollar that can be spent, assistance with Medicaid enrollment is accomplished through local intermediate school districts and other local human services agencies to assure that eligible children have access to funding sources for health care needs.

3. Infant Support Services Program (ISS): Families of infants with high-risk needs who appear to be Medicaid-eligible are assisted in Medicaid enrollment by the more than one hundred providers throughout the state. Both public and private agencies are ISS providers as are a variety of home health agencies and hospitals in addition to local health departments that provide outreach to high-risk infants to assist them in obtaining services.

4. Maternal Support Services (MSS): Pregnant women and teens who 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.

5. 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.

6. Children's Special Health Care Services Program (CSHCS): CSHCS, through its locally based services (LBS) component, is a major source of outreach activity for children with established and/or potential diagnoses of conditions covered by the program. LBS staff assist families in gathering salary-based information to aid in the determination of eligibility for Medicaid. The majority of children enrolled in this program are funded with a combination of Medicaid and state dollars.

7. 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.

8. Medicaid Outreach and Advocacy: For the 1997 local health department Comprehensive Planning, Budgeting and Contracting process, several categorical outreach funding sources and functions have been established as a block grant and have been identified as "Medicaid Outreach and Advocacy." This block grant is for the specific purpose of identifying individuals/families who are potentially Medicaid-eligible and assisting them in becoming enrolled in Medicaid. Target populations include: pregnant women, families with potentially eligible Medicaid children, families who are eligible for Medicaid but for whom cash assistance is no longer available or delayed due to TANF requirements that are not applicable to Medicaid, and enrollees in Children's Special Health Care Services who may be Medicaid eligible. Each local health department will be required to develop a plan for the utilization of these block grant funds, including information regarding coordination and collaboration with other community-based organizations, and how cultural, ethnic and racial minorities that reside in each jurisdiction will be targeted.

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: An example of public-private partnership in health care delivery to children in Michigan was the Caring Program for Children.

Michigan in 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.*

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))

State Response: As indicated in Section 4 (Eligibility Standards and Methodology) of this state plan application, Michigan will institute thorough eligibility standards and procedures. Our application process will ensure that only children eligible for *MIChild* and no other creditable health insurance will be enrolled in *MIChild*. The eligibility application will have specific questions about other health insurance coverage. Periodic sampling of the *MIChild* enrolled population will be conducted and the sample will be compared to Medicaid and Blue Cross and Blue Shield tapes to assure there is no duplicative coverage. We will also continue all child health activities as described in Section 2.2.1 to ensure that, to the extent possible, all children in Michigan will have access to heath care. Because of the close collaboration we will be establishing with Medicaid Program staff relative to *MIChild*'s eligibility determination process, both Medicaid and *MIChild* eligibility determinations will be seamless, i.e., referrals and enrollments in either program will be done expeditiously. Based upon review of the completed *MIChild* application, families will either be referred to Medicaid eligibility processing, enrolled in *MIChild*, or determined to be ineligible for either program based upon income, access to already existing coverage, or other disqualifying factors.

Section 4.3 on page 20 addresses the issue of coordination with Title V programs under the heading "CSHCS (Children's Special Health Care Services—Title V) COORDINATION".

As further indicated in Section 5 (Outreach and Coordination), our efforts in this area will target individual and community awareness of the potential for health care coverage. While our primary outreach goal will be to publicize and to foster enrollment in *MIChild*, we expect that we will also be increasing recognition relative to other creditable health insurance, particularly Medicaid. We will involve public and private carriers that have knowledge of health care coverage to assist us in these efforts.

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.

3.1. Describe the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Include a description of the choice of financing and 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) (42CFR 457.490(a))**

State Response: The State expects to have multiple providers offering *MIChild* medical benefits with a single Administrative Contractor responsible for most *MIChild* administrative duties and for interacting with the medical benefits providers and the State Department of Community Health.

Licensed health insurers, offering a preferred provider product, and health maintenance organizations (HMOs) will be *MIChild* medical benefits providers. Plans so qualified may choose to contract with the State as *MIChild* providers at any time, provided all state qualifying standards are met. The State will require *MIChild* providers to meet standards beyond ongoing licensure standards. The licensed insurers and HMOs participating in *MIChild* will perform the following functions:

- They will provide, or reimburse, accessible, quality medical services.

  - The Health Plans may determine initial *MIChild* eligibility prospectively and on the basis of a completed *MIChild* eligibility application.

  (When initial eligibility is determined, the carrier/HMO will advise the Administrative Contractor of the child's initial eligibility status and forward the *MIChild* application to the Administrative Contractor for a final determination of *MIChild* eligibility and State approval.)

  (Initial eligibility will be limited to less than two months in duration and will begin on the day the health plan approves the application.)

- They will issue plan cards and membership booklets to qualifying families.

- They will provide *MIChild* outreach to potential eligibles and market the features of the plan through State-approved normal HMO insurance business activities or as the insurer/HMO otherwise chooses to do.

  They will administer a complaint and grievance process for *MIChild* enrollees. Enrollee families may request a department review through the Insurance Bureau if not satisfied with the outcome of the Insurer's/HMO's review process.

MIChild administrative functions will be done by an Administrative Contractor chosen through a Request For Proposals process. The administrative functions will include the following activities: The contractor will perform *MIChild* outreach activities, primarily through oversight and coordination of subcontracted, locally-based outreach efforts. The administrative functions will include the following activities:

- The contractor will recommend eligibility for *MIChild* enrollment, based upon review of completed *MIChild* applications and supporting documentation.

- The contractor will enroll qualifying children in the program with maintenance of supporting eligibility file/data base.

- The contractor will monitor and assess medical carriers'/HMOs' quality of medical care provision as well as complaint and grievance activities. State staff will interact with the Administrative Contractor on an ongoing basis and will discharge already existing responsibilities relative to the licensed health care insurance providers and HMOs, e.g., adequacy of the carrier's/HMO's provider networks.

- The contractor will verify and forward to the State the insurer's/HMO's payment requests.

- The Administrative Contractor will collect and keep monthly family premiums.

The existing service delivery systems are involved in the *MIChild* program. Participating licensed health insurers and HMOs shall be required to include qualified school-based and school-linked adolescent health clinics and Indian health clinics in their networks at standard reimbursement rates when these providers are located in the insurer's/HMO's service area. In addition, Michigan has well-functioning service delivery networks that connect children with chronic illnesses and disabilities with services and these are expected to be incorporated in the *MIChild* service delivery network. As examples:

> The Part C-Early On system is specifically focused on the infant/toddler population and is closely linked to Children's Special Health Care Services (CSHCS), the Infant Support Services Program, and a wide variety of other public and private service agencies at the community level. The perinatal network, which encompasses every hospital in the state that delivers infants, is also closely linked with Early On and CSHCS, as are the Developmental Assessment Clinics that provide follow-up of high-risk (primarily NICU) infants.

Michigan has focused on the implementation of collaborative projects at the local level, including all service agencies and advocacy groups that serve or are interested in the welfare of children. The state directors of the human services departments (Community Health, which includes public health, mental health and Medicaid, as well as the Office on Aging; Education; and the Family Independence Agency, formerly Social Services) have committed to the development and implementation of community-based collaborative efforts and are committed to interagency planning, funding, and management of services at the local level. 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 children at risk, early intervention, family support, primary and secondary prevention activities, and services for special needs populations.

The program developed under Title XXI will utilize the current networks described above to publicize the availability of services under *MIChild*, encourage facilitation of access to enrollment providers, coordinate activities that include assisting families to access the *MIChild* program, 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."

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

~ **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. X Age: Children under 19 years of age

4.1.3. X Income: Above 150 percent and at or below 200 percent of the federal poverty level, depending on the child's age

- For children from conception through birth, the adjusted gross income is 0 to 185% of the federal poverty level (FPL).
- For children from age 1 to under 19 years of age, the adjusted gross income must be above 150 percent and at or below 200 percent of the FPL.
- For children under 1 year of age, the adjusted gross income must be above 185 percent and at or below 200 percent of the FPL.

4.1.4. ~ 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: Children with comprehensive medical coverage are not eligible for *MIChild*.

State Response: Comprehensive employer-based coverage by other creditable health insurance will preclude enrollment in *MIChild*. *MIChild* enrollment will also be precluded if the applicant was covered by creditable employer-based health insurance within six months of *MIChild* coverage. However, if the applicant was terminated from creditable employer-based health insurance within six months of making the *MIChild* application for reasons such as layoff, business closing, or similar circumstance that resulted in the involuntary loss of previous insurance, then *MIChild* enrollment will not be

precluded.

4.1.8. X Duration of eligibility:

State Response: Participating *MIChild* insurers and HMOs may determine *MIChild* eligibility on an initial basis if it appears the child will be eligible for *MIChild* based on review of a completed *MIChild* application.

The Administrative Contractor will recommend eligibility, with the Department making the final authorization of *MIChild* eligibility. With approval of the *MIChild* application, the child will be eligible for twelve months. MIChild eligibility may end prior to twelve months of coverage if the child is found ineligible at audit, turns age 19, moves from the area, or for nonpayment of the MIChild premium.

At the end of the twelve-month eligibility period, the family will be requested to confirm the eligibility information currently on file with *MIChild*. This information is pre-printed on a standard re-determination form. The family reviews and confirms or changes the information and then signs and returns the form. Following return of the re-determination form, eligibility will be reviewed, and if eligibility continues, the family will be sent payment coupons for another twelve-month period. They will also be sent information advising that if the family income is now lower, the application will be referred for Medicaid determination.

4.1.9. Ξ 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))**

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:

INITIAL START-UP

The Administrative Contractor will have the following responsibilities:

- The contractor will develop:
  - an application form that is easy to understand, complete, and short, including Arabic and Spanish versions (consistent with Michigan Enrolls' practice), and
  - approval/denial eligibility letters.

- The contractor will create and maintain eligibility files that are compatible with DCH data systems. These include, but are not limited to:

  - data regarding beneficiaries (e.g., birth dates, sex, race/ethnicity, primary language, social security number),
  - enrollment dates,
  - disenrollments (e.g., dates, reasons), and
  - annual financial re-determinations.

- Upon request, the contractor will provide the *MIChild* enrolled plans with the applications, processes, and procedures for determining *MIChild* initial eligibility. The processes and procedures must be approved by DCH.

- The contractor will have a cooperative written agreement with the Children's Special Health Care Services (CSHCS) Eligibility Division. The agreement will include provisions regarding referrals for potential CSHCS eligible children and enrollment in a qualified health plan for comprehensive health care.

- The contractor will pay all costs associated with the mailing of applications/letters/etc., telephone access (e.g., 1-888 number), maintenance of forms, maintenance of data systems compatible with DCH, and all other costs associated with the eligibility process.

- The contractor will make applications available at local sites (e.g., schools, health departments), and if the application is requested, mail applications to families within two days of request.

- The contractor will collect the monthly premium from the family.

- The contractor will maintain a listing of all *MIChild* eligibles enrolled by plan, their networks, and

MIChild enrollment capacity.

- The contractor will provide periodic reports to the DCH for the purpose of DCH administrative oversight and monitoring of federal requirements.

- The contractor will provide the family with a creditable certificate of coverage upon disenrollment from *MIChild*.

- The contractor will perform annual financial re-determinations.

Each plan will have the following responsibilities:

- The Plan will create and issue plan identification cards to be used for those beneficiaries that are *MIChild* eligible. These require DCH approval prior to use.

- The Plan will create and maintain eligibility files that are compatible with DCH data systems. These include, but are not limited to, data regarding beneficiaries':
  1. identifying information (e.g., address, birth dates, sex),
  2. enrollment dates,
  3. disenrollments (e.g., dates, reasons), and
  4. services provided.

.

ENROLLMENT PROCESS

Plans that choose to determine initial eligibility will have the following responsibilities:

- receive completed applications and any required verifications,

- within two days of receipt of the completed application, determine initial eligibility for up to two month's of coverage based on information presented,

- follow up on incomplete applications the plan has received by telephone or mail,

- forward applications and eligibility verifications within two days to the Administrative Contractor for final determination of *MIChild* eligibility,

The Administrative Contractor will have the following responsibilities:

- The Contractor will receive completed applications and any verifications at a central location.

- The Contractor will verify documents (e.g., insurance coverages) and determine eligibility for *MIChild* based on DCH criteria.

- The Contractor will process applications, including any required verifications, and mail notices of approvals/disapprovals within ten working days of receipt of the complete application.

- The Contractor will follow up on incomplete applications by telephone or mail.

- The Contractor will perform annual financial re-determinations of eligibility for each beneficiary.

- The Contractor will notify each plan of new *MIChild* enrollees who were enrolled by the Administrative Contractor.

- The Contractor will make referrals to the Family Independence Agency when the child may be Medicaid eligible. The local Department of Community Health will also be notified of these referrals for follow-up.

- The Contractor will verify the number of *MIChild* enrollees in each plan for determination of the capitation to be paid to each plan.

RE-ENROLLMENT

Re-application upon disenrollment due to failure to pay premiums is available immediately. Prior to disenrollment, the family will be given an opportunity to explain any changes in income or family size that may now qualify the family for Medicaid.

All other families may enroll in *MIChild* at any time.

BEGIN DATE OF *MICHILD* ENROLLMENT

Eligibility for *MIChild* will depend on the following:

- If the health plan makes an initial determination of eligibility, *MIChild* eligibility begins the day the health plan approves the application.
- If the Administrative Contractor notifies the beneficiary of an eligibility determination, *MIChild* eligibility begins the first day of the month following the month of approval. Note: For applications processed within five work days of the beginning of the next month, coverage will begin the first of the following month.

Effective Date: Approval Date:

ELIGIBILITY LOCK-IN

The *MIChild* enrollee will be "locked-into" the Contractor for twelve (12) months from the date of enrollment, as long as the child remains *MIChild* eligible. Effective October 1, 2010, beneficiaries shall have the first **90** days of that period to change Health and/or Dental Plans. MIChild enrollees will have an annual open enrollment period and must be notified sixty (60) days prior to the opportunity to change health plan and/or dental plan enrollment. An enrollee may change Health Plans and/or Dental Plans at any time for cause, as determined on an individual basis and approved by the Department.

Reasons for disenrollment will include:
- nonpayment of premiums
- the beneficiary reaches age 19
- move from area
- child is found ineligible at audit
- death

The Administrative Contractor must verify that the payment of the premium was made for each month. If the monthly premium for the next month has not been paid, the Administrative Contractor must notify the responsible relative, in writing, of:

- the amount due
- the date the past premium must be paid
- that the beneficiary will be disenrolled from the plan if the past premium is not paid
- the right to request a department review and how to request this review

This notification must be sent to the family at the beginning of the month. If the past premium is not paid within a reasonable time period, the beneficiary will be disenrolled from *MIChild*, effective the last day of the next month.

The Administrative Contractor must provide the beneficiary with a creditable certificate of coverage upon disenrollment from *MIChild*.

REDETERMINATION

With approval of the *MIChild* application, the child will be eligible for twelve months. MIChild eligibility may end prior to twelve months of coverage if the child is found ineligible at audit, turns age 19, moves from the area, or for nonpayment of the MIChild premium.

At the end of the twelve-month eligibility period, the family will be requested to confirm the eligibility information currently on file with *MIChild*. This information is pre-printed on a standard re-determination form. The family reviews and confirms or changes the information and then signs and returns the form. Following return of the re-determination form, eligibility will be reviewed, and if eligibility continues, the family will be sent payment coupons for another twelve-month period. They will also be sent information advising that if the family income is now lower, the application will be referred for Medicaid determination.

DCH ELIGIBILITY CRITERIA

In order to be eligible for *MIChild*:

- The child must be a resident of Michigan, a documented alien, or the family has come to Michigan with the intent to stay or work in Michigan. Some legal immigrants are not eligible for the first five years of residency. Excepted groups include refugees and children of veterans.

  Alien status can be verified by the I-551 or I-94. DCH will notify the plans and the Administrative Contractor of the appropriate methods for verifying alien status.

- The child must reside in a family with an adjusted gross income of less than or equal to 200 percent of poverty (185-200 percent of poverty for pregnant women and children under age 1). No asset test is used. The income will be verified by self-declaration.

- The child must be between the ages of 0 and 19 (once the child turns 19, he is no longer eligible for *MIChild after the month he turns 19*). Emancipated minors must be considered as a family in their own right.

- The child must have no comprehensive employer-based insurance coverage for the past six months. (Specialty insurance coverage such as dental only coverage is not considered a comprehensive insurance.) Coverage through the CSHCS program and the Indian Health Services is not to be considered as other insurance for eligibility purposes.

- The child's family must have paid the monthly MIChild premiums. Effective July 1, 2001, American Indians/Alaska Natives are exempt from payment of the *MIChild* premium if any family member listed on the application and living in the home is an American Indian/Alaska Native, even if that member is an adult or a Medicaid recipient.

The following must not be a factor in determining *MIChild* eligibility

- Disability status
- Pre-existing condition
- Diagnosis

EXCLUDED CHILDREN

The following individuals cannot participate in *MIChild*

- children who appear to be eligible for Medicaid (even if not enrolled in Medicaid)

- children who are involuntarily admitted to a non-medical public institution (A public institution means a government-operated facility that does not provide medical care, e.g., jail or prison)

- children who are admitted to an institution for the mentally disabled (e.g., ICF/MR)

- children who are members of a family that is eligible for health coverage under a state health benefits plan on the basis of a family member's employment by a public agency in Michigan

- children who have had comprehensive employer-based insurance in the past six months, including Medicare, with exception allowed for non-voluntary loss of insurance consistent with HCFA

crowd-out policy.

- children who are covered under a group health plan
- children who have court-ordered medical support as part of a divorce settlement (see below)

CSHCS (Children's Special Health Care Services—Title V) COORDINATION

CSHCS eligibles (non Medicaid) who do not have another source of creditable health care coverage will have a choice of enrolling in either the *MIChild* Program (that includes specialty services), the CSHCS managed care program with optional supplemental primary coverage, or the fee for service CSHCS program for specialty care only. (The services available under the supplemental primary coverage will ensure that all services available under the *MIChild* Program are covered through the CSHCS managed care plan.)

- If the family chooses only the *MIChild* Program, the child will be disenrolled from the CSHCS Program.
- If the family lives in a SHIP county and chooses the CSHCS specialty coverage and *MIChild*, the child may be enrolled with a CSHCS managed care provider for the specialty services and supplemental primary coverage equivalent to *MIChild* coverage.
- If the family chooses the fee for service CSHCS program, the child will have specialty coverage only, and that coverage will be through the CSHCS program.

The State will ensure that children currently enrolled in the CSHCS program are given the same choices that newly eligible children are given.

TMA PLUS COORDINATION

TMA Plus is a program operated by the State that allows persons losing transitional Medicaid coverage to buy-in to Medicaid. TMA Plus was originally operated in six Project Zero sites, but has been expanded statewide to afford families that have worked their way off welfare to continue health care coverage if no employer coverage is offered. TMA Plus is only available to families at or below 185 percent of the federal poverty level. TMA Plus families may purchase TMA Plus coverage for the adults and may purchase *MIChild* coverage for the children.

COURT-ORDERED MEDICAL SUPPORT COORDINATION

If the court has ordered medical support for the child through a divorce settlement, then the child is usually not eligible for *MIChild*. There are situations when the parent who is responsible for the medical support has not provided that insurance. In these situations, the child may be enrolled in *MIChild*. The Administrative Contractor must advise the custodial parent that he/she must pursue the court-ordered

support. The custodial parent must supply the Administrative Contractor with proof of efforts to obtain that court-ordered support (e.g., Friend of the Court verification).

- If the responsible parent has provided the insurance, then the child must be disenrolled from *MIChild*.

- If the custodial parent is still in the process of obtaining that insurance, the child may remain on *MIChild*.

- If the custodial parent has not pursued the court ordered medical support, the child must be disenrolled from *MIChild*.

SPENDDOWN BENEFICIARIES

A family may be required to meet a spend-down amount to become Medicaid eligible. In these situations:

- the children may be *MIChild* eligible until the family meets the spend-down amount
- anyone in the family may use incurred expenses to meet the spend-down amount
- the children on *MIChild* will not be disenrolled from *MIChild*
- once the family is Medicaid eligible, *MIChild* will be considered a third party resource
- as part of the random sample review, DCH will perform post-payment reviews of spend-down clients and will periodically run the *MIChild* enrollment list against Medicaid enrollment
- data provided to the Administrative Contractor will include a list of spend-down clients by Medicaid ID Number

RETROACTIVE MEDICAID

There may be cases where the child is on *MIChild*, but Medicaid coverage was made retroactive to cover that same time period. In these cases, the child should be disenrolled from *MIChild* as soon as he is identified as being Medicaid eligible. A child enrolled in *MIChild* cannot be retroactively disenrolled from *MIChild*.

Frequent tape matches between Medicaid and *MIChild* will be used to minimize this situation.

DEPARTMENT REVIEW PROCESS

Denial of *MIChild* Eligibility
The family may request review of any denial of *MIChild* eligibility. An attempt will first be made to settle such requests and complaints at the Administrative Contractor level. If the family remains dissatisfied with the decision after having had the opportunity to discuss the matter with supervisory personnel at the Administrative Contractor and they wish to pursue the issue, they may request a Department Review by the DCH for a final decision on the child's or children's eligibility.

Denial Letters
Denial letters must be sent to the family if *MIChild* eligibility is denied. The letter must include:

- reason for the denial
- family's right to request an Department Review and the process for that Department Review
- the time frames involved
- Spanish and Arabic translation

Denial of *MIChild* Benefits
An attempt should be made to settle all complaints at the plan level. If the beneficiary wishes to pursue the issue, he may request a review by the Insurance Bureau. The Administrative Contractor will assist the beneficiary with the process.

QUALITY ASSURANCE/MONITORING

The Administrative Contractor must maintain the following data from the plans for quality assurance purposes. This data must be available in a format that is agreed upon by DCH and the Administrative Contractor. The Administrative Contractor will be required to provide DCH with reports, in formats established by DCH, on a routine basis.

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:

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 periodic random reviews and post-eligibility audits of the applications to assure compliance with *MIChild* 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 *MIChild* services)

- number of applications received
- number of denials of applications with the reasons for denial
- number of children who were determined by the plans to be *MIChild* eligible, using presumptive eligibility, who were subsequently determined by the Administrative Contractor not to be *MIChild* eligible
- number of disenrollments with the reasons for disenrollment
- number of hearings requested and their disposition
- number of CSHCS beneficiaries who have chosen *MIChild*
- number of annual re-determinations
- enrollee survey results
- corrective actions, with DCH approval, taken with each plan 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 be available at the time of the Administrative Contractor's review to determine if the child is Medicaid or *MIChild* eligible.

If the Department determines the child to be Medicaid eligible, the child will NOT be enrolled in the *MIChild* Program. If the Department determines the child to be ineligible for Medicaid they will have eligibility determined for *MIChild*. DCH will conduct periodic matches of the *MIChild* enrollment lists against the Medicaid enrollment lists.

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 child to be Medicaid ineligible, the application will be reviewed at that time to determine *MIChild* eligibility.

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 200% FPL: describe the methods of monitoring substitution.

State Response: The *MIChild* application form will include a request for information regarding other insurance coverage for each child. The contractor will not enroll any child that has creditable employer-based group health coverage or any child who has dropped coverage in the previous six months, unless the reason for dropping the coverage is approved by the state. The fact that employer-based group health coverage was dropped is documented and there is a 6 month waiting period to apply for MIChild if the child has dropped employer-based group health coverage unless the exception criteria is met. BCBS and MIChild HMO's run monthly matches to insure that enrollees are not subsequently enrolled in the health plans through employer based coverage.

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. In addition, the local FIA offices are involved in the Indian centers for outreach for Medicaid. If a child is determined not eligible for Medicaid, he will be referred to the *MIChild* program, if appropriate.

The health plans will involve the Indian Health Centers in its considerations of network providers. This will ensure access to the primary care providers.

The *MIChild* application form also indicates the American Indian ethnicity in its demographic information requested. Understanding that submitting this information is voluntary; the contractor may use this information to track the number of American Indians that are receiving services through the *MIChild* program. Targeted outreach may be initiated if necessary. *MIChild* premiums are waived for any child in a household with an American Indian/Alaskan native member.

Section 5. Outreach (Section 2102(c))

Describe the procedures used by the state to accomplish:

Outreach to families of children likely to be eligible for child health assistance or other public or private health coverage to inform them of the availability of the programs, and to assist them in enrolling their children in such a program: **(Section 2102(c)(1)) (42CFR 457.90)**

State Response: The State's marketing and outreach efforts will be comprised of three components: (1) general marketing through use of demographically targeted media campaigns and existing information dissemination channels; 2) solicitation of cooperation and outreach from programs, agencies, organizations and systems that already know or have potential contact with families likely to have children eligible for *MIChild*; and 3) solicitation of community-developed plans from each multipurpose collaborative body (MPCB) currently organized in Michigan. Detail of these components follows:

1. General Outreach and Marketing

As part of the comprehensive approach to marketing and outreach of the *MIChild* program, a statewide media campaign will be conducted, including television, radio, and print. The design of the campaign will be based on the highly successful demographically targeted media campaign the State developed for immunizations. Demographic targeting maximizes the return for advertising dollars by matching the timing and placement of advertisements to the habits of the target population. We anticipate production of two television spots and two radio spots, which will be aired through paid media broadcast as well as through the Michigan Association of Broadcasters. Print media will also run statewide. In addition, collateral pieces, such as brochures and posters, will be developed that provide information regarding the *MIChild* program and that can be used by communities to reach the target segment. The information available will include an application form for return mailing. All materials will direct readers to a toll free number for further information or questions. Media efforts will be accomplished through the department's advertising agency of record. In addition, the state will do a kick-off, press event in one or more media markets, as well as quarterly news releases to further expand this outreach effort. The Department maintains a website with current information regarding the MIChild program for access by the general public. At this website, the public may either download and print an application to submit, or may elect to file the electronic application available at this web site.

2. Solicitation of cooperation and outreach from programs/agencies/systems likely to have contact with target families

For agencies and programs under the jurisdiction of, or funded by State agencies, each will be requested to develop a plan for how information on *MIChild* will be coordinated with current outreach, information dissemination, and marketing efforts and activities.

Because many agencies, programs, organizations, and systems in Michigan already exist that have as their general mission the improvement of the lives of families within the target population (200 percent of poverty), we expect there will be desire on their part to assist in marketing and providing outreach to families with whom they are already in contact and that may have children eligible for *MIChild*. Below is a preliminary listing of the agencies/programs/organizations/ that were contacted.

3. Development of Community developed plans for outreach and marketing of *MIChild*

The DCH may provide grants to the fiduciary of the Multipurpose Collaborative Bodies (MPCBs) for each county in which they exist. In exchange for funding, each MPCB will be responsible for the development of a plan reflecting how the resources of their jurisdiction will be dedicated toward marketing and outreach for the *MIChild* program. The plan will be required to reflect how the following stakeholders in the community will be involved:

Family Independence Agency
Local Public Health
Community Mental Health
Schools
Community Action Agencies
Advocacy organizations
Cooperative Extension
Primary and Migrant Health Centers
Hospitals
Public and private health clinics
Professional associations (e.g. local medical associations, dental associations)
Workforce development boards
Michigan Works agencies (responsible for enrolling Medicaid recipients in managed care programs)
Temporary Employment agencies
Family Courts
Head Start
WIC programs
Child Care coordinating councils
Neighborhood associations
The business community
Churches and other faith-based organizations
Service clubs serving youth (boys and girls clubs, scouting organizations, etc.)
The media (radio, newspapers, TV)
Civic organizations
Food banks

Each MPCB will be requested to identify a "coordinator" for its jurisdiction's activities to be a liaison with

the State regarding outreach and marketing for *MIChild*. Training and technical assistance will be made available to communities regarding *MIChild*. Training and technical assistance needs would be coordinated through this designee. At the end of each fiscal year, the MPCB will provide a report on the activities of the communities under its jurisdiction. It is anticipated that the funds provided will support the activities of the coordinator in his/her efforts to assure that the community plan is carried out and that all efforts are done in a collaborative and coordinated manner.

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. X Benchmark coverage; **(Section 2103(a)(1) and 42 CFR 457.420)**

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

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

State Response: See Addendum 1 for a description of covered services.

6.1.1.3. X 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. X 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. X 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. X Secretary-Approved Coverage. **(Section 2103(a)(4)) (42 CFR 457.450)**

6.1.4.1. X 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)

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. Ξ Inpatient services **(Section 2110(a)(1))**

6.2.2. Ξ Outpatient services **(Section 2110(a)(2))**

6.2.3. Ξ Physician services **(Section 2110(a)(3))**

6.2.4. Ξ Surgical services **(Section 2110(a)(4))**

6.2.5. Ξ Clinic services (including health center services) and other ambulatory health care services. **(Section 2110(a)(5))**

6.2.6. Ξ Prescription drugs **(Section 2110(a)(6))**

6.2.7. ~ Over-the-counter medications **(Section 2110(a)(7))**

6.2.8. Ξ Laboratory and radiological services **(Section 2110(a)(8))**

6.2.9. Ξ Prenatal care and pre-pregnancy family services and supplies **(Section 2110(a)(9))**

6.2.10. Ξ 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. Ξ 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. Ξ 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. Ξ 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. Ξ Nursing care services (See instructions) **(Section 2110(a)(15))**

6.2.16. Ξ Abortion only if necessary to save the life of the mother **(Section 2110(a)(16)**

6.2.17. Ξ Dental services **(Section 2110(a)(17))**

6.2.18. Ξ Inpatient substance abuse treatment services and residential substance abuse treatment services **(Section 2110(a)(18))**

6.2.19. Ξ Outpatient substance abuse treatment services **(Section 2110(a)(19))**

6.2.20. Ξ Case management services **(Section 2110(a)(20))**

6.2.21. Ξ Care coordination services **(Section 2110(a)(21))**

6.2.22. Ξ Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders **(Section 2110(a)(22))**

6.2.23. Ξ Hospice care **(Section 2110(a)(23))**

6.2.24. Ξ 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. Ξ 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.-D The State will provide dental coverage to children through one of the following. Dental services provided to children eligible for dental-only supplemental services must receive the same dental services as provided to otherwise eligible CHIP children (§2103(a)(5)):

6.2.1.-D X State specific dental benefit package. The State assures dental services represented by the following categories of common dental terminology (CDT) codes are included in the dental benefits:

1. Diagnostic
2. Preventive
3. Restorative
4. Endodontic
5. Periodontic
6. Prosthodontic
7. Oral and maxillofacial surgery
8. Orthodontics
9. Emergency dental services

6.2.1.1.-D Periodicity schedule
Medicaid

American Academy of Pediatric Dentistry
Other Nationally recognized periodicity schedule

6.2.2.-D Benchmark coverage (§2103(c)(5) and 42 CFR 457.410 and 42 CFR 457.420)
6.2.3.-D FEHBP-equivalent coverage (§2103(c)(5)(C)(i))
6.2.4.-D State employee coverage (§2103(c)(5)(C)(ii))
6.2.5.-D HMO with largest insured commercial enrollment (§2103(c)(5)(C)(iii))

State: Please see Attachment 1 for detail on the above coverages as they relate to children eligible for services under section 6.1.1.2.

State: Please see Attachment 2 for detail on the above coverages as they relate to unborn children eligible for services under section 6.1.4.

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. Ξ 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. Ξ Quality standards

7.1.2. Ξ Performance measurement

7.1.3. Ξ Information strategies

7.1.4. Ξ Quality improvement strategies

State Response: The State plans to assure the quality and appropriateness of care, particularly with respect to well-baby care, well-child care, and immunizations provided by the *MIChild* Plan, through quality standards, performance measurement information strategies, and quality improvement strategies detailed in the Administrative Contractor Request For Proposal and the *MIChild* services contract. By contracting for *MIChild* Plan services with licensed entities, the State believes that it can assure quality and access of care through licensure and oversight activities. The *MIChild* services will be contracted to Health Maintenance Organizations, Insurance Carriers, and Nonprofit Dental Corporations. Mental health and substance abuse services will be provided through community mental health service programs (CMHSPs) and coordinating agencies (CAs). Both CMHSPs and CAs are public agencies accountable to the department and local government.

Health Maintenance Organizations (Public Act 1978, No. 368 or Michigan Compiled Laws 333.21001)

The State plans to contract with any qualified health maintenance organization providing, when medically indicated, designated health services as described in the terms of the contract. The Department, in conjunction with the Insurance Bureau, has established a system of licensing and regulating of a health maintenance organization that DCH believes pertinent to the readiness of the health maintenance organization to perform *MIChild* services. Through licensing and regulation activities, the State protects and promotes the public health through the assurance that the organization provides:

- an acceptable quality of health care by qualified personnel
- health care facilities, equipment, and personnel which may reasonably be required to economically provide health maintenance services

- operational arrangements which integrate the delivery of various services
- a financially sound prepayment plan for meeting health care costs

Both the Department and the Insurance Bureau regulate the activities of a health maintenance organization by the following powers and duties:

The Department regulates the health delivery aspects of health maintenance organization operations for the purpose of assuring that the health maintenance organization is capable of providing care and services promptly, appropriately, and in a manner that assures continuity and acceptable quality of health care. The Department may visit or examine the health care service operations of a health maintenance organization and consult with enrollees to the extent necessary to carry out the intent of the Public Act.

The Insurance Bureau regulates the business and financial aspects of health maintenance organization operations for the purposes of assuring that the organization is financially sound and follows acceptable business practices. The Insurance Bureau may visit or examine the business and financial operations of a health maintenance organization to carry out the intent of the Public Act.

The Department and Insurance Bureau have access to the books, papers, and documents of the organization relating to the delivery of health services in a manner which preserves the confidentiality of the health records of individual enrollees. The Department or the Insurance Bureau each shall have access to the corporate books, papers, and documents of the organization relating to the business and finances of the organization.

The State verifies the following documents as part of ongoing review:

- a copy of the basic organizational document of the applicant, such as the articles of incorporation
- a copy of the bylaws
- a list of the names, addresses, and official positions of individuals responsible for the operation of the HMO
- a statement generally describing the organization, its operations, the type and quantity of health professionals engaged to provide services, the location of facilities, and a description of services available at the locations at which health maintenance services will be regularly available to enrollees
- a copy of all proposed contracts
- a copy of the financial statements
- a statement of projected enrollment levels
- a statement describing the geographic area serviced by the organization
- copies of solicitation materials and a general description of the marketing and enrollment techniques to be employed by the organization, including a plan for informing enrollees of the sources and methods of obtaining services and instructing them in their use
- a statement describing the applicant’s procedures for resolving enrollee complaints

Insurance Carrier (Public Act No. 350 of 1980 or Michigan Compiled Laws 550.1020)

The State plans to contract with any qualified corporation providing a managed health care benefit described in the terms of the contract under a certificate of authority by the Insurance Commissioner. As part of the examination by the Commissioner, the health care corporation shall file with the Office of the Commissioner a number of documents that DCH believes pertinent to the readiness of the corporation to perform *MIChild* services. The Commissioner shall examine the documents filed and may conduct any investigation which he or she considers necessary, may request additional oral and written information from the incorporators, and may examine under oath any persons interested in or connected with the proposed health care corporation. The documents pertinent to the *MIChild* Plan that the health care corporation shall file in the Office of the Insurance Commissioner are:

- a statement showing in full detail the plan upon which the corporation proposes to transact business
- a copy of all certificates to be issued to subscribers
- a copy of the financial statements of the corporation
- proposed advertising to be used in the solicitation of certificates for subscribers
- a copy of the bylaws
- a copy of all proposed contracts and reimbursement methods
- a community advisory board

Dental Care Organizations

The State plans to contract with any qualified dental care corporation that chooses to participate under the terms of the contract offered by the state and that provides a dental benefit described in the contract and operating under a certificate of authority by the Commissioner of Insurance. As part of the examination by the Commissioner, the nonprofit dental care corporation files with the Office of the Commissioner a number of documents that DCH believes pertinent to the readiness of the corporation to perform *MIChild* services. These documents are similar to the before mentioned documents for Health Maintenance Organizations and insurance carriers.

State Oversight and Monitoring

The State expects documentation from the licensed contractors regarding quality and access data collection, analysis, and trending as outlined below.

The plans must submit reports on the quality and access activities of the plans to the DCH. The plan must provide information relative to its enrollment data, HEDIS or HEDIS-like data, appeals, grievances and complaints, and the annual member survey to the Administrative Contractor. The Administrative Contractor analyzes the information submitted by the plans and summarizes the information in reports for the Department. The Department evaluates the information and recommends any corrective action measures necessary as a result of any deficiencies based on analysis of the data submitted. The Department shares the corrective action measures with the plans and monitors their implementation of the corrective actions. The plan will be required to provide other reports as determined necessary by the Department.

Overall it is important that the State have information regarding quality, access, and patient satisfaction

relative to the *MIChild* Plan. The content and format of reports will be finalized with those organizations that successfully contract with the State. The following is a list of items the State expects to monitor through various reports submitted by a contractor.

Enrollment Data
Enrollment
Demographic Data
Income and Resources Data
Health Coverage and Type Data, Previous to enrollment and Post-enrollment
Reason for Disenrollment
Residency
Referrals to Medicaid by name and by date of birth

HEDIS or HEDIS-like Data
Children's access to primary care providers
Childhood immunization rates
Adolescent immunization rates
Well-child visits in the first 15 months of life
Well-child visits in the third, fourth, fifth and sixth years of life
Adolescent well care
Physician specialists
Membership information
Inpatient hospitalizations
Ambulatory visits for primary care
Ambulatory visits for specialty care
Non-acute care visits
Maternity care
Newborn care
Pharmacy
Out-of-network care visits
Emergency room visits

Dental Data
Number of dental exams
Number of routine examinations
Number of cleanings
Number of restorations
Number of sealants
Number of emergency visits
Number of simple extractions

Mental Health and Substance Abuse Data will be monitored through the Community Mental Health Service Programs and the Coordinating Agencies responsible for the provision of these services.

Data Validation

The plan must agree to cooperate with the Department in carrying out validation of data provided by the plan and its subcontractors and by making available medical records and a sample of its data and data collection protocols. The plan must also agree to the development and implementation of corrective action plans to correct data validity problems as identified by the Administrative Contractor.

Grievance and Complaint Reporting

The plan must establish and maintain a complaint system which affords adequate and reasonable procedures for the expeditious resolution of written complaints initiated by members concerning any matter relating to the provisions of a service. A plan, within 30 days after receipt of a written complaint, shall give a reasonable written response to each complaint which it receives. The plan shall maintain a complete record of all the written complaints of its members which the plan has received since the date of the last report. This record shall indicate the total number of complaints; and by line of business, the nature of each complaint, the disposition of each complaint, and the time taken to process each complaint.

A plan shall submit to the *MIChild* Administrative Contractor an annual report which describes the complaint system of the corporation, and includes a compilation and analysis of the written complaints filed with the plan, their disposition and underlying causes, and measures being implemented to alleviate those causes. An analysis of the grievances shall include the total number of grievances resolved in favor of the member; number of grievances resolved in favor of the plan, and at what level the grievance was resolved.

At a minimum, procedures shall be developed by a plan for the resolution of claims for reimbursement; denial, cancellations, or non-renewals of certificates; and complaints regarding the quality of the services delivered by health care providers and health care facilities which receive reimbursement from the plan.

The report shall be compiled in a manner which protects an individual's right to privacy with respect to medical information and shall not disclose the identity of a member by name or other personal identifier without the member's consent. The annual report shall be a public record.

Appeals

The Department requires that the contractor follow the appeal guidelines described in the State's Patient Bill of Rights.

Member Satisfaction Survey

The Department requires that the contractors utilize the Consumer Assessment of Health Plans Survey (CAHPS) or CAHPS-like for completion of the member satisfaction survey. The survey must be designed to measure and report information regarding the following categories:

- ease of identifying a provider
- waiting time for an appointment
- phone waiting time for medical advice
- access to assessment, tests, treatment and specialists
- emergency room use
- ease of referral to specialists
- follow-up reminders

Evaluation of Outreach

The contractors and local agencies receiving outreach funding must submit reports on the outreach efforts.

The *MIChild* Plan will use quality standards, performance measures, information strategies, and quality improvement strategies to ensure high-quality care for *MIChild* enrollees. Table 1 is a list of the *MIChild* Plan quality methods and tools.

The State's contract(s) with a health carrier and/or plan will require them to collect and report enrollment, HEDIS or HEDIS-like, CAHPS, complaint, appeal, outreach, and dental (dental plan only) data. If it has an adequate quantity of children with continuous enrollment, the *MIChild* Plan contractor will produce these measures for its provider network either directly or through a contractor.

Table 1. List of *MIChild* Plan Quality Methods and Measurement Tools

METHODS (including Performance Measurement Strategies):	**TOOLS**	**BY WHOM**
Review of Quality & Access	Member Satisfaction Survey	Contractors
	Quality and Access Study	DCH
	Enrollment Data	Contractors
	Appeal Reporting	DCH & Insurance Bureau
Internal Review of Quality and Access	Grievance Reporting	Contractor and DCH
State Health Registers, e.g., Immunization	Data Validation	Administrative Contractor & DCH
	HEDIS or HEDIS-like	Plans & Administrative Contractor
Quality Standards:		
Licensure	Patient Bill of Rights, Public Health Codes and Insurance Code	State
Contract Standards	Access Standards, e.g., emergency room	DCH
Information Strategies:		
Provider Education	Sharing performance measurement results	DCH
	Sharing Clinical Practice Standards	Contractor
RFP - Administrative Contract Purchasing specs (capacity)	Competitive Bids for Administrative functions of the *MIChild* Plan	DCH
Enrollee Education	Enrollee Handbook - Rts & Responsibilities	Contractors
Ongoing Contract Monitoring	*MIChild* Contract	DCH
	Consumer Education	Contractor
Quality Improvement		

Strategies: Feedback to Plans on Quality and Access	Corrective Action Plans	DCH

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))**

State Response: See Chart below

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))**

State Response: See Chart below

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: See Chart below

A. The State assures access to covered services in the following manner:

Carrier	Plan	*MICHILD* ACCESS ASSURANCES
X	**X**	*MIChild* contracts will establish and maintain *MIChild* services statewide. A contractor may provide *MIChild* services statewide or at a minimum geographic area defined as a county.
X	**X**	The *MIChild* contracts allow plans to provide services based upon presumptive eligibility for two months for children eligible for *MIChild* as the Administrative Contractor approves the final *MIChild* application.
X	**X**	The *MIChild* contracts require the plan and Administrative Contractor to refer all Medicaid-eligible children to the State.
X	**X**	The *MIChild* administrative contract requires the Administrative Contractor to refer the application of a likely Medicaid-eligible child to the Family Independence Agency to assist the family in the Medicaid application process.
X	**X**	The *MIChild* services contract will specify that the contractor must reimburse for medically necessary services that include pediatric sub-specialists in the network of providers including (but not limited to): allergist, cardiac surgeon, cardiologist, critical care specialist,

		dermatologist, endocrinologist, gastroenterologist, nutrition specialist, geneticist, hematologist/oncologist, immunologist, infectious disease specialist, neonatologists nephrologist, neurologist, neurosurgeon, ophthalmologist, orthopedist, otolaryngologist, psychiatrist, pulmonologist, rheumatologist, surgeon and urologist.
X	**X**	The *MIChild* contract will require the plans to reimburse medically necessary services for out of the area or out of the plan's network of providers.
X	**X**	The contractor must have written procedures/protocols for emergency medical services for children. These must be consistent with *MIChild* contract language.
X	**X**	The contract will require the disclosure of any physician incentive plan.
X	**X**	The contractor must describe covered benefits and enrollee rights/responsibilities in an enrollee handbook (to include but not limited to the State contract language requirements for enrollee handbook).

B. The State will assure access through the following monitoring activities:

Carrier	**Health Plan**	***MICHILD* ACCESS MONITORING ASSURANCES**
X	**X**	The State requires the contractor to annually submit HEDIS 3.0 or HEDIS-like data, e.g., the children-appropriate sections.
NA	**NA**	The State requires the contractor to annually submit enrollment data and Medicaid referral data.
X	**X**	The State requires the contractor to do an annual member satisfaction survey.
X	**X**	The State requires the contractor to maintain and report grievances and complaint logs.
X	**X**	The State performs a quality and access study through a contractor.
X	**X**	The State requires the contractor to maintain a complaint log and resolution status of complaint.
X	**X**	The State analyzes the appeal reports from the Insurance Bureau
X	**X**	The State performs evaluations and reports as noted in Section 10.

7.2.4 Decisions related to the prior authorization of health services are completed in accordance with state law **or,** in accordance with the medical needs of the patient, within 14 days after the receipt of a request for services. **(Section 2102(a)(7)) (42CFR 457.495(d))**

State Response: The State intends to contract the *MIChild* Plan with any qualified health carrier or plan

that is licensed and meets the Department's participation standards. The State's contract for the *MIChild* Plan will incorporate access standards, including emergency services. The Request for Proposals for the Administrative Contractor will include eligibility and enrollment responsibilities and monitoring duties regarding enrollments by the plans.

Health Plans issue Membership handbooks to their members that detail the procedures for prior authorization of health care. For services that require Prior Authorization, enrollees are informed that in most cases, the health plan will approve, deny or partially approve/deny a request for prior approval within 15 days of receipt. In urgent cases, response will be within 72 hours. Prior authorization of services is acknowledged in state law at MCL 5000.2212a.

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. Ξ 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:

State Response: For families in the *MIChild* program, with incomes above 150% of the Federal Poverty Level (or above 185% of the Federal Poverty Level if the enrollee is less than age one) the family will be required to pay $10.00 per month, per family. However, the premium is waived if the fiscal group includes a member who is an American Indian/Alaskan native.

8.2.2. Deductibles:

State Response: Michigan will assess no deductibles.

8.2.3. Coinsurance or co-payments:

State Response: Michigan will assess no coinsurance amounts 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))**

State Response: Enrollment and outreach material will contain a notice and description of cost sharing.

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. x 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. x 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 x 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))**

State Response: Cost sharing will only apply to *MIChild* enrollees in families with incomes above 150 percent of the Federal Poverty Level (or above 185 percent of the Federal Poverty Level if the enrollee is less than age one). The cost sharing involves only a monthly premium of $10. This amount is never in excess of 5% of an eligible family's income. If a family's income is such that $10 exceeds 5% of their monthly income, the family would be eligible for Medicaid (with no premium) and not *MIChild*.

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)**

State Response: See Section 8.2.1 and 4.4.5

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))**

State Response: The Administrative Contractor must verify that the payment of the premium was made for each month. If the monthly premium for the next month has not been paid, the Administrative Contractor must notify the responsible relative, in writing, of:

- the amount due
- the date the past premium must be paid
- that the beneficiary will be disenrolled from the plan if the past premium is not paid
- the right to request a department review and how to request this review

This notification must be sent to the family at the beginning of the month. If the past premium is not paid within a reasonable time period, the beneficiary will be disenrolled from *MIChild*, effective the last day of the next month.

Re-enrollment after failure to pay is available immediately. Prior to disenrollment, the family will be given an opportunity to explain any changes in income or family size that may now qualify the family for Medicaid. Applicants that do not have unpaid MI Child premiums in the past 6 months will have a 1-month grace period to pay the initial monthly premium. Applicants that have an unpaid balance for one or more of the preceding 6 months will be required to pay all past due premiums prior to

being re-enrolled in MI Child.

New enrollees with no past due premiums are given a one-month grace period to ensure that they have ample time to pay the premium, prior to being terminated. After an initial notice of the amount due, individuals failing to pay prior to the due date are sent a reminder notice mid-month indicating that if payment is not received by the due date in the next month, coverage will be terminated. The grace period is only given to new enrollees to ensure that failure to pay is not the result of a misunderstanding or unfamiliarity with the program.

All other families may enroll in *MIChild* at any time.

8.7.1 Please provide an assurance that the following disenrollment protections are being applied to all enrollees:

X State has established a process that gives enrollees reasonable notice of and an opportunity to pay past due premiums, co-payments, coinsurance, deductibles or similar fees prior to disenrollment. **(42CFR 457.570(a))**

X The disenrollment process affords the enrollee an opportunity to show that the enrollee□s family income has declined prior to disenrollment for non payment of cost-sharing charges. **(42CFR 457.570(b))**

X In the instance mentioned above, that the state will facilitate enrolling the child in Medicaid or adjust the child□s cost-sharing category as appropriate. **(42CFR 457.570(b))**

X The state provides the enrollee with an opportunity for an impartial review to address disenrollment from the program. **(42CFR 457.570(c))**

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. Ξ No Federal funds will be used toward state matching requirements. **(Section 2105(c)(4)) (42CFR 457.220)**

8.8.2. Ξ 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. Ξ 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. Ξ Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1, 1997. **(Section 2105(d)(1)) (42CFR 457.622(b)(5))**

8.8.5. Ξ 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. Ξ 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)**

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))**

State Response: The strategic objective of the *MIChild* program is to increase the number of low income children in Michigan with creditable employer-based health insurance coverage by means of moving the children under age 19 without health insurance into either accessible, quality Medicaid or *MIChild* coverage while not simultaneously "crowding out" existing private coverage.

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 children in Michigan in either the Medicaid program or the *MIChild* program, as appropriate.

Goal 2. Obtain accurate, usable HEDIS or HEDIS-like reports from *MIChild* providers and monitor the following outcomes with emphasis on:

- well child examinations
- immunizations
- receipt of at least one (1) physician visit per *MIChild* enrollee annually
- receipt of at least one (1) dental examination per *MIChild* enrollee annually

Goal 3. Local agencies and programs will contact low-income families representing 106,000 uninsured children and make known to the families the availability of Medicaid and *MIChild* health insurance coverage.

Goal 4. Provide an application and enrollment process which is easy for families 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))**

State Response:

Goal 1. Count the number of children enrolled in the Medicaid program at the beginning of *MIChild* program implementation and at twelve months after *MIChild* program implementation, and add the difference to the number of *MIChild* enrollees after twelve months of *MIChild* implementation. Compare

this number to the base number.

Goal 2. Require *MIChild* insurers and HMOs to report HEDIS or HEDIS-like data to the State, work with these contractors to insure accuracy and timeliness of reporting, and assess the reported service counts against state goals.

Goal 3. Require local agencies receiving *MIChild* outreach funding to report to the State the number of target families contacted.

Goal 4. Assess the family's satisfaction survey.

Goal 5. The state will assess the extent to which community-based organizations participate in the *MIChild* outreach effort.

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

9.3.1. Ξ The increase in the percentage of Medicaid-eligible children enrolled in Medicaid.

9.3.2. Ξ 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. Ξ The extent to which outcome measures show progress on one or more of the health problems identified by the state.

9.3.5. Ξ HEDIS Measurement Set relevant to children and adolescents younger than 19.

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. Ξ 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. Ξ 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 Community Health 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).

A. The State will submit an evaluation of the effectiveness of the *MIChild* Plan in increasing the number of children with creditable health coverage. One of the plan's strategic objectives is to decrease the number of uninsured children in Michigan. The effectiveness of the plan in meeting this goal will be evaluated by comparing the number of children in families with incomes of 200 percent or less of the Federal Poverty Level who are uninsured and the number of children newly eligible for Medicaid and the *MIChild* program.

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

1. Demographics: The demographic characteristics of the children and families assisted under the State plan will be identified, including age of the children, family income, ethnicity, primary language, and the child's coverage by other health insurance prior to *MIChild* eligibility.

2. 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.

3. Subsidies and Cost-Sharing: The report will identify the amount of assistance provided by the State and the premium paid by the families of the enrollees.

4. Service area: The State offers *MIChild* coverage on a statewide basis. County-specific data is collected by the Administrative Contractor awarded the bid.

5. Time Limits: *MIChild* Plan enrollees are to be enrolled for twelve months of eligibility. The reports will analyze to what extent children received coverage for the full twelve months. If possible, the reason for disenrollment before twelve months will be obtained and evaluated.

6. Benefits Covered and other Methods Used to Provide Health Assistance: The State will evaluate the benefits covered annually and determine additions or deletions based on the State's employee health plan as a benchmark coverage.

7. Sources of Non-Federal Funding: The sources of non-federal funding used in the *MIChild* Plan will be described and detailed in the assessment.

C. An assessment of the effectiveness of other public and private programs in the state in increasing the availability of affordable quality individual and family health insurance for children is not within the scope of the State to be able to perform.

D. The State will review and assess State activities to coordinate the *MIChild* Plan under this title with other public and private programs providing health care and health care financing, including Medicaid and maternal and child health services.

E. The report will analyze changes and trends in the State that affect the provision of accessible, affordable, quality health insurance and health care to children.

F. As part of the reports, the State will assess and make recommendations for improving the program under this title.

9.6. Ξ 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. Ξ 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. Ξ Section 1902(a)(4)(C) (relating to conflict of interest standards)

9.8.2. Ξ Paragraphs (2), (16) and (17) of Section 1903(i) (relating to limitations on payment)

9.8.3. Ξ Section 1903(w) (relating to limitations on provider donations and taxes)

9.8.4. Ξ 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(c)) (42CFR 457.120(a) and (b))**

Ongoing Public Involvement:

- Public and private individuals and entities have the opportunity to offer input on the implementation of *MIChild* on an ongoing basis through the Department of Community Health's Health Plans Advisory Committee. In addition, the Department maintains an extensive list of individuals and entities that will receive the agendas and minutes of the Advisory Committee. The Advisory Committee meets monthly and subscribers receive agendas and minutes as meetings are scheduled and held.
- The Department requests comments from the general public as a routine part of the policy bulletin promulgation process. After the internal comment period, copies of all proposed policy bulletins are distributed to a statewide mailing list of interested parties, including advocates, local health agencies, and tribal centers. All returned comments are given consideration in the development of the final policy language.

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(c)) (42CFR 457.120(c))**

State Response: See Section 9.9

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: See Section 9.9

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. These changes made to the state plan are budget neutral.

Payments to Benefit Contractors. Premiums for health, vision, and dental coverage are estimated to be $90 per month. Enrollment in FY 01 reached 30,053 children by the end of the fiscal year. Average monthly enrollment for FY 01 was 27,178 children. For FY 2003 and beyond, the state hopes to achieve enrollment of 90 percent of the total number of eligible children. Average monthly enrollment in *MIChild* is estimated to be 34,000 children for FY 2003 and beyond.

Mental Health and Substance Abuse Services. Mental health and substance abuse services will be arranged through local Community Mental Health Service Programs (CMHSPs) and local Substance Abuse Coordinating Agencies (CAs). These entities are especially suited to serve this population because of their expertise and experience working with low-income populations. Funding for these services will be provided through state allocations to these local entities for the *MIChild* population.

Administrative Oversight. The Department of Community Health (DCH) will use the competitive bid process to contract with a private company to provide administrative services and eligibility recommendations for the *MIChild* program. An estimate of the cost of this contract has been included in the budget, but has not been explicitly broken out to prevent potential contractors from using it as a target for their bid. Michigan will minimize state administrative costs through the use of community agencies and the Administrative Contractor. DCH staff will provide appropriate contract monitoring and necessary oversight to ensure accountability for the program.

Payments for Outreach. The State will conduct a demographically-targeted advertising campaign to announce the *MIChild* program and to increase public awareness of the opportunity for enrollment in the program. Additional funds will be used to conduct training seminars for advocacy and other community-based agencies involved in the outreach effort. The budget for these functions is estimated at $250,000 per year. Local agencies in each community will be provided outreach grants to fund the development of an outreach plan for the community and providing an assessment of the community's success in enrolling children in *MIChild*.

This reporting period: Federal Fiscal Year 2010. This is a combination budget.

COST OF APPROVED SCHIP PLAN

Benefit Costs	**Reporting Period 2010**	**Next Fiscal Year 2011**	**Following Fiscal Year 2012**
Insurance payments			
Managed Care			
Per member/Per month rate @ # of eligibles	96,369,384	69,281,836	117,587,970
Fee for Service	39,186,550	27,304,000	28,123,120
Total Benefit Costs	135,555,934	96,585,836	145,711,090
(Offsetting beneficiary cost sharing payments)	(2,758,405)	(3,162,841)	(3,257,726)
Net Benefit Costs	**132,797,529**	**93,422,995**	**142,453,364**

Administration Costs			
Personnel			
General Administration	519,842	352,248	362,815
Contractors/Brokers (e.g., enrollment contractors)	3,932,104	4,675,811	4,816,085
Claims Processing			
Outreach/Marketing costs			
Other			
Total Administration Costs	4,451,946	5,028,059	5,028,059
10% Administrative Cap (net benefit costs ÷ 9)	14,755,281	10,380,333	15,828,151

Federal Title XXI Share	101,880,285	73,080,217	109,475,460
State Share	35,369,190	25,370,837	38,005,963

TOTAL COSTS OF APPROVED SCHIP PLAN	137,249,475	98,451,054	147,481,423

Non-Federal source of funding: State Appropriations (General Fund)

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. Ξ 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, and

Below is a chart listing the types of information that the state’s annual report might include. Submission of such information will allow comparisons to be made between states and on a nationwide basis.

Attributes of Population	Number of Children with Creditable Coverage XIX OTHER CHIP	Number of Children without Creditable Coverage	**TOTAL**
Income Level:			
< 100%			
≤ 133%			
≤ 185%			
≤ 200%			
> 200%			
Age			
0 - 1			
1 - 5			
6 - 12			
13 - 18			
Race and Ethnicity			
American Indian or Alaskan Native			
Asian or Pacific Islander			
Black, not of Hispanic origin			

Hispanic			
White, not of Hispanic origin			
<u>Location</u>			
MSA			
Non-MSA			

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

10.3. Ξ 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.

10.3-D X The State agrees to submit yearly the approved dental benefit package and to submit quarterly the required information on dental providers in the state to the Human Resources and Services Administration for posting on the Insure Kids Now! Website.

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: Procurement of Administrative Contractor is effected through Request for Proposal (RFP) bid process. Any HMO or PPO licensed by the state may be a provider.

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

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

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

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

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

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

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:
l) The denial of eligibility
2) Failure to make a timely determination of eligibility
3) Suspension or termination of enrollment, including disenrollment for failure to pay cost sharing.
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 Community Health conduct the formal review of the outside contractor's actions. Neither department representative has been directly involved in the disputed action/decision under review. The Quality Assurance Analyst with the Department of Community Health reviews the action taken by the contractor and determines if the contractor's actions were in compliance with the stated policy. The analyst then presents their findings to the Department of Community Health 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.

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.

Health Services Matters

12.2 Please describe the review process for **health services matters** that complies with 42 CFR . 457.1120.

(a) **State Response:** Health services are delivered through licensed HMO's and PPO's Contractual requirements addressing (among other things) the review process for health services matters is based on **Public Act 1978, No. 368 or Michigan Compiled Laws 333.21001.** Section 7 also addresses this issue. The state is using a standard statewide review to ensure that an enrollee has an opportunity for external review of a-- (1) Delay, denial, reduction, suspension, or termination of health services, in whole or in part, including a determination about the type or level of services; and (2) Failure to approve, furnish, or provide payment for health services in a timely manner.

Premium Assistance Programs

12.3 If providing coverage through a group health plan that does not meet the requirements of 42 CFR . 457.1120, please describe how the state will assure that applicants and enrollees have the option to obtain health benefits coverage other than through the group health plan at initial enrollment and at each re-determination of eligibility.

ADDENDUM 1

All services must be determined to be medically necessary and provided through a managed care environment.

Second Surgical Opinion Consultations are covered when recommended by a physician or desired by the enrolled member or member's representative.

Home Health Care is covered for 120 days per calendar year for home health care provided through a Medicare-certified home health care agency when:

- the member is confined to home,
- the member's physician recommends home health care, and
- the member's physician prepares a treatment plan.

Home health care visits do not reduce the available benefit for hospital days. Covered home health care benefits include the following:

- nursing care by a Registered Nurse (RN) or a Licensed Practical Nurse (LPN) if the

services of an RN are not available,

- home health aide services, such as meal preparation, bathing and feeding (with a 4 hour visit being defined as a "day"),
- nutritional guidance and social services,
- medical and surgical supplies, such as catheters, colostomy supplies and hypodermic needles,
- oxygen, laboratory services and drugs,
- physical, speech, and occupational therapy.

Hospice Care is covered when all of the following conditions are met:

- a physician certifies that the patient is terminally ill (that is, the person has been diagnosed as having six months or less to live);
- the patient chooses to receive care from a hospice instead of standard benefits for the terminal illness; and
- care is provided by either a Medicare or BCBSM-certified hospice program for both Medicare and non-Medicare enrollees.

The Plan will cover up to 210 days--two periods of 90 days each, and one period of 30 days--during the patient's lifetime. Covered hospice care benefits include the following:

- nursing care by or under the supervision of a Registered Professional Nurse (RN);
- home health aide and homemaker services;
- short-term inpatient care;
- medical supplies and drugs;
- physical, speech and occupational therapy;
- medical social services (including needs assessment, psychological and dietary counseling); and
- bereavement counseling for the family for up to 30 days following the patient's death.

Inpatient Hospital admissions are covered up to 365 days per benefit year including the following services and supplies:

- semi-private rooms and intensive care units,
- meals and special diets,
- general nursing services,
- use of operating, delivery and other treatment rooms,
- birthing center services,
- anesthesia when administered by an employee of the hospital,
- laboratory and pathology examinations,
- chemotherapy for the treatment of malignant and non-malignant disease,
- oxygen and other gas therapy,
- drugs, biologicals and solutions,
- diagnostic and therapeutic x-rays, EKGs, cobalt, isotopes, radiation therapy, CAT and MRI

scans,
- routine nursery care of the newborn when the mother is eligible for maternity care,
- dental and related anesthesia expenses in a hospital when a concurrent hazardous health condition exists, and
- hospital-billed ambulance service.

Mental Health Services are covered when arranged through a Community Mental Health Service Program. Services may include:

- inpatient care up to 365 days per benefit year,
- outpatient treatment,
- alternative treatment as deemed medically appropriate by the CMHSP, including client services management,
- prescription drugs related to mental health,
- laboratory/diagnostic tests related to mental health.

Substance Abuse Services are covered when medically necessary, as determined by a Substance Abuse Coordinating Agency.

Emergency treatment is covered without prior authorization if medically necessary, as defined in state statute.

Outpatient Hospital is covered for the following services**:**

- emergency room services for accidental injuries treated within 48 hours of the injury,
- emergency room services for an illness or disease if the condition is life-threatening (emergency room services are covered for emergencies only),
- surgery,
- hemodialysis,
- chemotherapy,
- diagnostic laboratory, x-ray and EKG services,
- preadmission testing within 72 hours of inpatient admission,
- termination of pregnancy when determined medically necessary to save the life of the mother, and
- special hospital programs including home hemophilia and home hemodialysis.

Pediatric Well-Child Care is covered for the following services**:**

- Physician office visits for well-baby care from a child's birth to age 24 months;
- Physician office visits for physical examinations for a child 24 months to age 19 years (maximum one exam every 12 months);
- Immunizations from a child's birth to age 19.

Skilled Nursing Facility benefits are covered up to 120 days per admission for skilled care in a skilled nursing or extended care facility while convalescing from general conditions and pulmonary TB including:

- semi-private room,
- meals and special diets,
- nursing services,
- use of special treatment rooms,
- x-ray and laboratory examinations,
- physical, speech and occupational therapy,
- oxygen and other gas therapy,
- drugs, biologicals and solutions, and
- materials used in dressings and casts.

After benefit days have been exhausted, they are renewed when there has been a lapse of at least 90 days from discharge date until the next admission date.

Physician and other professional provider services and medical/surgical supplies and services including the following:

- physicians charges for office and clinic visits and office consultations for the diagnosis or treatment of an injury, illness or disease,
- surgery,
- blood,
- blood storage when the member donates in preparation for scheduled surgery,
- cataract surgery and first lens implant(s),
- technical surgical assistance when an intern, resident or house officer is not available or qualified,
- inpatient medical care,
- anesthesia and oxygen,
- treatment of accidental injuries if treated within 48 hours of injury,
- emergency medical treatment of an illness if the patient is admitted directly from the emergency room or within 72 hours of illness,
- family planning services as defined within the *MIChild* benefit,
- termination of pregnancy when determined medically necessary to save the life of the mother,
- inpatient consultations including outpatient consultations,
- diagnostic and therapeutic EKG, x-ray, radium, isotope and radiation therapy,
- diagnostic laboratory and x-ray examinations including CAT and MRI scans,
- allergy testing,
- dermatology,
- hemodialysis,
- chemotherapy,
- chiropractor x-rays,
- certain dental work or oral surgery

- private duty skilled care nursing charges, except such care if provided by a person who ordinarily resides in your home or who is a member of your family or the family of your spouse,
- allergy extract and extract injection,
- papanicolaou (PAP) test once every 12 consecutive months,
- physical, occupational and speech therapy,
- prenatal and post natal care visits,
- contraceptive devices (one per year) requiring a prescription or physician insertion/removal,
- first contact lens(e.g.) obtained within one year of cataract surgery,
- chelation therapy for certain diagnosis, and
- eye and ear examinations for the diagnosis of an illness or injury.

Chiropractic Care benefits are as follows:

- manipulations,
- an initial office examination,
- x-rays relating to back and spine,
- first aid treatment of musculoskeletal injury are when performed by a physician, including a chiropractor acting within the scope of licensure.

Acupuncture therapy treatments are covered up to a maximum of 20 in a calendar year when performed by (not just under the direction of) a physician (M.D. or D.O.) for the treatment of any one of the following illnesses:

- Sciatica
- Neuritis
- Post Herpetic Neuralgia
- Tic Douloureaux
- Chronic Headaches, e.g., migraine
- Osteoarthritis
- Rheumatoid Arthritis
- Myofascial complaints, e.g., neck and lower back pain

Outpatient Psychiatric Care and Outpatient Substance Abuse Treatment Services are covered for the outpatient diagnosis, evaluation or treatment of mental and nervous conditions including such conditions as or relating to alcoholism or drug abuse when arranged through a CMHSP or a Substance Abuse Coordinating Agency as appropriate for the diagnosis being treated. For this outpatient mental/nervous benefit, services are provided by:

- a psychiatrist (M.D.);
- a psychologist (fully licensed);
- a limited licensed psychologist or a social worker at the masters degree level (M.S.W. or C.S.W.) or higher, if acting in accordance with a treatment plan reviewed at least every 6 months by a

psychiatrist or fully licensed psychologist and/or if providing services under the direction of a psychiatrist or fully licensed psychologist; or
- an alternate provider as deemed appropriate by the CMHSP.

Therapeutic Services are covered at home of member or outside of home if necessary equipment cannot be brought into the home.

- Physical Therapy
- Speech Therapy
- Occupational Therapy

Durable Medical Equipment is covered on a rental or purchase basis when:

- it is reasonably and medically necessary for the treatment of illness, injury or disease,
- prescribed by a physician and used in the course of medical treatment, and
- purchased from a professional supplier.

Repair of Purchased Durable Medical Equipment is covered due to normal wear and tear.

Replacement of Purchased Durable Medical Equipment is covered due to the following:

- the loss or irreparable damage of your equipment; or
- a change in your condition or size.

Prosthetic and Orthotic Appliances are covered when prescribed by a physician (within the scope of his or her license) as medically necessary. Prosthetics are defined as artificial and/or mechanical appliances (such as arms, legs, eyes, etc.) which replace all or part of the functions of a permanently inoperative or real functioning body organ. Orthotics are defined as appliances which support or straighten a deformed body part. Coverage includes:

- prosthetic and orthotic appliances which are pre-fabricated or custom-fitted,
- the repair, fitting and/or adjustment of a covered prosthetic or orthotic appliance,
- the replacement of appliances when they are damaged beyond repair or worn out, or because of a change in the child's condition or size.

Organ and Tissue Transplants are covered including hospital and professional medical services required to receive a non-experimental transplant of a human organ or body tissue. Transplants of artificial organs are not covered. Coverage includes hospital, surgical and laboratory and x-ray expenses incurred by the person donating an organ or tissue to an enrolled member.

Orthopedic Shoe Inserts are covered when prescribed by a physician.

Hearing Care is covered for the following services and supplies payable once in every 36 consecutive months:

- Audiometric examination to measure hearing ability, including tests for air conduction, bone conduction, speech reception and speech discrimination,
- Hearing aid evaluation tests to determine what type of hearing aid(s) should be prescribed to compensate for loss of hearing,
- Hearing Aids including in-the-ear, behind-the-ear, and on-the-body designs, and Binaural Aids purchased together,
- Dispensing fees for the normal services required in the fitting of a hearing aid,
- Hearing aid conformity tests to evaluate the performance of a hearing aid and its conformity to the original prescription after the aid has been fitted.

Hearing care benefits are not payable for hearing aid repairs or for the replacement of parts (including batteries and ear molds). Benefits are also not payable for the replacement of lost or broken hearing aids unless the 36 month coverage limitation does not apply.

Vision Care is covered for the following services:

- annual vision exam
- annual glaucoma testing
- eye glasses once every 24 months or once every 12 months with a prescription change

Pharmacy is covered for each prescription drug or refill purchased up to a 34-day supply. Certain medications can be covered in a 100 unit dosage or 34-day supply (whichever is greater) or a 200 unit dosage or 34-day supply (whichever is greater).

Prescription are to be filled with a generic medication unless prescribing physician has indicated "dispense as written" ("DAW') on the prescription.

Benefits cover the following:

- a drug, biological or compounded medication which, by federal law, may be dispensed only by prescription and which is required to be labeled "Caution: Federal Law Prohibits Dispensing without a Prescription",
- injectable insulin,
- hypodermic syringes or needles prescribed by an attending physician, and
- birth control prescriptions.

The following are not covered benefits:

- any drug entirely consumed at the time and place it is prescribed,
- the administration or injection of any drug,
- any refill of a drug if it is more than the number of refills specified by the prescription,
- any refill of a drug dispensed more than one year after the latest prescription for that drug,
- any drug which is provided while the member is an inpatient in a facility,

- any drug provided on an outpatient basis in any facility if benefits are paid under any other part of the plan, and
- over-the-counter drugs available without a prescription.

Weight Loss Clinic attendance is covered for morbid obesity when prescribed by a physician.

Ambulance Services are covered as follows**:**

- Hospital-billed ambulance service for a trip to or from the hospital, a skilled nursing facility or member's home, or

- Professional ambulance service when used to transport the member from the place where injured to the first hospital where treatment is given.

Dental Benefits include at a minimum, preventive, diagnostic and basic restorative services.

Maximum Annual Benefit	*$1500 calculated on a fee schedule basis. When medically necessary and prior approved, additional services are covered on a case by case basis.*
Clinical exams	*recommended by age 1; required by age 3 and every 6 months thereafter*
X-rays	*covered*
Fillings	*covered*
Fluoride Treatments	*2x year, up to age 19*
Prophylaxes	*3x year*
Sealants	*1st permanent molar, up to age 9* *2nd permanent molar, up to age 14* *1 per 3 years per tooth*
Extractions	*simple and surgical*
Oral Surgery – including maxillofacial surgery	*covered, including pre- and post- operative care the excision of teeth partly or completely impacted in the bone of the jaw, the excision of teeth that will not erupt through the gum, the excision of other teeth that cannot be removed without cutting into bone, the excision of a tooth root without extracting the entire tooth, but not including root canal therapy, the treatment of a jaw fracture, dislocation or wound, the treatment of cysts, tumors or other disease tissues, apicoectomy, other incision or excision procedures on the gums and tissues of the mouth when not performed in connection with tooth repair or extraction,* *the alteration of the jaw, jaw joints or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement.*
Endodontics	*covered*
Periapical Services	*covered*
Periodontics	*covered*
Crowns	*1 per tooth per 5 years*
Veneers	*Covered for medical necessity:* *- severe tetracycline staining*

	- severe fluorosis
	- hereditary opalescent dentin
	- ameleo-genesis imperfecta
Prosthodontics	*covered*
Relines/Repairs	*covered*
Orthodontics	*when medically necessary with prior approval**
Emergency dental services	*covered*

*Requests for prior approval must be initiated by the dentists. The dentist submits photos and x-rays along with a narrative of required services to the professional services section. The request for special consideration is reviewed by professional staff and a determination is sent back to the requesting provider.

Draft Preprint- Addition of SCHIP Coverage for Prenatal Care and Associated Health Care Services to the State Child Health Plan

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

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

4.1.2.1 Age: from conception through birth

4.1.3.1 Income: 0 % of the FPL (and not eligible for Medicaid) through 185 % of the FPL

Effective Date: December 1, 2002 (date costs begin to be incurred) Implementation Date: December 1, 2002 (dates services begin to be provided)

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

9.10. Please provide a l-year projected budget for all targeted low-income children covered under the state plan using the attached financial form. Additionally, please provide the following:

- Total l- year cost of adding prenatal coverage: $6,000,000
- Estimate of unborn children covered in year 1: 5,163

ATTACHMENT 2

Medical service coverage for unborn children is limited to the following prenatal and pregnancy-related services. All pregnancy-related services must be determined to be medically necessary. Services will be provided on a fee-for-service basis.

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.