MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Bulletin: MSA 09-46

Distribution: All Providers

Issued: August 18, 2009

Subject: Community Health Automated Medicaid Processing System (CHAMPS) Implementation Update

Effective: As Indicated

Programs Affected: Medicaid, Adult Benefits Waiver (ABW), Children's Special Health Care Services (CSHCS), Children's Serious Emotional Disturbance Waiver (SED), Maternity Outpatient Medical Services (MOMS), Plan First!, and other Health Care Programs Administered by Michigan Department of Community Health (MDCH)

The purpose of this bulletin is to provide additional details related to the next implementation phase of the Community Health Automated Medicaid Processing System (CHAMPS). Both Fee-for-Service (FFS) providers and Managed Care Organizations (e.g. Medicaid Health Plans, Program of All-Inclusive Care for the Elderly [PACE], etc.) will be affected by these changes. As stated in MSA Bulletin 09-30, the Eligibility and Enrollment, Prior Authorization, Claims and Encounters, and Contracts Management Subsystems will be launched effective September 18, 2009. This bulletin provides clarification for the following:

1. Provider Training and Claim Testing Opportunities
2. Provider Enrollment Subsystem
3. Eligibility and Enrollment Subsystem
4. Prior Authorization Subsystem
5. Claims and Encounters Subsystem
6. Contracts Management Subsystem

1. PROVIDER TRAINING AND CLAIM TESTING OPPORTUNITIES

CHAMPS Webinars and Quick Reference Guides

MDCH is in the process of developing web-based training sessions (Webinars) and Quick Reference Guides that outline how to utilize the CHAMPS system for FFS providers. These training materials will include information on the following topics:

- Domain Administrator/Security Access
- My Inbox
- Prior Authorization
- Eligibility
- Claim Direct Data Entry
- Claim Status
- Claim Void
- Claim Adjust (Replacement)
- Viewing Remittance Advice

The FFS Webinars and the Quick Reference Guides will be located on the CHAMPS website at www.michigan.gov/mdch >> CHAMPS, beginning mid-September 2009. MCOs should refer to the information shared within this bulletin for further clarification.

In addition to the Webinars and Quick Reference Guides, MDCH Provider Outreach will also be offering Instructor Led Training (ILT) sessions at various locations throughout the State. These sessions will be posted early September at the following MDCH website: www.michigan.gov/mdch >> CHAMPS.

Business-To-Business Testing (B2B) Requirements for Billing Agents

MDCH continues to conduct a phased-in approach to CHAMPS testing with billing agents prior to implementation. A sample set of MDCH-registered billing agents have successfully validated their technical interfaces and basic file structure components. In addition, B2B has been extended to a larger segment of billing agents to test the complete set of possible transaction types.

The final stage of B2B testing will be available soon for additional billing agents to utilize in validating their systems' ability to access and interchange transactions within CHAMPS. In most cases, the files will duplicate the processes and structures that are currently in place with MDCH.

For MCO providers, B2B testing will continue through early September 2009. During August and September of 2009, the schedule for distribution of the test Health Insurance Portability and Accountability Act of 1996 (HIPAA) 834 files and test HIPAA 820 files should closely follow the current schedule. MDCH will send the last 834 test file at the end of August/beginning of September for the September enrollment depending on the legacy schedule for the HIPAA 834 enrollment file. MDCH will not operate parallel systems once CHAMPS is implemented. After September 18, 2009, CHAMPS will create all of the HIPAA 834 and HIPAA 820 files sent to MCOs.

2. PROVIDER ENROLLMENT (PE) SUBSYSTEM

Clarification of Provider Domains and Provider Profiles

FFS providers must log onto https://sso.state.mi.us to register for their Single Sign-On (SSO) user identification (ID) and password to access CHAMPS. All users within a provider's organization who will need access to information within CHAMPS (PE, CE, PA, etc.) must obtain a SSO user ID and password. The SSO user who submits the Provider Enrollment application (which subsequently becomes approved) will become the Provider Domain Administrator for that application. The Provider Domain Administrator will have responsibility of assigning rights for all other users within the organization to access the provider's file. If necessary, multiple Provider Domain Administrators may be established for a single organization but a separate application must be completed and approved for each administrator.

MCO providers must also log onto https://sso.state.mi.us to register for their SSO user ID and password to access CHAMPS. All users within an MCO provider's organization who will need access to information within CHAMPS, must obtain a SSO user ID and password. MDCH has completed the enrollment process of all MCO providers and will serve temporarily as the Provider Domain Administrator. As the current Provider Domain Administrator, MDCH will begin passing the Provider Domain Administrator profile to a single user in each MCO. All MCO providers must submit the SSO user ID of the Provider Domain Administrator to MDCH before September 1, 2009. The SSO information must be submitted via e-mail to wolfs@michigan.gov.

There are several profiles for both FFS and MCO providers that may be assigned to each user within CHAMPS. Profiles must be established to grant access to the subsystems within CHAMPS. Users may have multiple profiles if necessary.

The following is a list of the profiles and definitions that will be available for providers to access CHAMPS beginning September 18, 2009:

- Domain Administrator - The individual who assigns or removes domain and profile access for other CHAMPS users.
- CHAMPS Full Access - Full FFS access to Provider Enrollment, Prior Authorization, Eligibility, and Claims Subsystems.
- CHAMPS Limited Access - View only access to Provider Enrollment and full FFS access to Prior Authorization, Eligibility and Enrollment, and Claims Subsystems.
- Prior Authorization Access - FFS access to Prior Authorization only.
- MCO Provider Access - View Only Access to MCO Provider Enrollment.
- Eligibility Inquiry - FFS access to Eligibility only.
- Provider Enrollment Access - FFS full access to Provider Enrollment only.
- Provider Enrollment View Access - View only access to Provider Enrollment.
- Billing Agent Access - Access to Billing Agent Provider Enrollment only.
- Claims Access - Full FFS access to Claims only.

Table 1 listed below includes the available profiles for each type of provider accessing the system.

Table 1 – CHAMPS Provider Profiles

Provider Profiles Available for Providers:	Domain Administrator	CHAMPS Full Access	CHAMPS Limited Access	Prior Authorization Access	MCO Provider Access	Eligibility Inquiry	Provider Enrollment Access	Provider Enrollment View Access	Billing Agent Access	Claims Access
FFS Provider	X	X	X	X		X	X	X		X
MCO Provider	X		X			X		X	X	X
Billing Agent	X						X	X	X	X
Pharmacy	X					X				

Temporary Suspension of PE Subsystem

As part of the CHAMPS implementation plan, MDCH will not allow any system changes or updates beginning August 28, 2009 through September 17, 2009. This includes any FFS provider new enrollments or modifications to existing applications including any Domain Administrator functions.

FFS providers should hold any new applications or enrollment changes during the temporary suspension period until September 18, 2009, and then complete the transaction using the CHAMPS PE Subsystem. Applications held during this timeframe will be automatically assigned an effective date of August 28, 2009, unless otherwise requested. Questions or concerns regarding the CHAMPS PE Subsystem should be directed to the CHAMPS Helpline at 1-888-643-2408 or CHAMPS@michigan.gov.

For MCO providers, it is the billing agent's enrollment in the system that allows the MCO provider to access the Data Exchange Gateway (DEG). In CHAMPS, the MCO providers must maintain the billing agent enrollment within the PE Subsystem. MCO providers will be unable to make changes to the billing agent enrollment information during the temporary suspension of the PE Subsystem.

3. ELIGIBILITY AND ENROLLMENT (EE) SUBSYSTEM

Benefit Plan Information

The eligibility response through the CHAMPS provider portal or the HIPAA 270/271 transaction format will contain benefit plan data for the date of service that is assigned by the EE Subsystem. The benefit plan data is based on the source of data (e.g., Medicaid, CSHCS, MOMS, etc.) and program assignment factors (e.g., scope/coverage codes, Level of Care [LOC] codes, etc.). Providers will need to utilize the Benefit Plan ID(s) indicated in the response to determine a beneficiary's program coverage and related covered services for a specific date of service. A complete listing of Benefit Plan IDs, names, and descriptions are attached to this bulletin.

The MCO eligibility verification responses will also contain the benefit plan information as stated above. MCOs will have the Limited View Access profile through CHAMPS to access the EE Subsystem provider portal or may continue to use the current methods of eligibility verification available through the Michigan Health Plan Benefits' website and/or HIPAA 270/271 through the Michigan Public Health Institute (MPHI).

Clarification of the HIPAA 270/271 Eligibility Transaction

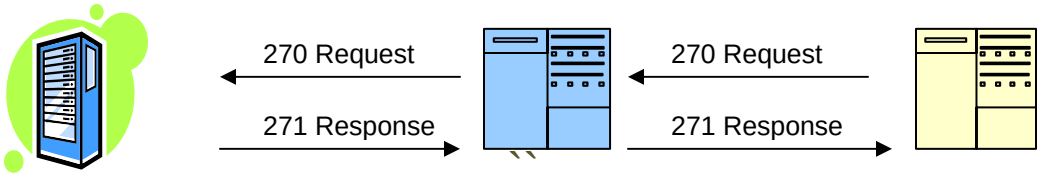
The HIPAA 270/271 transaction for batch requests will not be available directly from the EE Subsystem when it is released on September 18, 2009. The following alternatives will be available for providers and/or their clearinghouse vendors through MPHI:

- **HIPAA 270/271 (Real-time) Transaction**: This transaction allows users to submit individual eligibility requests at any time using a single date of service (DOS) or DOS span. This option provides an immediate real-time response to each eligibility request.

- **HIPAA 270/271 (Batch) Transaction**: This transaction allows users to submit a batch file at any time using a single DOS or DOS span and receive a response file within 24 hours. Typically, responses should be returned within an hour. Factors such as file size and number of files being processed can slow response time.

Providers and/or their clearinghouse vendors will need to complete MPHI's HIPAA 270/271 enrollment form to be able to submit/receive the above HIPAA 270/271 transactions. MPHI's HIPAA 270/271 enrollment form and companion guide including testing information is available on the following website http://mihealth.org.

Graph 1: Eligibility Transaction Process



The eligibility data in the HIPAA 271 response will be provided from the EE Subsystem and includes the following information:

- Benefit Plan ID and additional provider information returned in the 2120C loop, if applicable.
- Beneficiary address data.
- Medicaid Health Plan (MHP) Primary Care Physician (PCP), including the PCP name, telephone number, and National Provider Identifier (NPI). (Note: Data provided only if the date of service is the current date.)
- Third Party Liability (TPL), including the payer name, payer ID, coverage type code, group number, and policy number.
- CSHCS restriction data, including qualifying diagnosis code(s) and authorized provider data if the provider submitting the inquiry is authorized for the date of service.

- Other information, including current county of residence, DHS case number, DHS county office, and DHS local office home number.
- Pending eligibility data (Medicaid-related programs only).

Note: Clearinghouse vendors will need to enroll as a billing agent in CHAMPS and also be associated to their providers to be able to submit HIPAA 270/271 transactions on their behalf. Additional information is provided on the MDCH website at www.michigan.gov/medicaidproviders >> CHAMPS >> Billing Agent.

4. PRIOR AUTHORIZATION (PA) SUBSYSTEM

Effective September 18, 2009, the PA Subsystem will allow FFS providers to submit single PA requests through the online web portal in addition to the existing HIPAA 278 batch transaction format and paper PA process. PA Inquiry is also a new feature available through CHAMPS that will allow providers to check on the status of submitted PA requests or query on completed PAs on file. Up to seven years of PA history from the legacy system will be converted and accessible to providers in CHAMPS.

MCO providers will not have access to the CHAMPS PA Subsystem.

Clarification of PA Direct Data Entry (DDE) Requests

The PA Subsystem will allow providers to submit PA requests directly online through DDE by accessing the "PA Request List" web portal. Questions regarding PAs submitted prior to CHAMPS or PA requests with no tracking number (denied, returned, no action, etc.) should be directed to the MDCH Program Review Division. The approved PAs in legacy with a PA number will be viewable through the CHAMPS PA Inquiry screens.

Private Duty Nursing providers with an authorization on file for a beneficiary in the Children's Waiver Program or Habilitation Supports Waiver should contact the Community Mental Health Services Program (CMHSP) for assistance.

Submitting Documentation for DDE PA Requests

The documentation web portal within the DDE PA request screen will allow supporting documentation to be linked to a PA request either through facsimile or electronically.

For electronically submitted documentation, the DDE screen will open Internet Explorer on the user's computer and allow the retrieval of the appropriate record to link to the PA request. The system will limit each PA request to 10 document attachments and each attachment is limited to a maximum size of 100MB.

For documents submitted through facsimile, the CHAMPS system will generate a cover sheet pre-populated with the beneficiary ID number and the tracking number of the request. The fax cover sheet will contain the applicable fax number and must precede the documents being uploaded into CHAMPS. There is no system limit for the maximum number of pages for faxed documents.

Additional information regarding the online documentation process for DDE PA will be available within the upcoming PA Webinar.

5. CLAIMS AND ENCOUNTERS (CE) SUBSYSTEM

Effective September 18, 2009, the CE Subsystem will allow FFS claims submission, inquiry, and adjustments/voids through the CHAMPS online system. **FFS claims submitted on and after September 18, 2009, will be processed for payment starting on October 1, 2009.**

The ability for MCOs to submit encounter claims into CHAMPS will be delayed until the next phase release. The implementation date of this next release has not been finalized. Until then, MCO providers must continue to submit encounters through the current legacy system. MDCH will provide a minimum of a 60 day notice prior to this transition.

CHAMPS Place of Service Editing for HIPAA 837 Dental/DDE and American Dental Association (ADA)

Effective September 18, 2009, the CHAMPS system will edit all dental claims (HIPAA 837 Dental, DDE, or ADA 2006 paper claim forms) for the correct place of service (POS) code.

Within both the 837 Dental and DDE claim formats, the correct two-digit POS code must be reported. For the ADA paper claim form, Field 38 (Place of Treatment) must be completed with an "X" and it will be crosswalked into CHAMPS with the applicable two-digit POS code.

If the correct POS code is not reported, Claim Adjustment Reason Code (CARC) - 58 and Remittance Advice Remark Code (RARC) - M77 will reject the claim in CHAMPS.

CHAMPS NPI Editing for Billing Provider and Rendering/Servicing Only Provider

Effective September 18, 2009, the CHAMPS system will edit both the Billing Provider and/or Rendering/Servicing Provider NPIs for all professional and dental claims submitted electronically or via a paper claim form (HIPAA 837, DDE, or CMS 1500/ADA 2006). If the NPI of the rendering/servicing only provider is reported in the billing provider loop/field, the claim will reject in CHAMPS with CARC - 133 and RARC - N198.

Within the professional claim format, providers enrolled as rendering/servicing only must report the group NPI of the billing provider (Type 2 NPI) in Loop 2010AA, Segment NM108, Qualifier 85 for electronic claims or Field 33a on the CMS 1500 paper claim form. The rendering/servicing provider NPI (Type 1 NPI) must be reported in Loop 2310B, Segment NM108, Qualifier 82 for electronic claims or Field 24J on the CMS 1500 paper claim form.

Within the dental claim format, providers enrolled as rendering/servicing only must report the group NPI of the billing provider (Type 2 NPI) in Loop 2010AA for electronic claims or Field 49 on the ADA 2006 paper claim form. The rendering/servicing provider NPI (Type 1 NPI) must be reported in Loop 2310B for electronic claims or Field 54 on the ADA 2006 paper claim form.

Note: If an individual provider's enrollment with MDCH is limited to his/her association with a group practice, facility, etc. (e.g., payment for the individual's services is made to the entity and not the individual), the individual should be revalidated within the CHAMPS PE Subsystem as a rendering/servicing only provider.

Migration of Legacy Suspended Claims into CHAMPS

All existing suspended claims within the current legacy system must be migrated into CHAMPS. To accomplish this, a phased approach will be used to reject these claims in the legacy system and later resurrect them in CHAMPS. Providers will be able to track all claims that will be migrated in this manner by accessing their current Remittance Advice.

Any remaining suspended claims in the legacy system beginning August 26, 2009 (Pay Cycle 34) and extending through September 9, 2009 (Pay Cycle 36), will be rejected with:

- Proprietary edit 743 (Claim manually rejected due to technical reasons.)
- CARC 101 and RARC N185

Do not resubmit these claims as they will be migrated into CHAMPS. **Any claims submitted into the legacy system on or after August 20, 2009, if they suspend, will be automatically rejected with edit 743 and transferred into CHAMPS.** (Note: This date supersedes the date referenced in MSA Numbered Letter L 09-19.)

Three years of claim history will be available for users to review at CHAMPS Go-Live. After October 1, 2009, MDCH will begin the process to resurrect all claims that rejected earlier with proprietary edit 743 for adjudication in CHAMPS. One of the following possible dispositions will occur:

- The claim will suspend with the normal resolution process,
- The claim will reject due to technical or business reasons, or
- The claim will be paid.

All of the above dispositions will be reported with applicable CARCs or RARCs to providers through the Remittance Advice in CHAMPS.

Claims will not be recreated in CHAMPS if:

- The claim was submitted without a reported billing NPI,
- The rendering/servicing only NPI was incorrectly reported in the billing NPI loop/field, or
- The provider has not revalidated in the CHAMPS PE Subsystem.

These claims will need to be corrected and resubmitted by the provider to successfully adjudicate in CHAMPS.

Paper claims (CMS 1500) with Other Insurance/Medicare that have been rejected with proprietary edit 743 should be resubmitted via the electronic HIPAA 837 or through the CHAMPS DDE screens. These claims will not be automatically recreated in CHAMPS.

Pay Cycle 38 – Temporary Suspension of Payment

Due to the final transition from the legacy system into CHAMPS, there will be no payments generated on pay cycle 38 (pay date 9/23/09). Pay cycle 39 (pay date 9/30/09) will include payments for both pay cycles.

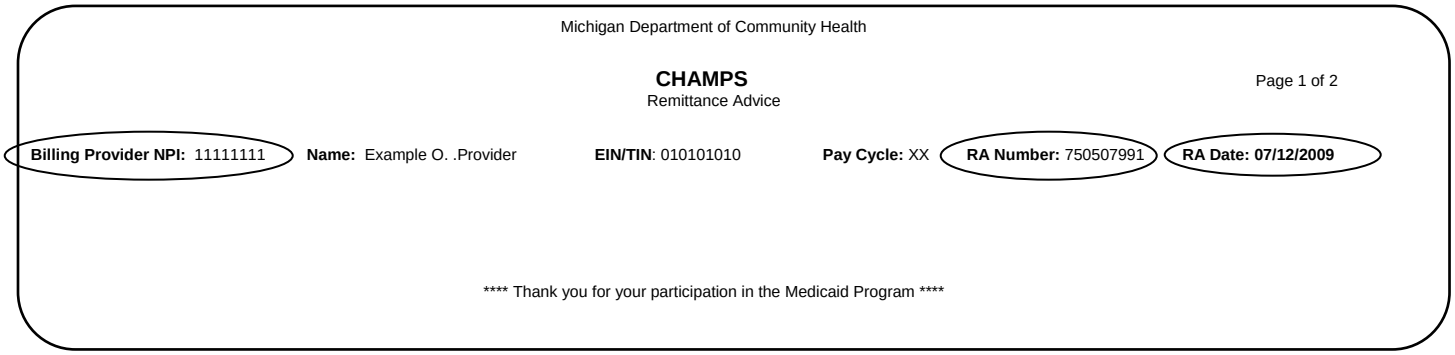
Hospital Medicaid Interim Payment (MIP) Program payments and Quality Assurance Supplement (QAS) payments for Long Term Care Facilities that were originally scheduled for pay cycle 38 will be processed on pay cycle 37 (pay date 9/16/09) a week early.

CHAMPS Remittance Advice (RA)

An RA will be generated for all providers and/or billing agents who submitted and processed claims through CHAMPS on and after the first payment date of October 1, 2009. The new CHAMPS RA will be available to providers online or will be sent to providers via paper only if requested through the PE Subsystem. The unsolicited submission of the paper RA to all providers will end with the implementation of the CE Subsystem and instead will be available online based on the weekly pay cycle.

Suspended claims will no longer be reported on the RA. Instead, providers will be able to access this information through Claim Inquiry within the CE Subsystem or through the HIPAA 276/277 process.

The RA generated for providers through CHAMPS will contain new elements and format. The RA will contain three main sections: cover sheet, summary page, and detail page(s). Below is an example of the revised layout. The new elements have also been identified.



Michigan Department of Community Health

CHAMPS
Remittance Advice

Page 1 of 2

Billing Provider NPI: 11111111 **Name:** Example O. .Provider **EIN/TIN**: 010101010 **Pay Cycle:** XX **RA Number:** 750507991 **RA Date: 07/12/2009**

**** Thank you for your participation in the Medicaid Program ****

Billing Provider NPI: 11111111 **Name:** Example O. .Provider **EIN/TIN**: 010101010 **Pay Cycle:** XX **RA Number:** 750507991 **RA Date: 07/12/2009**

FINANCIAL ADJUSTMENTS

Adjustment Type	Previous Balance	Adjustment Amount	Remaining Balance

CLAIM SUMMARY

Category	County
Paid	5
Suspended	0
Rejected	1
GA	0

Total Approved $78.89 Total Adjusted $0.00 Total Paid $78.89

Warrant/EFT #: 000032295 Warrant/EFT Date: 07/21/2009

*

Billing Provider NPI: 11111111 **Name:** Example O. .Provider **EIN/TIN**: 010101010 **Pay Cycle:** XX **RA Number:** 750507991 **RA Date: 07/12/2009**

Gross Adj ID / Beneficiary Name / ~~Beneficiary ID~~ / Patient Account # / Medical Record #	Original TCN / TCN / Type of Bill	Submitter ID / Rendering Provider NPI	Invoice Date / Service Date(s)	Revenue / Procedure / Modifier	PPS / DRG / APC	Qty	Total Charges	Approved Amount	Category	Reason	Remark
Patient, One 0095124282 0005711862	310918410089841000	12345678 11111111111	03/07/2008-03/07/2008				$80.00	$18.24	Paid		
	310918410089841001		03/07/2008-03/07/2008	99213		1	$80.00	$18.24	Paid	2.45	
Patient, Two 0022332423 0006269322	310918410003215000	12345678 11111111111	12/09/2008-12/09/2008				$1,887.00	$0.00	Denied		
	310918410003215001		12/09/2008-12/09/2008	15340		1	$375.00	$0.00	Denied	133, 23, 31	
	310918410003215002		12/09/2008-12/09/2008	15341		1	$60.00	$0.00	Denied	133, 23, 31	
	310918410003215003		12/09/2008-12/09/2008	J7340		1	$1,452.00	$0.00	Denied	133, 23, 31, B5	
Patient, Three 0039280695 0006166072	310918410089848000	12345678 11111111111	10/13/2008-10/13/2008				$50.00	20.61	Paid		
	310918410089848001		10/13/2008-10/13/2008	11721-59		1	$50.00	20.61	Paid	45, 2	
Patient, Four 0008852450 0005959072	310918410020326000	12345678 11111111111	09/29/2008-09/29/2008				$60.00	$0.00	Paid		
	310918410020326001		09/29/2008-09/29/2008	11721		0	$60.00	$0.00	Paid	22, 1, 45	
Patient, Five 0038936990 0006334707	310918410020326000	12345678 11111111111	02/03/2009-02/03/2009				$87.00	$18.73	Paid	2, 45	
	310918410020326000		02/03/2009-02/03/2009	99213		1	$87.00	$18.73	Paid		
Patient, Six 0026066713 0006160642	310918410089845000	12345678 11111111111	10/14/2008-10/14/2008				$160.00	$21.31	Paid		
	310918410089845001		10/14/2008-10/14/2008	99213-25		1	$80.00	$0.00	Paid	2, 22, 45	
	310918410089845002		10/14/2008-10/14/2008	29580		1	$80.00	$21.31	Paid	45	

6. CONTRACTS MANAGEMENT (CM) SUBSYSTEM

Effective September 18, 2009, the CM Subsystem in CHAMPS will be implemented for managed care contracts and certain general service contracts. The CM Subsystem will generate the enrollment files (HIPAA 834 files) and remittance advice files for capitated payments (HIPAA 820 files) for the MCOs.

The MCO enrollment files (HIPAA 834) will continue to include the scope and coverage codes, not benefit plan information. (Refer to the 834 Companion Guide available on the MDCH website.) The applicable MDCH Contract Manager may be contacted if further clarification of the Companion Guide is needed. A schedule for the availability of the HIPAA 834 and HIPAA 820 files will be posted to the MDCH website prior to CHAMPS Go-Live.

Within the legacy system, some MCO providers currently receive the paper RA to view capitated payments. MDCH will no longer provide paper RAs to MCO providers on or after the CHAMPS Go-Live date. At CHAMPS Go-Live, MCOs will instead have access to the claims inquiry function within the CE Subsystem (through their Limited View Access profile) to query capitated payments.

Public Comment

The public comment portion of the policy promulgation process is being conducted concurrently with the implementation of the change noted in this bulletin. Any interested party wishing to comment on the change may do so by submitting comments in writing to:

Faye Ruhno
Michigan Department of Community Health
Medical Services Administration
P.O. Box 30479
Lansing, Michigan 48909-7979
Or
E-mail: ruhnof@michigan.gov

If responding by e-mail, please include "CHAMPS Implementation" in the subject line.

Manual Maintenance

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

Questions

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

APPROVED

Stephen Fitton, Acting Director
Medical Services Administration

Michigan Department of Community Health

BENEFIT PLANS

Benefit plan data is assigned by the CHAMPS Eligibility and Enrollment (EE) Subsystem based on the source of the data (e.g., Medicaid, CSHCS, etc.) and program assignment factors (e.g., scope/coverage codes, level of care codes, etc.). Providers will now need to utilize the Benefit Plan ID(s) indicated in the eligibility response to determine a beneficiary's program coverage and related covered services for a specific date of service. The following table provides the Benefit Plan ID, Name, Description, and Type (e.g., Fee-for-Service, Managed Care Organization, or No Benefits). Beneficiary eligibility data related to select Benefit Plans will not be included within either the HIPAA 271 response or through the CHAMPS EE Subsystem provider portal. For these Benefit Plans, other eligibility sources may apply (e.g. HIPAA 834 response, etc.).

Benefit Plan ID	Benefit Plan Name	Benefit Plan Description	Type	Included In: HIPAA 271 and EE Subsystem
ABW	Adult Benefits Waiver Program	This benefit plan provides basic medical care to low income childless adults who do not qualify for Medicaid. ABW medical coverages are limited (e.g., ambulatory benefit – no inpatient coverage). The ABW program covers individuals with income less than 35% of the Federal Poverty Level. The Department of Human Services (DHS) determines eligibility.	Fee-for-Service	Yes
ABW-ESO	Adult Benefits Waiver (Emergency Services)	This benefit plan provides benefits similar to ABW benefits but is for Emergency Services Only (ESO). For the purpose of ESO coverage, federal Medicaid regulations define an emergency medical condition as a sudden onset of a physical or mental condition which causes acute symptoms, including severe pain, where the absence of immediate medical attention could reasonably be expected to: • Place the person's health in serious jeopardy, or • Cause serious impairment to bodily functions, or • Cause serious dysfunction of any bodily organ or part.	Fee-for-Service	Yes
ABW-MC	Adult Benefits Waiver Program (Managed Care)	This benefit plan provides benefits similar to ABW benefits but on a capitated basis.	Managed Care Organization	Yes
ALMB	Additional Low Income Medicare Beneficiary	This benefit plan is part of the Medicare Savings Program (MSP), also know as the "Buy-In" Program.	No Benefits	No
BMP	Beneficiary Monitoring Program	The objectives of the Beneficiary Monitoring Program (BMP) are to reduce overuse and misuse of Medicaid services, improve the quality of health care for Medicaid beneficiaries, and reduce costs to the Medicaid program. The BMP providers bill on a FFS basis for services provided, and receive $8 per month for each beneficiary monitored in the Lock-in program.	Managed Care Organization	Yes

BENEFIT PLANS

Benefit Plan ID	Benefit Plan Name	Benefit Plan Description	Type	Included In: HIPAA 271 and EE Subsystem
CMH	Community Mental Health	This is a carve out program that can be assigned to members from multiple eligibility sources, such as ABW or MIChild, etc.	Managed Care Organization	No
CSHCS	Children's Special Health Care Services	This benefit plan is designed to find, diagnose, and treat children under age 21 with chronic illness or disabling conditions. Persons over age 21 with chronic cystic fibrosis or certain blood coagulation blood disorders may also qualify. Covers services related to the client's CSHCS-qualifying diagnoses. Certain providers must be authorized on a client file.	Fee-for-Service	Yes
CSHCS-MH	CSHCS Medical Home	This is a capitated "case management" benefit plan for CSHCS members. CSHCS Medical Home clients are identified by the Medical Home Indicator in the Member's CSHCS eligibility file.	Managed Care Organization	No
CWP	Children's Home and Community Based Services Waiver	This benefit plan provides services that are enhancements or additions to Medicaid state plan services for children under age 18 with developmental disabilities who are enrolled in the Children's Home and Community-Based Services Waiver Program (CWP). The CWP is a statewide Fee-for-Service program administered by Community Mental Health Service Programs (CMHSPs). The CWP enables Medicaid to fund necessary home and community-based services for children with developmental disabilities who have challenging behaviors and/or complex medical needs, meet the criteria for admission to an Intermediate Care Facility for the Mentally Retarded (ICF/MR) and who are at risk for placement without waiver services.	Fee-for-Service	No
HK - Dental	Healthy Kids Dental	This program is a selective contract between the Michigan Department of Community Health and the Delta Dental Plan of Michigan to administer the Medicaid dental benefit in selected counties to beneficiaries under the age of 21.	Managed Care Organization	Yes
HK-EXP	Full Fee-for-Service Healthy Kids - Expansion	This benefit plan covers children ages 16 through 18 from 100% Federal Poverty Level (FPL) up to 150% FPL. Funding for this program is State Children's Health Insurance Program (SCHIP) Fund, and the benefits mirror Fee-for-Service Medicaid.	Fee-for-Service	Yes

BENEFIT PLANS

Benefit Plan ID	Benefit Plan Name	Benefit Plan Description	Type	Included In: HIPAA 271 and EE Subsystem
HK-EXP-ESO	Healthy Kids Expansion - Emergency Services	Benefits mirror Medical Assistance Emergency Services Only (MA ESO). Children who do not meet the Medicaid citizenship requirements to be eligible for full Medicaid may be eligible for Emergency Services Only (ESO). This benefit plan is funded by SCHIP. For the purpose of ESO coverage, federal Medicaid regulations define an emergency medical condition as a sudden onset of a physical or mental condition which causes acute symptoms, including severe pain, where the absence of immediate medical attention could reasonably be expected to: • Place the person's health in serious jeopardy, • Cause serious impairment to bodily functions, or • Cause serious dysfunction of any bodily organ or part.	Fee-for-Service	Yes
Hospice	Hospice	This healthcare program is designed to meet the needs of terminally ill individuals when the individual decides that curative treatment is no longer in their best interest. These individuals choose palliative care, which is not a cure, but ensures comfort, dignity, and quality of life. Hospice is intended to address the needs of the individual with a terminal illness, while also considering family needs. Michigan Medicaid covers hospice care for a terminally ill beneficiary whose life expectancy is six months or less (if the illness runs its normal course), as determined by a licensed physician and the Hospice Medical Director.	Fee-for-Service	Yes
HSW	Habilitation Supports Waiver Program	Beneficiaries with developmental disabilities may be enrolled in this Program to receive the supports and services as defined. HSW beneficiaries may also receive other Medicaid state plan or additional/B3 services.	Managed Care Organization	No
ICF/MR-DD	Intermediate Care Facility for Mental Retarded - DD	The facility primarily provides health-related care and services above the level of custodial care to mentally retarded individuals, but does not provide the level of care or treatment available in a hospital or SNF. This is an all inclusive program.	Fee-for-Service	Yes
INCAR	Incarceration - Other	A non-Medicaid funded benefit plan that restricts services to an off-site inpatient hospital while an otherwise eligible member is incarcerated.	Fee-for-Service	Yes
INCAR-ABW	Incarceration – ABW (No Benefits)	This program will not provide benefits after 3/1/05, while an otherwise ABW eligible member is incarcerated.	No Benefits	Yes
INCAR-ESO	Incarceration – Emergency Services	This benefit plan restricts services to off-site inpatient hospital emergencies only while the member is incarcerated.	Fee-for-Service	Yes

BENEFIT PLANS

Benefit Plan ID	Benefit Plan Name	Benefit Plan Description	Type	Included In: HIPAA 271 and EE Subsystem
INCAR-MA	Incarceration - MA	A Medicaid-funded benefit plan that restricts services to an off-site inpatient hospital while an otherwise eligible member is incarcerated.	Fee-for-Service	Yes
INCAR-MA-E	Incarceration – MA Emergency Services	A Medicaid-funded benefit plan that restricts services to an emergency hospital while an otherwise eligible member is incarcerated.	Fee-for-Service	Yes
MA	Full Fee-for-Service Medicaid	Members are generally assigned to this benefit plan upon approval of their eligibility information and remain active even if eventually assigned to MA Managed Care [MA-MC]. Once assigned to a managed care plan, the health plan is the primary payer.	Fee-for-Service	Yes
MA-ESO	Medical Assistance Emergency Services	Individuals who do not meet the Medicaid citizenship requirements to be eligible for full Medicaid may be eligible for Emergency Services Only (ESO). For the purpose of ESO coverage, federal Medicaid regulations define an emergency medical condition as a sudden onset of a physical or mental condition which causes acute symptoms, including severe pain, where the absence of immediate medical attention could reasonably be expected to: • Place the person's health in serious jeopardy, • Cause serious impairment to bodily functions, or • Cause serious dysfunction of any bodily organ or part.	Fee-for-Service	Yes
MA-MC	Medicaid Managed Care	Full Medicaid for Managed Care Organization enrollment. This capitated plan will be set to a higher priority than MA [Fee-for-Service]. The services not covered under this plan will be covered in MA.	Managed Care Organization	Yes
MI Choice	Home and Community Based Waiver Services	The MI Choice Waiver provides home and community based healthcare services for aged and disabled persons. The program's goal is to allow persons to remain at home to receive health services. These persons require nursing home care but opt to receive services in their home. MI Choice beneficiaries are not enrolled in a Medicaid health plan.	Fee-for-Service	Yes
MIChild	MIChild Program (SCHIP)	This healthcare program is administered by the Michigan Department of Community Health (MDCH). It is for the low income uninsured children of Michigan's working families. Like Healthy Kids, MIChild is for children who are under age 19. The child must be enrolled in a MIChild health and dental plan in order to receive services.	Managed Care Organization	Yes
MIChild-D	MIChild - Dental	This benefit plan is for dental services administered by MDCH. Only members eligible for MIChild can be assigned to this plan.	Managed Care Organization	Yes

BENEFIT PLANS

Benefit Plan ID	Benefit Plan Name	Benefit Plan Description	Type	Included In: HIPAA 271 and EE Subsystem
MOMS	Maternity Outpatient Medical Services	This program provides immediate health coverage for pregnant women. The MOMS program is available to provide immediate prenatal care while a Medicaid application is pending. The woman must use Medicaid benefits if and when they become available. Coverage also includes individuals who are not citizens. Prenatal health care services will be covered by MOMS and/or Medicaid for up to the entire pregnancy and for 60 days after the pregnancy ends.	Fee-for-Service	Yes
NH	Nursing Home	This benefit is for qualifying members residing in a nursing home. A facility or institution must be licensed, certified, or otherwise qualified as a nursing home or long term care facility by the state in which services are rendered. This term includes skilled, intermediate, and custodial care facilities which operate within the terms of licensure.	Fee-for-Service	Yes
PACE	Program All-Inclusive Care for Elderly	This program is an innovative model of community-based care that enables elderly individuals, who are certified by their state as needing nursing facility care, to live as independently as possible. PACE provides an alternative to traditional nursing facility care by offering pre-paid, capitated, comprehensive health care services.	Managed Care Organization	Yes
PIHP	Prepaid Inpatient Health Plan	This benefit plan covers mental health and substance abuse services for MA who have a specialty level of need.	Managed Care Organization	No
Plan First!	Family Planning Waiver	This waiver program allows MDCH to provide family planning services to women who otherwise would not have medical coverage for these services.	Fee-for-Service	Yes
QDWI	Qualified Disabled Working Individual	A client must have applied for or be enrolled in Medicare Part A as a working disabled person who has exhausted Premium-free Part A and whose SSA disability benefits ended because the client's earnings exceed SSA's gainful activity limits. Medicaid pays the client's Medicare Part A premium only.	No Benefits	No
QMB	Qualified Medicare Beneficiary – All Inclusive	This benefit plan is part of the Medicare Savings Program (MSP), also known as the "Buy-In" program. A client must be entitled to Medicare Part A. Under certain income limits, Medicaid pays for Medicare Part B premiums, deductibles and co-payments. This is an all-inclusive benefit plan.	Fee-for-Service	Yes
SA	Substance Abuse	This is a carve out program that can be assigned to members from multiple eligibility sources, such as ABW or MIChild, etc.	Managed Care Organization	No

BENEFIT PLANS

Benefit Plan ID	Benefit Plan Name	Benefit Plan Description	Type	Included In: HIPAA 271 and EE Subsystem
SED	Children's Serious Emotional Disturbance Waiver Program	This benefit plan provides services that are enhancements or additions to Medicaid state plan services for children under age 18 with a serious emotional disturbance who are enrolled in this Program. MDCH operates this Program through contracts with Community Mental Health Service Programs (CMHSPs). The Children's Serious Emotional Waiver (SEDW) is a Fee-for-Service program administered by the CMHSP in partnership with other community agencies. The SEDW is currently available in a limited number of counties and CMHSPs. The SEDW enables Medicaid to fund necessary home and community-based services for children with serious emotional disturbance who meet the criteria for admission to the state inpatient psychiatric hospital (Hawthorn Center) and who are at risk of hospitalization without waiver services.	Fee-for-Service	No
SLMB	Special Low Income Medicare Beneficiary	A client must have applied for or be enrolled in Medicare Part A. Under certain income limits, Medicaid pays the client's Medicare Part B premium only; Expanded Special Low-Income Medicare Beneficiary (ESLMB): A client must have applied for or be enrolled in Medicare Part B and not be eligible for any other Medicaid coverage. Under certain income limits, Medicaid pays the client's Medicare Part B premium only. No specific benefits are defined for this plan.	No Benefits	No
Spend-down	Medical Spend-down	If the family's or individual's net income is over the Medicaid limit, the amount in excess is established as a "spend-down amount." In order for the person to qualify for Medicaid during the months, he/she must incur medical bills equal to the spend-down amount. Medicaid will pay expenses incurred above this amount. If a group member is liable for bills incurred before the spend-down period began, these bills can be used to meet the spend-down.	No Benefits	Yes
SPF	State Psychiatric Hospital	This benefit plan offers inpatient and outpatient services for the observation, diagnosis, active treatment, and overnight care of persons with a mental disease or with a chronic mental condition who require daily direction or supervision of physicians and mental health professionals who are licensed to practice in this state.	Fee-for-Service	No
TMA-PLUS	Full Fee-for-Service Transitional Medical Assistance - Plus	This benefit plan is available to families after Transitional MA (TMA) ends to assist families who are unable to purchase employer-sponsored healthcare. TMA-Plus offers a way to extend medical coverage through a premium-payment plan. Funding for this program is General Fund. Benefits mirror Fee-for-Service Medicaid.	Fee-for-Service	Yes

BENEFIT PLANS

Benefit Plan ID	Benefit Plan Name	Benefit Plan Description	Type	Included In: HIPAA 271 and EE Subsystem
TMA-PLUS-E	Transitional Medical Assistance - Plus - Emergency Services	Benefits mirror MA ESO. Individuals who are not otherwise eligible for full TMA-PLUS because of citizenship status may be eligible for Emergency Services Only (ESO). Funding for this benefit plan is General Fund. For the purpose of ESO coverage, federal Medicaid regulations define an emergency medical condition as a sudden onset of a physical or mental condition which causes acute symptoms, including severe pain, where the absence of immediate medical attention could reasonably be expected to: • Place the person's health in serious jeopardy, • Cause serious impairment to bodily functions, or • Cause serious dysfunction of any bodily organ or part.	Fee-for-Service	Yes