

**Michigan System of Payments Policy for Part C of the Individuals with Disabilities Education Act (IDEA)**

Under federal law for Part C of IDEA, a System of Payments must address core components to detail how services will be paid for in its early intervention system for infants and toddlers. Michigan's System of Payments includes the core components as outlined below.

1. **Core Early Intervention Services** are provided at **no cost** to the family as mandated by federal regulations.

- Screening, identification and referral
- Evaluation
- Assessment
- Development and review of the Individualized Family Service Plan (IFSP)
- Service coordination
- Procedure safeguards and other components under subparts D, E, and F of the IDEA part C regulations in 34 CFR Part 303.
- All special education and related services for eligible children under the Michigan Administrative Rules for Special Education that constitute a free and appropriate public education (FAPE) that may address: 1) Autism; 2) Deaf-blindness; 3) Developmental delay (this category can be used at the discretion of local school systems); 4) Emotional disturbance; 5) Hearing impairment, including deafness; 6) Multiple disabilities; 7) Orthopedic impairments; 8) Other health impairments (including, but not limited to, Tourette Syndrome, HIV, epilepsy or sickle cell anemia); 9) Speech or language impairment; 10) Traumatic brain injury; 11) Visual impairment (including blindness) and any related services such as: 1) Transportation; 2) Speech pathology; 3) Audiology; 4) Psychological services (including psychotherapy); 5) Physical therapy; 6) Occupational therapy; 7) Social work services; 8) Medical services for the purpose of diagnosing and evaluating the child; 9) Assistive technology devices or services; 10) Orientation and mobility services; or 11) Interpreting services.
- Michigan Medicaid School-Based Services available to a child with an Individual Education Program or Individualized Family Service Plan detailed in the state Medicaid Provider Manual and include such services as: Occupational Therapy; Physical therapy; Speech and Language; Orientation and Mobility; Assistive technology services; Psychological/social work; evaluations; Developmental testing; Nursing; Personal care; and Transportation.

2. **Payor of Last Resort:** Michigan *Early On* assures funds available under Part C of the IDEA shall be used in a manner consistent with 34 CFR §303.527 and will assist families to access all available federal, state, and local resources that provide payment for services and supports such as:
- Michigan Department of Community Health-Public Health MI Child program which is the State Child Health Insurance Program.
  - Michigan Department Community Health-Mental Health (Please see Appendix A for the sliding fee scale).
  - Michigan Department of Human Services General Medicaid Services (Please see Appendix B).
- (a) **Co-payments/Deductibles:** Co-payments for services provided through state and local programs will be allowed as specified under participating agency policies (e.g., Michigan Department of Community Health-Public Health's MI Child program which is the State Child Health Insurance Program charges a \$10.00 monthly fee per family.)
- (b) **Sliding Fee Scales:** Michigan will use the sliding fee scales, if applicable, for services indicated in Attachment B, Appendix A.
3. **Private insurance will not be accessed for Part C FAPE services by the intermediate school districts.**
4. Parents may use the IDEA procedural safeguards if there are any questions regarding the parent's rights as specified in section 639 of the IDEA, including the provisions in section 615 of the IDEA that apply to the IDEA Part C programs through section 639(a)(8) of the IDEA. Additional information on these procedural safeguards may also be found in the 2012 *Early On* Revised State Plan.

**PUBLIC MENTAL HEALTH SYSTEM  
ABILITY TO PAY SCHEDULE**

**R 330.8239 Determination of ability to pay from ability-to-pay schedule.**

**(1) Not Applicable.**

**(2) A responsible party who has been determined under the medical assistance program or its successor to be Medicaid eligible shall be deemed to have a \$0.00 ability to pay from the schedule specified in this rule. (See schedule below)**

(3) If the ability to pay for parents is assessed separately and their combined ability to pay is more than the cost of services, then the charges shall be prorated.

(4) A responsible party may request a new determination, based on the party's total financial circumstances, within 30 days from notification of the initial determination made from the ability-to-pay schedule specified in this rule.

**(5) Parents of children receiving public mental health services under the home and community-based children's waiver shall be deemed to have a \$0.00 ability to pay for the services provided.**

DRAFT

**PUBLIC MENTAL HEALTH SYSTEM  
ABILITY TO PAY SCHEDULE, cont.**

	STATE TAXABLE INCOME MONTHLY	ABILITY TO PAY ANNUAL
\$0.00 to: \$6,000.00	\$0.00	\$0.00
\$6,001.00 to: \$7,000.00	\$2.00	\$24.00
\$7,001.00 to: \$8,000.00	\$4.00	\$48.00
\$8,001.00 to: \$9,000.00	\$6.00	\$72.00
\$9,001.00 to: \$10,000.00	\$8.00	\$96.00
\$10,001.00 to: \$11,000.00	\$11.00	\$132.00
\$11,001.00 to: \$12,000.00	\$14.00	\$168.00
\$12,001.00 to: \$13,000.00	\$18.00	\$216.00
\$13,001.00 to: \$14,000.00	\$22.00	\$264.00
\$14,001.00 to: \$15,000.00	\$27.00	\$324.00
\$15,001.00 to: \$16,000.00	\$32.00	\$384.00
\$16,001.00 to: \$17,000.00	\$38.00	\$456.00
\$17,001.00 to: \$18,000.00	\$45.00	\$540.00
\$18,001.00 to: \$19,000.00	\$53.00	\$636.00
\$19,001.00 to: \$20,000.00	\$62.00	\$744.00
\$20,001.00 to: \$21,000.00	\$72.00	\$864.00
\$21,001.00 to: \$22,000.00	\$83.00	\$996.00
\$22,001.00 to: \$23,000.00	\$95.00	\$1,140.00
\$23,001.00 to: \$24,000.00	\$108.00	\$1,296.00
\$24,001.00 to: \$25,000.00	\$122.00	\$1,464.00
\$25,001.00 to: \$26,000.00	\$137.00	\$1,644.00
\$26,001.00 to: \$27,000.00	\$153.00	\$1,836.00
\$27,001.00 to: \$28,000.00	\$170.00	\$2,040.00
\$28,001.00 to: \$29,000.00	\$188.00	\$2,256.00
\$29,001.00 to: \$30,000.00	\$206.00	\$2,472.00
\$30,001.00 to: \$31,000.00	\$225.00	\$2,700.00
\$31,001.00 to: \$32,000.00	\$244.00	\$2,928.00
\$32,001.00 to: \$33,000.00	\$264.00	\$3,168.00
\$33,001.00 to: \$34,000.00	\$284.00	\$3,408.00
\$34,001.00 to: \$35,000.00	\$304.00	\$3,648.00
\$35,001.00 to: \$36,000.00	\$324.00	\$3,888.00
\$36,001.00 to: \$37,000.00	\$344.00	\$4,128.00
\$37,001.00 to: \$38,000.00	\$364.00	\$4,368.00
\$38,001.00 to: \$39,000.00	\$384.00	\$4,608.00
\$39,001.00 to: \$40,000.00	\$405.00	\$4,860.00
\$40,001.00 to: \$41,000.00	\$426.00	\$5,112.00
\$41,001.00 to: \$42,000.00	\$447.00	\$5,364.00
\$42,001.00 to: \$43,000.00	\$468.00	\$5,616.00
\$43,001.00 to: \$44,000.00	\$489.00	\$5,868.00
\$44,001.00 to: \$45,000.00	\$510.00	\$6,120.00
\$45,001.00 to: \$46,000.00	\$531.00	\$6,372.00
\$46,001.00 to: \$47,000.00	\$552.00	\$6,624.00
\$47,001.00 to: \$48,000.00	\$573.00	\$6,876.00
\$48,001.00 to: \$49,000.00	\$594.00	\$7,128.00
\$49,001.00 to: \$50,000.00	\$615.00	\$7,380.00

For state taxable income over \$50,000.00, ability to pay shall be 15% of that income.

## Medicaid Covered Services

You don't pay for services covered as long as they are medically necessary and arranged by the Primary Care Provider. The following is a list of those services:

- Blood lead testing for members under age 21
- Breast cancer services – services to treat breast cancer as required by federal and state women's health and cancer protection acts, including diagnostic, outpatient treatment and rehabilitative services
- Chiropractic services and podiatric (foot specialist) services for members under age 21
- Diagnostic laboratory, X-ray and other imaging services
- Doctor office visits
- Emergent and urgent care services
- Family-planning services
- Health education – disease management programs
- Hearing examinations for all members and hearing aids for members under age 21
- Home health services and skilled nursing home services, when medically necessary (You can use these after you leave the hospital or instead of going to the hospital. Your primary care physician will help you arrange these services.)
- Hospice services (if you request)
- Hospital services requiring an overnight stay  
These include:
  - Cost of a semi-private room (sharing a room with one other person)
  - Intensive care nursing services
  - Doctor services
  - Surgical services
  - Anesthesia (medication to relax or put you to sleep before surgery)
  - X-rays
  - Laboratory services
- Medical equipment and supplies, durable
- Mental health services – short term, up to 20 outpatient visits per year
- Midwife services – when provided by a certified nurse midwife
- Nurse practitioner services – when provided by a certified pediatric or family nurse
- Out-of-network services – when authorized by BlueCaid, except as otherwise stated in this Certificate
- Parenting and birthing classes
- Physical exams – routine or annual physical exams
- Podiatric (foot specialist) services, when medically necessary
- Practitioner services – such as those provided by physicians and specialists
- Pregnancy care – including prenatal and postpartum care (before and after birth)
- Prescriptions and pharmacy services
- Prosthetics and orthotics
- Rehabilitative or restorative services – intermittent or short term, in a nursing facility for up to 45 days

**Medicaid Covered Services  
APPENDIX B (cont.)**

- Rehabilitative or restorative services in a place of service other than a nursing facility
- Renal disease services – end stage
- Sexually transmitted disease treatment
- Smoking and tobacco cessation treatment, including drugs and behavioral support (Quit the Nic program)
- Specialist visits
- Surgical services – not requiring an overnight hospital stay
- Therapy – physical, speech and language, occupational
- Transplant services
- Transportation – by ambulance and other emergency medical transport
- Transportation – to nonemergency covered medical services
- Vaccinations (Covered vaccinations do not require prior authorization if provided by local health departments.)
- Vision – some services for members under age 21; limited services for members age 21 and older
- Weight-reduction services – if medically necessary
- Well-baby and well-child care – Early Periodic Screening Diagnosis and Treatment Program for persons under age 21

DRAFT