MDHHS Michigan Department of Health & Human Services | Children's Special Health Care Services

Guidance Manual for Local Health Departments

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INTRODUCTION

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Children's Special Health Care Services (CSHCS) has developed this Guidance Manual for Local Health Departments (LHDs) as a resource document. It contains CSHCS program policy in addition to procedural and guidance information that assists an LHD serving CSHCS clients. It also promotes enhanced communication between state and local offices.

CSHCS will send updated information to the Guidance Manual as it becomes available and/or as policies change. Sections within the manual, as well as some subsections, are designed so that entire replacement documents can be inserted without disturbing the continuity of the manual.
When using the manual, keep in mind the following:

"MDHHS" is used interchangeably to reference the Michigan Department of Health and Human Services and the CSHCS program.
Except for headings and sub-headings, text that appears in **blue**-bold reflects CSHCS policy as published in the Children's Special Health Care Services Chapter of the Medicaid Provider Manual and the Minimum Program Requirements (MPR).
Additional information and procedures appear in regular text.
Specific information related to covered services, prior authorization requirements, etc. should be obtained from the Medicaid Provider Manual, which is updated quarterly. The Medicaid Provider Manual can be accessed through the MDHHS Website.
Medicaid related policy bulletins, draft policy, fee screens, and other pertinent information can be accessed on the website.
Contact information does not appear throughout the manual. All contact information can be found on the Who to Call List on the CSHCS Guidance Manual Website, and in Appendix B of the Medicaid Provider Manual Directory Appendix.
Official forms (published by MDHHS) related to CSHCS or referenced in the Guidance Manual can be found online in CSHCS and MSA Forms.

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SECTION 1: CSHCS MISSION STATEMENT

Children's Special Health Care Services (CSHCS) Program Mission:

CSHCS strives to enable individuals with special health care needs to gain improved health outcomes and an enhanced quality of life through the appropriate use of the CSHCS system of care.

The CSHCS program aims to:

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

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SECTION 2: CSHCS PROGRAM OVERVIEW

2.1 General Program Description

CSHCS is mandated by the Michigan Public Health Code, Public Act 368 of 1978, Part 58, children and youth with special health care needs (MCL 333.5801 – 333.5879), in cooperation with the federal government under Title V of the Social Security Act, Sec.501. [42 U.S.C. 701] (a) 1 (D) and the annual Michigan Department of Health and Human Services (MDHHS) Appropriations Act. This makes CSHCS a separate program from Medicaid.

However, CSHCS partners closely with the Medicaid program regarding the use of the Medicaid system. This allows for greater efficiency in administering the two programs and allows both programs to collaborate on the care of a beneficiary to avert duplication of services. CSHCS does not pay for Medicaid-covered services that have been denied by Medicaid.

CSHCS is charged by the Social Security Act, Title V, Maternal and Child Health office with promoting the development of systems of care that are family-centered, community-based, coordinated, and culturally-competent with a focus on health equity. CSHCS strives for having the most appropriate pediatric subspecialists and services that are identified by combining the family's expertise regarding their child and the condition, the medical services provider, MDHHS medical expertise and CSHCS policy and program intent.

CSHCS increases access to resources and supports for the families and beneficiaries. Services occur in partnership, recognizing the family as the constant in the child's life. The goal is to reduce or eliminate barriers that are inherent to the condition. This, in turn, is intended to increase the quality of life for the beneficiary and the family. This family-centered approach impacts the level of independence most beneficiaries are able to achieve.

CSHCS identifies children with special health care needs when the child appears to have a condition that CSHCS may cover. CSHCS does not cover behavioral, developmental, or mental health conditions. The child's pediatric subspecialist submits medical reports to CSHCS for determination of medical eligibility. When the child does not have a pediatric subspecialist and there is no other option to obtain a medical report (i.e. private insurance, Medicaid,

etc.), CSHCS pays for a diagnostic evaluation of medical conditions that are likely to be covered by CSHCS. The beneficiary may be diagnosed with a CSHCS covered condition, which is the first step toward CSHCS eligibility but is not the only criterion. The condition must also meet chronicity, medical severity criteria and the need for treatment by a pediatric subspecialist before the beneficiary can be determined medically eligible for CSHCS. Unlike other programs, there are no financial criteria that would limit eligibility for CSHCS. Eligibility is determined based upon medical circumstances and not on financial circumstances. Medical eligibility (and allowable citizenship/permanent residency status) must be established by the department before the beneficiary can enroll in CSHCS.

Once enrolled, CSHCS covers pediatric specialty medical treatment (adult specialty for the few enrolled adults) related to the qualifying condition. Care is limited to the qualifying diagnosis and related conditions. The limitation occurs by authorizing particular specialty providers for each child and having the authorized provider(s) order additional services, such as therapies, lab tests, etc., as needed as related to their specialty. Providers who are not CSHCS-authorized are not eligible for reimbursement. CSHCS does not cover primary care or condition-related care delivered by a primary care provider.

NOTE: CSHCS and Medicaid interface – CSHCS follows Medicaid policy except where specified in this chapter. Many of the CSHCS processes (e.g. prior authorization, medical determinations, claims, etc.) are integrated into the Medicaid system and processes for CSHCS beneficiaries.

CSHCS strives to enroll CSHCS beneficiaries into Medicaid when they are eligible in order to access the broader range of medical services that are covered by Medicaid.

CSHCS also partners with Medicaid when beneficiaries have both CSHCS and Medicaid. Most beneficiaries who also have Medicaid are required to enroll with a Medicaid Health Plan. Under this situation, medical coverage is subject to the Medicaid rules. CSHCS can, at times, provide additional services beyond what is available through the Medicaid benefit package. These services include care coordination, the development of a plan of care in which the family participates, referral to appropriate medical providers,

and assistance with locating, accessing, and navigating community support services, etc.

The CSHCS Program does not issue "Emergency Services Only" coverage. The program issues coverage for services related to the CSHCS qualifying diagnosis(es) to those who are medically eligible, meet all program requirements, and complete the application process.

2.2 Family-Centered Care

The CSHCS program (and every state's program legislated by Title V of the Social Security Act) has a strong commitment to family-centered care. The Institute for Family-Centered Care defines the term as follows:

> "Family-centered care is an approach to health care that offers a new way of thinking about the relationships between families and health care providers. Family-centered providers recognize the vital role that families play in ensuring the health and well-being of infants, children, adolescents, and family members of all ages. Family-centered practitioners assume that families, even those who are living in difficult circumstances, bring important strengths to their health care experiences."
>
> "Family-centered practitioners acknowledge that emotional, social, and developmental support are integral components of health care. A family-centered approach to care empowers individuals and families and fosters independence; supports family care giving and decision making; respects patient and family choices and their values, beliefs, and cultural backgrounds; builds on individual and family strengths; and involves patients and families in planning, delivery, and evaluation of health care services. Information sharing and collaboration between patients, families, and health care staff are cornerstones of family-centered care."

For more than two decades, Michigan's CSHCS program has earned national recognition for the way family-centered care is woven into all facets of its operations. Notably, CSHCS includes a parent of a child with special health care needs on its management team. The impact is that "the family point of view" influences all CSHCS policies, procedures, communications, and day-to-day operations. Therefore, CSHCS has institutionalized the concept of collaboration between families and professionals. This partnership shapes policies and programs to improve care and support for children with special needs and their families.

Local health department (LHD) staff members are encouraged to access the Family Center for Children and Youth with Special Health Care Needs, also known as the Family Center, for both the support it can offer to help solve a family's CSHCS problems, and as a referral resource.

Family-centered care includes the use of "people first" language. A federal fact sheet that addresses people first language, and includes tips on communicating with and about persons with special needs and disabilities can be accessed through the CDC's Website.

2.3 Maternal and Child Health Bureau (MCHB) Core Outcomes

The Maternal and Child Health Bureau (MCHB) resides under the Health Resources and Services Administration (HRSA) within the U.S. Department of Health and Human Services (DHHS). The MCHB, along with many partners, identified six core indicators to measure outcomes of community-based of services mandated for all children with special health care needs under Title V, Healthy People 2020, and the President's New Freedom Initiative (NFI). These indicators have been chosen as six (6) of MCHB's eighteen (18) national performance measures reported on each year through the MCHB Title V block grant process and are designed to break down barriers to community living for people with disabilities. They also allow Michigan and other states to monitor progress toward establishing family-centered care and toward putting in place the systems all children with special health care needs deserve.

Outcome 1: Families of children and youth with special health care needs partner in decision-making regarding their child's health.

The physician is knowledgeable about the needs of the child and family and recognizes that the family is the principal care giver and the center of strength and support for the child. The family receives clear and complete information and options, shares in the responsibility for decision making, and has a central role in care coordination. Concern for the well-being of the child and family is expressed and demonstrated, showing empathy for the feelings of the child and family.

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Outcome 2: Children and youth with special health care needs receive coordinated, ongoing, comprehensive care within a medical home.
A medical home provides care that is accessible, family-centered, comprehensive, continuous, coordinated, compassionate, and culturally competent. In a medical home, the physician works in partnership with the client and family to ensure that all medical and non-medical needs of the client are met. Through this partnership, the physician can help the client or family access and coordinate specialty care, educational services, out-of-home care, family support, and other private and community services that are important to the overall health of the client and family.

Outcome 3: Families of children with special health care needs have adequate private and/or public insurance to pay for needed services.
Information is available to families regarding private insurance and public resources. Providers accommodate changes in insurance; and all insurances, including Medicaid, are accepted.

Outcome 4: Children are screened early and continuously for special health care needs.
Screening is performed on an on-going basis to identify special health care needs and ensure timely and appropriate follow-up for those who screen positive. Children identified with special health care needs receive on-going monitoring for secondary conditions.

Outcome 5: Community-based services are organized so families can use them easily.
Health care is delivered or directed by a well-trained, community physician and is available 24 hours a day, seven days a week. Care is provided in the client's community and is accessible by public transportation. Families are linked to support, educational and other community-based services through a coordinated plan of care that is developed by a physician, client and family.

Outcome 6: Youth with special health care needs receive the services necessary to make transitions to adult health care.
Family and youth are supported in playing a central role in care coordination and share the responsibility for decision making. Physicians are available to speak directly to youth

and family when needed and provide assistance with transitions in the form of developmentally appropriate health assessments and counseling. Care coordination for adult clients refers to, and includes, the identification of the client's needs-as-a-whole, and the offer of assistance and/or referral to other community resources as needed.

2.4 Medical Home

The HRSA Maternal and Child Health Bureau (MCHB) core outcomes state that "children and youth with special health care needs receive coordinated, on-going, comprehensive care within a medical home." CSHCS strives to fulfill this objective by collaborating with families, insurers, government, medical educators, and other components of the health care system. A medical home is an approach to providing comprehensive care that is:

- **Accessible:** Care is easy for the child and family to obtain, including geographic access and insurance accommodation.
- **Family-centered:** The family is recognized and acknowledged as the primary caregiver and support for the child, ensuring all medical decisions are made in true partnership with the family.
- **Continuous:** The same pediatric health care professionals are available from infancy through adolescence and young adulthood, providing assistance and support to transition to adult care.
- **Comprehensive:** Preventative, primary, and specialty care are provided for the child and family.
- **Coordinated:** A care plan is created in partnership with the family and communicated with all health care clinicians and necessary community agencies and organizations.
- **Compassionate:** Genuine concern for the well-being of the child and family is emphasized and addressed.
- **Culturally-competent:** The child and family's culture, language, beliefs, and traditions are recognized, valued, and respected.

In a medical home, a pediatric clinician works in partnership with the family/client to ensure that all medical and non-medical needs of the client are met. Through this partnership, the pediatric clinician can help the family/client access and coordinate specialty care, educational services, out-of-home care, family support, and other private and community services that are important to the overall health of the client and family. For more information about medical home, refer to the American Academy of Pediatrics website American Academy of Pediatrics website.

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2.5 Transition

HRSA's Maternal and Child Health Bureau (MCHB) core outcomes specify that "youth with special health care needs receive the services necessary to make transitions to adult health care." Michigan has implemented this indicator by collaborating with youth, families, providers, and professionals. Through these collaborative efforts, Michigan provides education about the process of transition, tools to begin transition planning, and coordination of systems of care for youth. Transition to adult life includes:

- **Health Care:** Youth with special health care needs will most likely need to make the transition from pediatric care to adult care. Health care planning should also include acquiring proper health care coverage, learning independent health care skills, and finding adult health care providers.
- **Employment:** Employment training opportunities are important in building self-sufficiency and independent living skills.
- **Independence:** As youth with special health care needs transition from adolescence to adult life, they must develop appropriate skills for independent living. This includes skills such as managing a savings account, paying bills, cleaning a home, and making meals.

Many people, agencies, and organizations may be involved in facilitating a successful transition to adulthood for youth with special health care needs. As youth approach adulthood, the process of transition should provide them with tools and resources to increase their ability to lead productive and successful adult lives.

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SECTION 3: HISTORY OF CSHCS

The people of the State of Michigan and their legislators have a long history of concern for children with special health care needs. This concern has been translated into a state and federally supported program, with a goal to achieve the fullest potential for each child with special health care needs in Michigan.

The Michigan Crippled Children Program was initiated by the state legislature in 1927, although services to this population can be traced back to 1881. Public Act 236 of 1927 established the Michigan Crippled Children Commission as the official state agency for the program. The agency's task was to locate, examine, and treat children with special health care needs for the purpose of making them self-sustaining to the extent possible rather than "charges on the public" for support.

In 1935, the program was federally mandated by Title V of the Social Security Act, which is commonly referred to as the Maternal and Child Health Services Block Grant. Section 501 (D) of Title V authorizes appropriations which enable each state:

> "to provide and to promote family-centered, community-based, coordinated care (including care coordination services) for children with special health care needs and to facilitate the development of community-based systems of services for such children and their families."

With the passage of Public Act 158 of 1937 (commonly referred to as the Crippled Children Act), the powers and duties of the Crippled Children's Commission were expanded. The new focus was to develop, extend, and improve services for locating such children to provide medical, surgical, corrective, and other services of care, and to provide facilities for diagnosis, hospitalization, and special education.

In 1944, Dr. James T. Pardee, a founder of Dow Chemical, made a generous bequest of Dow Chemical stock to support children with special needs. This marked the beginning of the Crippled Children's Fund, known today as the Children with Special Needs (CSN) Fund. See Section 24 for information on the CSN Fund.

In 1965, the Crippled Children's Commission became part of the Michigan Department of Public Health under the executive reorganization that year. Administration of the

Crippled Children Program was transferred to the Bureau of Community Services, Division of Services to Crippled Children (DSCC).

The Michigan Public Health Code, Act 368 of the Public Acts of 1978, Part 58, replaced the Crippled Children's Act and provides for the "medical, surgical, corrective, nutritional, and other services and care, including aftercare when necessary, and facilities for diagnosis and hospitalization of crippled children." With the institution of the Public Health Code, the Crippled Children's Commission was replaced by the newly created Crippled Children Advisory Committee, created to "confer with and advise the department as to its functions under this part." As of 2015, references to "crippled children" were replaced with "children and youth with special health care needs."

The program has always been committed to removing barriers to appropriate health care so that children with special health care needs may grow and develop to their full potential. This commitment led to a comprehensive review of the Division of Services to Crippled Children (DSCC) in 1982 and 1983. This review resulted in several recommendations, including the strengthening of services on a local level, which was regarded as DSCC's first priority. The implementation of Locally Based Services was expected to improve case finding, case planning, and case management services to Michigan children with eligible qualifying conditions or chronic illness.

The Parent Participation Program, a national innovation, was initiated in 1988 and is now known as the Family Center for Children and Youth with Special Health Care Needs, Michigan's prominent Title V family-centered care initiative. The Parent Participation Program was a national innovation to employ a parent of a child with special health care needs to represent families on the Title V administrative team. Today, numerous Title V programs nationwide have adopted this concept. See Section 5 for more information about the Family Center for CYSHCN.

Also in 1988, the Parent Participation Program was influential in DSCC changing the name of the Crippled Children's Program. The major focus of the concern was the use of the term "crippled" which had a negative connotation in the minds of the public and does not accurately describe all conditions covered by the program. After much discussion, a new name was chosen for the purpose of communication with the public and providers. However, the term "Division of Services to Crippled Children" was

retained for statutory and legislative purposes as the title of the organizational entity since this name had a well-known identity in achieving funding support. The title "Children's Special Health Care Services" was used to describe the broad scope of services provided by the program. Over time, Children's Special Health Care Services (CSHCS) became more widely used and recognized, and eventually replaced the former name "Crippled Children."

Due to the executive reorganization of 1996, the Department of Public Health was merged with the Department of Mental Health and the Medical Services Administration of the Department of Social Services to become the newly created Michigan Department of Community Health (MDCH). CSHCS was moved into the Medical Services Administration, along with the Medicaid program as part of the reorganization.

Also in 1996, the Public Health Code was amended to remove the requirement and conditions of the Crippled Children's Advisory Committee, and transferred the powers and duties to the director of the MDCH. By choice, the CSHCS division continues to organize and support the CSHCS Advisory Committee. The by-laws of the committee, as approved in 2003, call for at least one-third consumer representation. The committee typically meets bi-monthly and advises the CSHCS division on all aspects of the program.

Another restructuring occurred within MDCH in 2002 and moved CSHCS out of the Medical Services Administration and under the MDCH Public Health Administration. In 2015, another restructuring occurred merging the Department of Human Services (DHS) with MDCH to create the new Michigan Department of Health and Human Services (MDHHS). Soon after this restructuring (2016), CSHCS was moved back under the Medical Services Administration.

In 2003, the CSHCS Division created an Ad Hoc Advisory Committee, specifically and solely to receive input from the CSHCS staff at the LHDs. Fifteen LHD professional staff members were appointed to work with the CSHCS Director to develop, implement, evaluate, and revise components of the CSHCS program. The committee continues to function in this role and is now called the CSHCS Local Advisory Council (CLAC).

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SECTION 4: CSHCS ORGANIZATIONAL STRUCTURE

As of 2003, the Children's Special Health Care Services division became part of what is now called the Bureau of Medicaid Care Management and Customer Service in the Medical Services Administration (MSA) of the Michigan Department of Health and Human Services (MDHHS).

4.1 CSHCS Program Sections and Responsibilities

The CSHCS division contains the following management sections:

- Customer Support Section
- Policy and Program Development
- Quality and Program Services
- Children with Special Needs Fund
- Family Center for Children and Youth with Special Health Care Needs (the Family Center)

4.1-A Customer Support Section (CSS) Responsibilities

- Assign a specific analyst to work with the CSHCS office in each county
- Process medical eligibility determinations made by the Office of Medical Affairs (OMA)
- Process program applications for clients determined to have a qualifying diagnosis
- Process providers authorized by OMA onto the system
- Conduct financial assessments and audits
- Determine and implement payment agreements
- Issue and renew client program coverage
- Maintain current client information on the CSHCS Oracle database (e.g. address, diagnoses, etc.)

4.1-B Policy and Program Development Responsibilities

- Develop, implement and revise program policies
- Develop CSHCS data collection and analysis for application to policy development
- Research, advise, recommend, and assist with implementation of program development plans
- Develop transition planning strategies for various CSHCS sub-populations
- Administer contracts
- Assist LHDs and families with complex billing/reimbursement problems
- Administer the insurance premium payment benefit
- Administer and monitor the Children's Multi-Disciplinary Specialty (CMDS) clinics

4.1-C Quality and Program Services Responsibilities

- Ensure program quality and improvement planning
- Coordinate and manage CSHCS forms
- Monitor CSHCS customer satisfaction
- Monitor Minimum Program Requirements (MPR)
- Monitor the CSHCS office operations in the local health department
- Schedule out-of-state travel
- Organize and conduct LHD meetings and trainings, including new employee orientation for local CSHCS programs

4.1-D Children with Special Needs (CSN) Fund

- Provide services and equipment to children with special health care needs that no other resource, including state or federal programs, provides
- The child must be under age 21 and a Michigan resident to receive benefits from the CSN Fund
- The child must be enrolled, or medically eligible to enroll, in the CSHCS program to be eligible for assistance through the CSN Fund (See Section 24)

4.1-E Family Center for Children and Youth with Special Health Care Needs (the Family Center)

- Ensure that CSHCS program policies and practices reflect the needs and priorities of families who have children with special heath care needs
- Maintain a communication system between the CSHCS program and families of children with special health care needs
- Ensure that families of children with special health care needs have access to responsive network of peer support that includes matching individual families with similar circumstances
- Assist in educating families of children with special health care needs by providing information for families to help them identify options to meet the needs of their child and family and make informed decisions regarding their child's health care
- Conduct workshops and other training and information opportunities for families of children with special health care needs
- Assist families in addressing inquiries or problems via the toll-free CSHCS Family Phone Line

4.2 Office of Medical Affairs

The Office of Medical Affairs (OMA) is part of the Medical Services Administration within MDHHS. The CSHCS medical consultants operate out of OMA. OMA and CSHCS are in continual collaboration regarding all aspects of the CSHCS program.

The Office of Medical Affairs is responsible for:

- Reviewing medical reports and determining medical eligibility
- Providing medical testimony at Department Reviews regarding appeals of medical eligibility decisions
- Providing consultation regarding all aspects of CSHCS

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SECTION 5: FAMILY CENTER FOR CHILDREN AND YOUTH WITH SPECIAL HEALTH CARE NEEDS-CYSHCN (commonly known as the Family Center)

5.1 Description

The Family Center for Children and Youth with Special Health Care Needs (Family Center) is the statewide parent-directed center within Children's Special Health Care Services (CSHCS), which offers emotional support, information, and connections to community-based resources for families of children and youth with special health care needs, including all children who have, or are at an increased risk for, physical, developmental, behavioral, or emotional conditions.

The Family Center offers a parental perspective relating to health care matters while focusing on families' access to optimal and comprehensive care. The role of the Family Center is to promote family/professional partnerships by offering a family-centered point of view and consultation to ensure that families participate in the decision-making process and are satisfied with services received.

The Family Center promotes a coordinated system of care that is family-centered, culturally-competent, and community-based by providing input related to programming, policies, direct family support initiatives, community education, and collaborative partnerships. The Family Center is primarily comprised of parent consultants who have children with special health care needs and is located in Lansing.

The Family Center's primary functions are to support families of children with special health care needs by providing emotional support and helping families navigate various systems of care. The parent consultants within the Family Center offer consultation to improve service delivery and eliminate barriers for families, as well as offer a parental perspective related to programming, policies, and health care matters.

The MDHHS Minimum Program Requirements (MPR) require LHDs to "provide outreach, case-finding, program representation, and referral services to children and youth with special health care needs and their families in a family-centered manner and to community providers." The LHDs can assist in accomplishing these MPRs by

encouraging parents to use resources provided by the Family Center or take part in the Family Center's activities.

5.2 Program Services and Support

The Family Center ensures that the Family Phone Line is responsive and timely. Operators can transfer families to any CSHCS office, including those in the LHDs. The Family Center operators can help resolve a CSHCS problem by explaining a process or by transferring the caller to the appropriate party for answers to his/her questions. Operators can answer basic enrollment inquiries, such as dates of service and listed providers.

For any call, families who prefer to speak a language other than English can access a translator through connection to Linguistica International, a company that provides over-the-phone translators who speak dozens of languages. The subscription to Linguistica International extends to all CSHCS offices in the LHDs. Further information regarding Linguistica International can be found in Section 6 of this Guidance Manual.

LHDs are encouraged to make the Family Center aware of family members interested in volunteering to serve on committees to improve special health care. CSHCS offers support services to parent volunteers, such as reimbursement of mileage and childcare expenses, when he/she serves on CSHCS advisory committees.

Additional Family Center services include:

- Administration of scholarships (financed by the CSN Fund) for parents/youth to attend conferences related to the medical condition of his/her child with special needs
- Administration of parent mentor matches using the statewide database
- Providing a quarterly newsletter

Provides emotional support after the loss of a child through providing community-based resource referrals.

5.3 Purpose of the Family Center

The Family Center Assists With:

- Information and referrals
- Sibling support/workshops
- Bereavement support

- Support for family/youth transition
- Peer support through the Family Phone Line
- Parent-to-Parent Support Network
- Parent mentor trainings
- Connection to community-based support services and resources

Professional Partnerships

Support to local health departments (LHDs)
Consultation to CSHCS
LHD accreditation site visits
Family and youth participation and feedback
Family advisory workgroup
Special grant-related projects
Small grants to LHDs
Trainings on CSHCS and the Family Center for LHDs, managed health plans, healthcare providers, and other agencies

Who should use the Family Phone Line?

The Family Phone Line is intended for parents, caregivers, guardians, and professionals who:

- Want to be matched with a parent mentor
- Want to get information about local, state, or national resources
- Would like information on how to apply for conference scholarships
- Need to speak to a parent consultant within the Family Center
- Would like to obtain information on how to join CSHCS
- Need help to resolve issues related to CSHCS
- Want to learn more about the Family Center or CSHCS

Family Phone Line Policy

The Family Center staff may ask the following questions to incoming callers:

- Is your child on the CSHCS program?
- What is your child's diagnosis?
- What is your child's identification number?
- Have you been matched with another parent for parent-to-parent support?
- Protected Health Information (PHI) validation

To protect the privacy of all beneficiaries, a written consent to release protected health information must be on file with CSHCS to discuss health information for anyone over the age of 18. Either the Authorization to Disclose Protected Health Information (DCH-1183) or the Release to Obtain Medical Information (MSA-0838) can be used. Both can be found through the CSHCS and MSA Forms website.

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SECTION 6: ROLE OF THE LOCAL HEALTH DEPARTMENT

Local Health Departments (LHDs) throughout the state are committed to serving children with special health care needs in the community. The CSHCS office within the LHD is the agent of the CSHCS program at the community level. It is through the LHD that CSHCS succeeds in achieving its charge to be community-based. The LHD CSHCS offices are located within every LHD throughout the State of Michigan, including in the city of Detroit. LHDs provide a critical link for families to connect with resources within the larger community setting.

The LHDs are essential in:

- Serving as a vital link between the CSHCS program, the family, the local community, and the Medicaid Health Plan (as applicable) to ensure that children with special health care needs are aware of services available and how to navigate them.
- Providing information regarding various ways to access insurance, as well as public or private resources for assistance (e.g. SSI, waivers, insurance premium benefit).
- Ensuring families have access to coordinated, ongoing, comprehensive care.
- Connecting families to support services within the local community as well as the State (e.g. Family Center, transportation assistance, CSN Fund, other health resources).
- Helping to advocate within various systems (health care, schools, churches, clubs) and encouraging families to gain the skills necessary to advocate for their child and family (e.g., modelling, teaching, supporting).
- Preparing for transitional periods throughout a child's life.
- Providing outreach and education regarding CSHCS to families and the community.
- Building and maintaining partnerships with local providers, schools, Community Mental Health, MDHHS local offices, and other agencies within the LHD (e.g. Early On, WIC).
- Ensuring a smooth transfer to another county CSHCS office when families move.
- Supporting families through traumatic life situations (e.g. mental health situations, extended hospital stays, financial challenges, bereavement).
- Providing Care Coordination and Case Management services when appropriate.
- Partnering with the family to create a Plan of Care with goals for the family and LHD staff to ensure the highest attainment of health for the client.

The LHD is uniquely situated within the Public Health framework to continually assess families in the community and to promote health and help with prevention of disease

and injury across the entire population. Utilizing nursing as one of the most trusted professions, the LHD is a resource for reliable health information. LHDs strive to provide awareness to promote and protect the public's health and safety. LHD services are crucial when working with families and CYSHCN to plan for and safeguard the child, for ongoing family growth, and to ensure the best possible outcome in different situations (e.g. emergency preparedness, immunizations).

6.1 LHD Resources

Several resources are available, as well as training opportunities for staff.

6.1-A Linguistica International

When LHD staff encounter situations where the CSHCS client or family chooses to speak a language other than English and requires an interpreter, LHD staff should utilize telephone conferencing to connect the family directly to Linguistica International. Direct connection to Linguistica International is the most efficient way to use this service.

To connect directly to Linguistica International, follow the instructions below:

Step 1: Call 866-908-5744

- If you need a Spanish interpreter, you will be connected immediately by pressing "1" when prompted.
- If you need any other language press "2" or stay on the line.

Step 2: Hold as the operator connects you to your interpreter.

Step 3: Conference in the non-English speaker (if you do not have conferencing capability, contact a Family Phone Line operator and a representative will conference all parties).

Step 4: Begin conversation

LHDs without conferencing features on existing office telephone systems can call the Family Phone Line (FPL); the LHD representative and client will then be transferred to Linguistica International.

Note: The directions provided above, along with additional information, can be found on the Linguistica International website. Billing codes for Linguistica International for CSHCS calls can be found on the CSHCS LHD SharePoint site. Please contact Bruce Turnbull for SharePoint access.

6.1-B MiHealth Training

For anyone interested in knowing more about the CSHCS program, as well as other programs within MDHHS, educational and other helpful information is provided through MiHealth training. MiHealth training is an online resource offering a variety of courses suitable for providers, staff, and families.

MiHealth training courses can be found at MiHealth Training. The courses provide information and education on topics such as breast and cervical cancer control, newborn screening, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), Michigan Childhood Immunization Registry (MCIR), HIPAA transactions, and UB-92 and HCFA-1500 claim forms.

Courses are also available that provide a basic overview of CSHCS, Medicaid, and Medicaid managed care. These on-line courses are excellent resources for families who would like basic information about these programs.

6.2 Retention Schedule

Children's Special Health Care Services program files may include family/client data sheets, assessments, referrals, care plans, medical reports, narrative, physician orders, lab results, etc. Records must be retained in accordance with the Local Health Department Retention Schedule.

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SECTION 7: ACCREDITATION & MINIMUM PROGRAM REQUIREMENTS

7.1 Local Public Health Accreditation Mission

The Michigan Local Public Health Accreditation Program seeks to ensure and enhance the quality of local public health in Michigan by identifying and promoting the implementation of public health standards and evaluating and accrediting local health departments on their ability to meet these standards.

The Program's goals are to:

- Assist in continuously improving the quality of local public health departments
- Establish a uniform set of standards that define public health and that serve as a fair measurement for all local public health departments
- Establish a process by which the state can ensure that there is capacity at the local level to address core functions of public health
- Provide a mechanism for accountability, so that public health can demonstrate that financial resources are being effectively used and community needs are being met

7.2 CSHCS Accreditation Mission

Accreditation is a partnership between the State and local health departments (LHDs) to ensure greater consistency across Michigan regarding the level of local CSHCS services available. CSHCS and the Family Center work collaboratively with LHDs to refine and improve the Minimum Program Requirements and accreditation indicators for each new 3-year cycle. The accreditation process ensures that all LHDs are meeting the minimum program expectations. Outside of accreditation, LHDs should consult their local contract for other contractual requirements such as annual reporting, funding, and HIPAA.

7.3 Minimum Program Requirements (MPRs)

The Children's Special Health Care Services (CSHCS) program has six MPRs, each with indicators which provide evidence that MPRs have been met. For additional details, please see the MPR Indicator Guide Tool.

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MPR 1
The local health department CSHCS program shall ensure that adequate, trained personnel are available to provide outreach, enrollment, and support services for children and youth with special health care needs (CYSHCN) and their families.

MPR 2
In accordance with the security and privacy provisions of the Health Insurance Portability and Accountability Act (HIPAA), the local health department CSHCS program shall manage CSHCS client protected health information (PHI) in a secure and private manner that results in coordinated care.

MPR 3
The local health department CSHCS program shall have family-centered policies and procedures in place, as well as accurate and timely reporting.

MPR 4
The local health department CSHCS program shall collaborate with community partners and provide outreach, case-finding, program representation, and referral services to CYSHCN/families in a family-centered manner.

MPR 5
The local health department CSHCS program shall assist families in the CSHCS application and renewal process as well as the application processes for other relevant programs.

MPR 6
The local health department CSHCS program shall provide information and support services to CSHCS enrollees and their families.

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SECTION 8: CSHCS PROGRAM ELIGIBILITY

8.1 Medical Eligibility

CSHCS covers over 2,700 medical diagnoses that are handicapping in nature and require care by a medical or surgical subspecialist. A current list of covered diagnoses is maintained on the MDHHS website (refer to the Directory Appendix for website information). Diagnosis alone does not guarantee medical eligibility for CSHCS. To be medically eligible, the individual must:

- **Have at least one of the CSHCS qualifying diagnoses.**
- **Be within the age limits of the program:**
  - **Under the age of 26; or**
  - **Age 26 and above with cystic fibrosis or hereditary coagulation defects commonly known as hemophilia, or hereditary red blood cell disorders commonly known as sickle cell disease.**
  - **Meet the medical evaluation criteria during the required medical review period as determined by a MDHHS medical consultant regarding the level of severity, chronicity and need for treatment (refer to the Medical Renewal Period subsection of the Coverage Period Section of** the Children's Special Health Care chapter of the Medicaid Provider Manual**).**

The information needed from an appropriate subspecialist to establish or renew CSHCS medical eligibility includes the following:

- Primary diagnosis(es)
- Current problems (noting severity)
- Current treatment plan (including medications, services, equipment, anticipated hospitalization and follow-up care)
- Type(s) of specialty care required

A MDHHS medical consultant conducts the medical determination by reviewing the written report of a physician subspecialist. The medical information may be provided to CSHCS in the form of a comprehensive letter, hospital consultation or summary, or the Medical Eligibility Report Form (MERF) (MSA-4114). (A copy of the form is available in the Forms Appendix). Medical information is reviewed in the context of current standards of care, as interpreted by a MDHHS medical consultant. All of the criteria described below must be met for the individual to be considered medically eligible:

- **Diagnosis: The individual must have a CSHCS qualifying diagnosis where his activity is or may become so restricted by disease or other medical condition as to reduce his normal capacity for education and self-support. Psychiatric, emotional and behavioral disorders, attention deficit disorder, developmental delay, intellectual disability, autism, or other mental health diagnoses are not conditions covered by the CSHCS program.**
- **Severity of Condition: The severity criteria is met when it is determined by the MDHHS medical consultant that specialty medical care is needed to prevent, delay, or significantly reduce the risk of activity becoming so restricted by disease or other medical condition as to reduce the individual's normal capacity for education and self-support.**
- **Chronicity of Condition: A condition is considered to be chronic when it is determined to require specialty medical care for not less than 12 months.**
- **Need for Treatment by a Physician subspecialist: The condition must require treatment by a medical and/or surgical subspecialist at least annually, as opposed to being managed exclusively by a primary care physician.**

Medical information submitted for the purpose of renewing CSHCS eligibility is generally considered current when it is no more than 12 months old. Initial determination of medical eligibility may require reports that are more current to document the individual's current medical status. Medical information should be uploaded to the Document Management Portal (DMP) or faxed to the CSHCS Customer Support Section if DMP is unavailable. Initial medical eligibility is applicable for one year from the MDHHS medical consultant determination date.

Covered medical diagnostic categories include, but are not limited to:

- **Cardiovascular Disorders**
- **Certain chronic conditions peculiar to newborn infants**
- **Congenital anomalies**
- **Digestive Disorders**
- **Endocrine Disorders**
- **Genito-Urinary Disorders**
- **Immune Disorders**
- **Late effects of injuries and poisonings**
- **Musculoskeletal Disorders**
- **Neoplastic Diseases**
- **Neurologic Disorders**

- **Oncologic and Hematologic Disorders**
- **Respiratory Disorders**
- **Special Senses (e.g. vision, hearing)**

CSHCS does not cover acute/specialty care that is not related to the CSHCS qualifying diagnosis. CSHCS also does not cover mental health care, primary care, well-child visits, or immunizations (with the exception of seasonal influenza and COVID-19 for those otherwise uninsured)**. Examples of diagnoses, conditions or procedures not covered include, but are not limited to:**

- **Acne**
- **Allergies, without anaphylaxis**
- **Anorexia Nervosa**
- **Appendicitis**
- **Attention Deficit Disorder**
- **Autism**
- **Behavioral Problems**
- **Bronchitis (acute), croup**
- **Childhood illnesses (measles, mumps, chicken pox, scarlet fever, etc.)**
- **Cosmetic Surgery**
- **Depression**
- **Developmental Delay**
- **Headache, migraines**
- **Hernia (inguinal or umbilical)**
- **In utero treatment**
- **Pneumonia**
- **Refractive Errors and Astigmatism**
- **Sinusitis**
- **Tonsillitis, strep throat**

8.2 Release of Information

When a client requests that a provider send medical information to CSHCS or another entity, the provider usually requires the client to sign a Release to Obtain Medical Information (MSA-0838). Medical information is necessary to:

- Establish or renew medical eligibility for the CSHCS Program
- Obtain information about the client to assist with care coordination needs
- Assist the LHDs in understanding the client's case management needs

The person legally responsible for the client, or the client when responsible for self, can sign the release form for the provider's records. Individual providers may require that a different form be signed by the legally responsible party prior to releasing medical information.

When attempting to renew medical eligibility, CSHCS mails the Request to Obtain Medical Information (MSA-0838) to the family/client for the purpose of assisting in the renewal process. The request must be signed as indicated above and taken to the subspecialist.

In certain situations, it may be necessary to transfer a client's medical information or other protected health information from one LHD to another (e.g. family moves to a different county, etc.). The sending LHD must transfer medical information within the automated Document Management Portal (DMP).

The client or legally responsible party has the right to limit the duration of the authorization to release medical information and may withdraw his/her authorization at any time. Information released prior to withdrawal of authorization cannot be rescinded.

8.3 Diagnostic Evaluations

CSHCS covers diagnostic evaluations for individuals when symptoms and history indicate the possibility of a CSHCS qualifying condition but the appropriate medical information cannot be obtained from the current provider(s). Diagnostic evaluations are to determine whether an individual meets the medical eligibility criteria for CSHCS, not for providing treatment. The local health department (LHD) assists in obtaining these diagnostic evaluations. Treatment is not a CSHCS benefit until a qualifying diagnosis is established and the individual has enrolled in the CSHCS Program. Individuals currently enrolled in a commercial Health Maintenance Organization (HMO), Medicaid Health Plan (MHP), or with other commercial insurance coverage must seek an evaluation by an appropriate physician subspecialist through the network of the respective health plan or health insurance carrier to provide medical documentation of a CSHCS qualifying diagnosis.

Travel assistance, commonly referred to as non-emergency medical transportation (NEMT) is available when:

- **NEMT assistance may be authorized for individuals who do not have CSHCS but need NEMT assistance to participate in a diagnostic evaluation that is performed for the purpose of determining CSHCS eligibility.**

- **There must be verification that no other resources are available and the individual is otherwise unable to access the site of the diagnostic evaluation.**

A Referral and Authorization for CSHCS Diagnostic Evaluation (MSA-0650) must be completed for any individual in need of a diagnostic evaluation. When completing the MSA-0650, the section titled Reason(s) for Referral or Follow-Up must include the reason for the referral, including any tests that have already been completed, and pertinent questions the LHD would like addressed. All referrals for diagnostic evaluations must be approved and signed by the LHD nurse as stated in the care coordination and case management sections of this Guidance Manual**.** A copy of the MSA-0650 needs to be uploaded to CSHCS through the Document Management Portal (DMP).

The purpose of a diagnostic evaluation is to determine whether an individual meets the medical eligibility criteria for CSHCS. Diagnostic evaluations should only be authorized by the LHD when determination of CSHCS eligibility is needed and all other means of obtaining the information have been exhausted. Diagnostics are not appropriate for:

Evaluating conditions that are not covered by CSHCS
General monitoring purposes
Obtaining treatment
Saving families from the cost of co-pays or deductibles when a diagnostic evaluation is not warranted
Avoiding enrollment in CSHCS because of a payment agreement
Yearly check-ups in field clinics; or
A visit to a developmental assessment clinic (DAC).

If a child sees a specialist on a yearly basis for the same diagnosis and the family does not enroll, it is acceptable to discuss with the family their intent to enroll in CSHCS prior to authorizing the diagnostic evaluation. When it is clear that there is no intent to

enroll, or if there is a repeated pattern of not following through with the enrollment process, the LHD may deny requests for a diagnostic evaluation. Requests for a new diagnosis are authorized according to the usual procedure.

Diagnostic evaluations may be covered for current CSHCS clients to determine if the client has additional diagnoses that are covered by the CSHCS program. When a currently enrolled, CSHCS-only client requires a diagnostic evaluation, instead of completing an MSA-0650, LHDs should upload to the Document Management Portal a Notice of Action from Local Health Department (MSA-0730-B) requesting that the analyst add the diagnostic provider for the date of service. The Notice of Action must indicate the anticipated date of service, the provider's National Provider Identifier (NPI) number and the reason for the diagnostic evaluation. The preferred method for establishing eligible diagnoses is through the receipt of medical reports whenever possible. Diagnostic referral is performed if appropriate documentation is not available.

The initial diagnostic referral is generally made to the physician subspecialist. Occasionally, further testing (e.g. laboratory, x-ray, etc.) is required to determine the diagnosis or may be requested by the CSHCS medical consultants to determine medical eligibility. Additional facilities usually have separate billing agents (unless all are housed under one clinic) and each facility requires a diagnostic authorization to bill for services. Inpatient testing requires review/approval prior to authorization at the local level.

If an individual has been evaluated and denied CSHCS medical eligibility in the past, the CSHCS medical consultant may approve a return diagnostic visit to determine and establish eligibility at a later date in the event that a condition has changed and could meet medical eligibility criteria. The subspecialist's medical report and any other test results from the diagnostic evaluation should be sent to CSHCS for determination of medical eligibility. The LHD may issue a diagnostic for a return visit if it has been determined that no other payment source is available (Medicaid, private insurance, etc.) and no new medical reports have become available. In the event that that family has already enrolled in CSHCS prior to the return visit, the provider can be added to the authorized provider list for the date of the return visit only. The CSHCS medical consultants will need to approve an additional diagnosis in order for the subspecialist to be added for the entire eligibility year.

Diagnostic evaluations are usually performed in outpatient hospital-based specialty clinics. There are certain types of evaluations that may be appropriately authorized in a physician's office due to the unique diagnostic equipment requirements of a particular specialty (e.g. ophthalmology, otology, neurology, and pediatric allergy). When the diagnostic evaluation has been completed, the clinic or physician sends a copy of the medical report to the CSHCS division.

Diagnostic evaluations do not require a referral from a pediatric subspecialist or physician. A CSHCS representative or LHD nurse can initiate diagnostic evaluations for:

Individuals without current CSHCS coverage who are not enrolled in a commercial or Medicaid Health Plan
CSHCS-only clients
Clients who have commercial insurance in certain circumstances
Non-U.S. citizens (even if family may not be eligible to enroll in CSHCS)

If the beneficiary has Medicaid fee-for-service (FFS), a diagnostic referral is not necessary. The LHD should contact the CSHCS regional nurse consultant (RNC) if the family encounters any difficulties in obtaining the appointment.

If the individual is enrolled in a Medicaid Health Plan, the Medicaid Health Plan is responsible for the evaluation. If the Medicaid Health Plan has declined the request to be seen by a pediatric subspecialist, the CSHCS medical consultant may speak with the Medicaid Health Plan on a case-by-case basis to discuss the need for appropriate referral for diagnostic or medical information. If the Medicaid Health Plan refuses to authorize the diagnostic evaluation, the family should request the denial in writing and pursue the appeals process through the Medicaid Health Plan and/or the Michigan Office of Administrative Hearings and Rules (MOAHR).

When an individual has other health insurance coverage, the rules of the other health insurance (provider network, prior approval, etc.) must be followed and the other health insurance must be billed prior to billing CSHCS. A diagnostic may be issued for persons with other insurance coverage to reimburse for costs not covered by the other insurance carrier (e.g. co-pay, deductible, etc.). If the client has no other health insurance coverage, CSHCS will cover the cost of the diagnostic evaluation.

In the event that the other insurance or HMO refuses to allow the client access to the appropriate subspecialist, the client should file an appeal with the other insurance carrier or HMO.

CSHCS does not cover diagnostic evaluations as part of school-based services. Any evaluations needed for educational purposes are to be covered by the intermediate school district (ISD). If there is a potential that an individual will meet the medical eligibility criteria for CSHCS, the LHD may issue a diagnostic.

It is not appropriate to issue a diagnostic if a child is receiving care at an out-of-state (OOS) facility and it becomes apparent that additional tests are indicated. OOS referrals are for specific services. Medical reports from the OOS physician should be submitted to update the status of the individual. The program can provide retroactive coverage for additional diagnoses or services, if needed. The CSHCS medical consultants are equipped to handle these matters as expeditiously as necessary.

Retroactive authorization of a diagnostic evaluation is rarely necessary; however, the LHD is advised to call its RNC before authorizing a diagnostic evaluation retroactively:

When a currently enrolled CSHCS client is evaluated by a subspecialist for a condition unrelated to the CSHCS qualifying diagnosis, the provider can be added to the client's authorized provider list for the date of service only
When a currently enrolled CSHCS client is evaluated by a subspecialist for a condition unrelated to the CSHCS qualifying diagnosis and the client was determined medically eligible for an additional CSHCS diagnosis, the provider can be added to the client's authorized provider list

CSHCS supports the Early Hearing Detection and Intervention (EHDI) guidelines for screening by one month of age, diagnosis by three months of age and intervention by six months of age. Some LHDs and/or Early On providers are equipped to perform hearing screenings for newborns who failed the initial screen. If this is not available in the LHD's respective area, it is appropriate to issue a diagnostic to the:

Audiologist for failed newborn screening cases
Audiologist for children less than six months of age
Otolaryngologist for children over six months of age

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8.4 Other Eligibility Considerations

8.4-A Citizenship Status

The individual, parent of a minor, or court-appointed guardian of the individual must be a citizen of the U.S., a non-citizen lawfully admitted for permanent residence, or a lawfully admitted migrant farm worker (i.e., temporary agricultural worker).

Any individual born in the United States who meets all other program eligibility criteria is deemed eligible regardless of the citizenship status of the parents/court-appointed guardian.

- **Noncitizens who have been granted admission to the U.S. for a temporary or specific period of time are not eligible for CSHCS coverage other than as specified below.**
- **MDHHS requires a statement of citizenship status from the family if the information is unclear from the application.**
- **MDHHS may request verification of citizenship or permanent resident status.**

There are some exceptions by the U.S. Citizenship and Immigration Services (USCIS) that allow legal status for individuals with specific reasons for nonpermanent entry in the U.S. who are recognized as potentially eligible for full Medicaid coverage (as opposed to Emergency Services Only coverage). CSHCS recognizes the same individuals for coverage when all other CSHCS qualifying criteria are met.

CSHCS will send a Citizenship Inquiry form to all families whose information on the application indicates that the individual is not a U.S. citizen. The Visa class/type code can be found on the front of the Visa; the class/type code of either the parent/court-appointed guardian or the child is acceptable. If the expiration date on the front of the Visa has passed and the term of the Visa has been extended, use the most current expiration date. A new expiration date may be stamped on the back of the Visa or the family may have additional paperwork with a new date. Copies of citizenship documents can be returned by mail or through the Document Management Portal (DMP) with the Citizenship Inquiry form. Original documents should never be submitted.

Documentation may be requested from families who already have CSHCS coverage if information becomes available that their citizenship status may not meet eligibility criteria. CSHCS may end coverage if the submitted documentation does not support the citizenship status required for CSHCS eligibility.

8.4-B Residency

The individual, parent, court-appointed guardian, or foster parent of the individual must be:

- **A Michigan resident(s); or**
- **Working or looking for a job in Michigan, and living in Michigan (including migrant status); or**
- **In Michigan with the clear intent to make Michigan their home.**

A Michigan resident who is temporarily absent from the state (e.g. out-of-state college attendance, member of a family stationed out-of-state for military service, or other extenuating circumstances allowed by MDHHS) and agrees to return to Michigan at least annually for subspecialty medical treatment of the qualifying diagnosis(es) meets the criteria for residency.

CSHCS does not issue or maintain coverage when the individual is known to be out-of-state (except for the circumstances listed above) even if the parent, court-appointed guardian or foster parent meets the criteria for residency.

8.4-C Long Term Care Facility

CSHCS does not issue or maintain coverage when the individual is known to reside in a long term care facility whose rate of payment includes medical care and treatment (e.g. nursing facility, ICF/IID, inpatient psychiatric hospitals, etc.). The individual can re-apply for CSHCS coverage or have CSHCS coverage reinstated when the living arrangement changes and all other eligibility criteria are met.

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SECTION 9: CSHCS APPLICATION PROCESS

9.1 General Information

When a medical report is submitted to CSHCS on behalf of a beneficiary with full Medicaid, MIChild or Healthy Michigan Plan coverage, and the CSHCS medical consultant determines that the beneficiary is medically eligible for CSHCS, the beneficiary is automatically enrolled in CSHCS without completing the CSHCS application.

When the MDHHS medical consultant determines the individual is medically eligible for CSHCS, and the individual does not have full Medicaid, MIChild and/or Healthy Michigan Plan coverage, **MDHHS sends the individual:**

- **Children's Special Health Care Services (CSHCS) Application (MSA-0737)**
- Income Review/Payment Agreement (MSA-0738)
- CSHCS Payment Agreement Guide (MSA-0738-B)
- Important Information about the CSHCS Application Process informational sheet
- Authorization to Disclose Protected Health Information (DCH-1183)
- Resources for Families of Infants and Toddlers with Special Health Care Needs brochure (DCH-0951)
- Family Center for Children and Youth with Special Health Care Needs brochure (PUB-1168)
- CSHCS Caring for Kids with Chronic Conditions brochure (PUB-1188)
- Notice of Non-Discrimination
- Postage paid, pre-addressed return envelope (MSA-100-CSHCS-P)

The individual must complete the application, including the Income Review/Payment Agreement form **and return it to MDHHS** within one year of medical eligibility determination date **to be considered for enrollment in the program. Applications submitted by the family cannot be processed until medical eligibility has been determined by MDHHS.**

Applications must be signed by the medically eligible individual (when legally responsible for self) or the person(s) who is legally responsible for the individual. Verification of court-appointed guardianship may be required. Either parent can apply for CSHCS coverage for the individual regardless of shared custody.

Stepparents are not considered the legally responsible persons to sign the application unless the stepparent is in the legal process of adopting the child or is the child's court-appointed guardian.

The application must be completed and submitted to MDHHS (CSHCS) **as directed on the application form. MDHHS** (CSHCS) **will notify the individual by mail if the application is incomplete and cannot be processed. The individual has 30 calendar days from the date of the MDHHS** (CSHCS) **letter to submit the required information in order to preserve the initial coverage date. Failure to submit the required information within the required time frame may result in the coverage date being delayed.**

When a medical report is submitted to CSHCS on behalf of a beneficiary with full Medicaid, MIChild or Healthy Michigan Plan coverage, and the CSHCS medical consultant determines that the beneficiary is medically eligible for CSHCS, the beneficiary is automatically enrolled in CSHCS without completing the CSHCS application.

The medically eligible individual, parent or court-appointed guardian, designated patient advocate, personal health care representative, or person(s) with power of attorney can:

Complete the application and income review independently
Call or go to the CSHCS office in the LHD for assistance in completing the forms

The LHD should call the CSHCS Customer Support Section (CSS) for answers to questions related to completing the required forms.

The individual must complete the application process in order to receive CSHCS benefits. Interviews are not required. A chronological summary of the application process is included at the end of this section.

If the applicant has other insurance coverage, include a copy of the insurance card (front and back) with the application.

9.2 Financial Determination

MDHHS conducts an initial financial determination for new applicants/families, and annual financial determinations thereafter of all CSHCS families/clients, as required through the Michigan Public Health Code (Act 368 of Public Acts of 1978 – Part 58,

Section 333.5823, 333.5825, & 333.5841). Financial resources do not prevent a medically eligible individual from enrolling in the CSHCS program.

MDHHS (CSHCS) **reviews the CSHCS Income Review/Payment Agreement form (MSA-0738) submitted by all* individuals to evaluate the family/individual financial resources. The review serves to:**

- **Determine whether the family/individual income is sufficient to establish a payment agreement to pay toward the costs of the medical care received through CSHCS.**
- **Aid in identifying additional services or benefits for which the family/individual may be eligible.**

*** Individuals determined medically eligible based on documentation submitted by their Medicaid Health Plan (MHP) are not required to submit the MSA-0738 as MHP enrollment is pre-verification of Medicaid coverage resulting in exemption from a payment agreement.**

9.3 Financial Determination Process

Families/Individuals are exempt from a payment agreement if at least one of the following applies:

- **The beneficiary to be covered has full Medicaid coverage or is enrolled in MIChild or the Healthy Michigan Plan;**
- **The beneficiary is a ward of the county or state;**
- **The beneficiary lives in a foster home or a private placement agency;**
- **The beneficiary has a court-appointed guardian** (with submitted documentation of court-appointed guardianship); **or**
- **The beneficiary is deceased (retroactive coverage).**

The MSA-0738 form must be completed and submitted when applicable, either indicating the family/individual status is exempt from a payment agreement, or with the legally **responsible party's income and family size as reported on the federal income tax return from the previous year.** Clients who have partial Medicaid coverage (e.g. ESO, Spenddown, etc.) are not exempt from having a CSHCS payment agreement based on partial Medicaid coverage.

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During the time period January 1 through April 15 of any given year, an individual/family may, or may not have, filed a federal income tax return for the previous year:

If the individual/family has filed a federal income tax return for the previous year, the information from that tax return is required to complete the MSA 0738.
If the individual/family has not filed a federal income tax return from the previous year, CSHCS can accept information from the tax return for the year ending December 31, two years prior to the current year. This information can be accepted until April 15 of the current year. After the April 15th filing deadline, CSHCS requires the submission of information from the new federal income tax return. (See example below).
If the individual/family has received an extension of the April 15 filing deadline, the Financial Worksheet (MSA-0742) must be completed with the tax information from the previous year. (See the example below).

> Example: If the individual/family applies for CSHCS coverage in 2020, the information from the federal income tax return for the year 2019 is required. Between January 1, 2020 and April 15, 2020, if the individual/family has not yet filed a federal income tax return for the year 2019, CSHCS can accept information from the 2018 federal income tax return. After April 15, 2020, the family must submit the 2019 federal income tax return. If the individual/family has been granted a filing extension for the year 2019, the completed Financial Worksheet (MSA-0742) form must be submitted with income and family size information relevant to the 2019 tax year.

If no federal income tax return is available, families may contact the local health department (LHD) or the CSHCS Family Phone Line for further assistance.

When an individual/family contacts the LHD for assistance and no federal income tax return is available, the LHD may use the Financial Worksheet (MSA-0742) to determine the individual/family's income and payment agreement amount.

The following guidelines may be used to evaluate income:

When the individual is a legally responsible adult (age 18 or over), or otherwise emancipated, include the income of the individual based on the federal income tax return from the previous year.

When the individual is married and the most recent federal income tax return was filed jointly, include the income of both the individual and the spouse.
When the individual is married and the most recent federal income tax return was filed separately, include only the income and family size reported on the individual's tax return.
When the individual is a minor living with both birth/adoptive parents, and the most recent federal income tax return was filed jointly, include the income of both parents.
When the individual is a minor living with both birth/adoptive parents, and the most recent federal income tax return was filed separately, include only the income and family size of the parent who claimed the minor child as a dependent.
When the individual is a minor living with only one birth/adoptive parent, and that parent is applying for CSHCS coverage, include only the income of the applying parent.
When the individual is a minor living with only one birth/adoptive parent, and the individual is not living with the parent applying for CSHCS coverage, include only the income of the applying parent.

The LHD should instruct the individual/family to retain a copy of the Financial Worksheet (MSA-0742) as documentation for their records. Income verification may be requested.

9.4 Verification of Income

Families/individuals self-declare income at the time of CSHCS application and renewal. Periodic reviews of randomly selected family/individual financial documentation are conducted. When the information submitted is problematic to completing the payment participation determination, or when a family/individual is randomly selected for verification of income, their federal income tax return may be requested. When the federal income tax return is not available, the family/individual may contact the LHD or CSHCS Family Phone Line for further assistance.

When an individual/family contacts the LHD for assistance with income verification and no federal income tax return is available, the documentation used to complete the Financial Worksheet (MSA-0742), is needed to verify the individual/family's income.

9.5 Payment Agreement

CSHCS is required to determine a family's/individual's ability to pay toward the cost of the individual's care through the financial determination process. Those determined to be exempt from payment participation, as described in

the Financial Determination Process subsection, are not required to pay toward the cost of care covered by CSHCS. The family/individual payment amount is established based on the income and family size reported by the legally **responsible party on their most recent federal income tax return as indicated on the CSHCS Payment Agreement guide (MSA-0738-B). The income is applied to a tiered scale to determine the amount of the payment agreement. The MSA-0738-B is updated at least annually.**

Financial reviews occur and new payment agreements are redetermined annually and implemented (if still applicable) according to the beneficiary's CSHCS coverage period.

The MSA-0738 form must be signed by the legally **responsible party for CSHCS coverage to be implemented. The amount of the payment agreement is the total family/beneficiary financial obligation for one year, regardless of the number of family members with CSHCS coverage. The total amount of the financial obligation is due upon receipt of the payment agreement notification. The family/beneficiary is responsible for the total amount even if CSHCS coverage ends. Payments are non-refundable.**

If corrections are needed to the MSA-0738, the LHD is permitted to make changes with permission of the family following a conversation regarding corrections needed. The LHD representative must initial any changes made. The LHD may not sign the MSA-0738 on behalf of the family, but may add a signature date when it is missing.

A client who reaches the age of majority is considered a family of one and assessed a payment agreement based on his/her individual income, regardless if he/she is being claimed as a dependent by another adult. If multiple family members receive CSHCS coverage, any client in the family over the age of 18 will have a separate payment agreement. All minor children in the family are covered under a single-family payment agreement. When a parent(s) also has CSHCS coverage, all minor children and the parent(s) are covered under a single payment agreement.

Families who have a change in financial circumstances should notify the LHD. When the LHD becomes aware of a change in circumstances that may affect the amount of the current payment agreement, the LHD representative completes the Income Review/ Payment Agreement Amendment (MSA-0927) and submits to CSHCS. The LHD and the family will receive a copy of the form showing the computation and approval (or denial)

of the new payment agreement amount. The agreement may be pro-rated up to 12 months back to the date of the event, though not further than the beginning of the current payment agreement. Payment agreement adjustments may not be applied to previous agreements (except when Medicaid or MIChild is obtained).

If the change in circumstances indicates that a payment agreement is no longer required, the client may be eligible for forgiveness of the unpaid balance or a refund of any overpayment. In that circumstance, the current year payment agreement would be terminated, and the outstanding balance forgiven within 30 days of notification to CSHCS of the change.

Beneficiaries who acquire full Medicaid, MIChild or Healthy Michigan Plan coverage after enrollment into CSHCS will be reimbursed in full for any money paid toward the payment agreement that is in place for the current CSHCS coverage period. Unpaid balances may be forgiven and CSHCS coverage continued when the client has acquired full Medicaid, MIChild or Healthy Michigan Plan coverage. Clients who have partial Medicaid coverage (ESO, Spenddown, etc.) do not qualify for forgiveness of outstanding balance or return of money.

Beneficiaries can call the local health department or the CSHCS Family Phone Line to request assistance with the CSHCS payment agreement.
When death of a beneficiary occurs during the beneficiary's CSHCS coverage period, a notice is sent to the family that the unpaid balance is forgiven. When the family notifies MDHHS that the payment agreement has been paid ahead, in part or in full, MDHHS pro-rates the monthly amount related to the coverage period for which the beneficiary is no longer covered due to death. The family is reimbursed the pro-rated amount. When death of a beneficiary occurs and one or more of the surviving family members have CSHCS coverage, the payment agreement remains intact for the remaining family members.

A family/beneficiary may have no more than two outstanding years of incomplete or unpaid payment agreements. The family/beneficiary will not receive CSHCS coverage under a third year of a payment agreement until the oldest payment agreement obligation has been met.
When the beneficiary reaches the age of majority, or otherwise becomes emancipated, outstanding payment agreements remain with the family who

entered into the original agreement. When a change occurs in family finances after the client has reached age 18, the family is still liable for outstanding payment agreements and is not eligible for forgiveness of outstanding balances. **When a beneficiary acquires Medicaid, MIChild or Healthy Michigan Plan coverage after the beneficiary reaches the age of majority, the current payment agreement entered into by the family while the beneficiary was a minor does not qualify for forgiveness of balance or return of money. The income of the legally independent beneficiary is not assessed for a payment agreement until the beneficiary's next CSHCS renewal period.**

Example 1: Client has a CSHCS coverage period from January 1 through December 31 with a payment agreement. Client turns 18 years old on May 25 and acquires full Medicaid coverage beginning June 1. The payment agreement remains with the family who entered into it on the client's behalf and does not qualify for forgiveness of outstanding balance or return of money because the Medicaid coverage became active after the client's 18th birthday when he/she became a legal adult.

Example 2: Client has a CSHCS coverage period from January 1 through December 31 with a payment agreement. Client turns 18 years old on May 25 and acquires full Medicaid coverage retroactive to April 1. The payment agreement qualifies for forgiveness of outstanding balance(s) and/or return of money because the Medicaid coverage became active prior to the client's 18th birthday while the client was still a dependent.

Example 3: An 18-year-old client renews CSHCS coverage for the time period January 1 through December 31. He/she has completed all renewal requirements and has entered into payment agreement for the CSHCS coverage year. The client then acquires full Medicaid coverage effective May 1. The payment agreement qualifies for return of money because the client entered into it as an independent adult.

9.6 Chronological Summary of CSHCS Application Process

- Physician subspecialist, hospital, or Medicaid Health Plan submits a medical report for determination of CSHCS eligibility to the Customer Support Section (CSS). The report describes the client's potentially eligible diagnosis and current treatment plan. Family (especially those enrolled in a MIChild or Medicaid Health Plan) may be unaware the information was sent to CSHCS.
- Medical report is forwarded to CSHCS medical consultant for eligibility decision.

- Family/client demographic information and Medicaid ID number, if available, are entered in CSHCS database along with the name of the provider who submitted the report.
- If the information is not complete for a determination, the case is pended. The decision and reason for the 'pend' are entered in CSHCS database. A 'pend' letter is sent to the family requesting more specific information. A copy of the medical report and the pend decision are sent to the LHD.
- If the information results in a denial of eligibility, the decision and reason for the denial are entered in the CSHCS database. A denial letter is sent to the family. A copy of the medical report and denial decision are sent to the LHD.
- If the client is eligible for CSHCS, the decision and eligible diagnosis code(s) are entered into the CSHCS database. A copy of the medical report is forwarded to the LHD. CSS may receive new medical information during the application process resulting in the client being eligible for additional diagnosis(es). Copies of the reports with the eligibility decision are sent to the LHD.
- A welcome letter is sent to the client if they have full Medicaid, MIChild, and/or Healthy Michigan Plan, and they are automatically enrolled into the CSHCS program.
- An invitation letter with an application packet to enroll is sent if the client does not have full Medicaid, MIChild, and/or Healthy Michigan Plan.
- The family has the option to complete and return the application, which includes the Income Review/Payment Agreement, or to request phone or in-person assistance to complete the application.
    - If the family requests phone or face-to-face assistance, a Family Phone Line operator assists or transfers the call to the LHD.
    - If the family contacts the LHD directly, assistance in completing the application forms is provided by phone or in-person, in accordance with the family's preference.
- If the family does not respond to the application packet within 30 days:
    - CSS requests the LHD's assistance to contact the family and document the response utilizing the Application Follow-Up Report.
    - If the family declines the application, the LHD notes any reasons given and advises CSS.
    - If the family is interested in joining CSHCS, the LHD offers the family options for completing the application with or without assistance.
    - If the LHD is unable to locate the family, the LHD notes that status.
- The date CSS receives the completed application is entered in the CSHCS database. A client ID number, if available, is obtained from the Medicaid eligibility system, or a

new number is generated. The ID number and any demographic updates are entered into the CSHCS database.

- The application is forwarded to the analyst assigned to the LHD and the analyst reviews the application for completeness.
- If the information is not complete, the analyst contacts the local health department or the family to request missing information.
- If the information is complete, the remaining family/client information, coverage start and end dates, authorized providers, and payment agreement details are entered into the CSHCS database.
- If more than one sibling in a family has CSHCS coverage:
  - The coverage dates are adjusted to be the same for the family's convenience; and
  - The amount of the payment agreement is whatever it would be for one child, regardless of the number of children covered.
- If applicable, information regarding other insurance must be submitted to the Third Party Liability division using the Insurance Coverage Request Form.
- Once CSHCS coverage has been issued, CSS sends a copy of the application to the LHD. The MDHHS system generates a mihealth card to the client and a Client Eligibility Notice (CEN) to the family which lists the client's ID number, authorized providers, and CSHCS coverage start and end dates.
- CSS sends a welcome packet to the family that includes:
  - Caring for Kids with Chronic Conditions brochure (PUB-1188)
  - Frequently Asked Questions About CSHCS (MDHHS-PUB-1173)
  - Children with Special Needs Fund brochure
  - Family Center for Children and Youth with Special Health Care Needs brochure (PUB-1168)
  - CSHCS Insurance Premium Payment Benefit brochure (PUB-1164)
  - Using Other Health Care Insurance with CSHCS (PUB-1163)
  - Notice of Non-Discrimination
- The LHD is required to contact the family to explain the LHD role as a local resource for information and assistance in navigating CSHCS and community service systems.
- The LHD offers the family the opportunity to receive additional information about the CSHCS program and other community resources. Accepting the offer for additional information and assistance is optional for the family. When requested, additional information and assistance must be available and provided in a manner that is most convenient to the family through the mail, by telephone, or in-person (at home, hospital, LHD, another site, etc.).

- If the family chooses to receive the additional information/assistance, the LHD partners with the family to share information, identify needs, and document routine LHD and/or family follow-up planned, or case management/care coordination activities needed.
  - The LHD may use the CSHCS Service Needs Summary Record (MSA-0741) to document information shared, referrals made, and action/follow-up planned.
  - If the family does not desire additional information, the LHD will note that status on the CSHCS Service Needs Summary Record (MSA-0741), or by submission of a Notice of Action.

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SECTION 10: CSHCS EFFECTIVE DATE AND COVERAGE PERIODS

10.1 Effective Date

The effective date of CSHCS coverage is dependent upon the date of the event that medically qualifies the individual for CSHCS. The CSHCS begin date is the first day of the month of this qualifying event, and may be retroactive up to six (6) months from the date MDHHS receives all necessary documentation that results in a final determination of CSHCS eligibility. When application information is missing, the individual has 30 days from the date of the letter sent from MDHHS requesting the missing information to submit* the information in order to preserve the initial effective date of coverage. If the information is not submitted within 30 days, the effective date of coverage may be retroactive up to six (6) months from the date the required information has been submitted. Retroactive coverage does not guarantee that providers of services already rendered will accept CSHCS payment.

CSHCS does not reimburse families directly for payments made to providers. Families/individuals are required to provide complete and accurate information at the time of application and as circumstances change. At a minimum, changes in address and insurance must be reported as they occur.

***Submission date is considered the date the document is received by CSHCS.**

10.2 Coverage Period

Upon completion of the application or renewal process requirement, CSHCS coverage is typically issued in 12-month increments. All coverage periods end on the last day of a month, or the beneficiary's 26th birthday if the beneficiary does not have a qualifying diagnosis that is covered beyond age 26.

10.2-A Medicaid/MIChild/Healthy Michigan Plan

Beneficiaries are required to apply for MIChild/Healthy Kids/Healthy Michigan Plan coverage when the Income Review/Payment Agreement (MSA-0738) indicates the beneficiary may be eligible for one of these programs based on age and family income. The Income Review/Payment Agreement is submitted at the time of the initial CSHCS application or

renewal (refer to the Payment Agreement subsection of the CSHCS chapter of the Medicaid Provider Manual**). A CSHCS temporary eligibility period (TEP) of 90 days is activated to allow the family time to complete the MIChild/Healthy Kids/Healthy Michigan Plan application process.**

Upon notification that the family has completed the MIChild/Healthy Kids/Healthy Michigan Plan application process, CSHCS coverage is extended to complete the full 12-month enrollment period from the initial coverage date (begin date of the TEP), regardless of the MIChild/Healthy Kids/Healthy Michigan Plan eligibility decision. CSHCS coverage terminates at the end of the 90-day TEP if the family fails to submit the application for one of these programs. The payment agreement is still in effect even if coverage ends after the 90-day TEP. If the family completes the application for MIChild/Healthy Kids/Healthy Michigan Plan after the TEP has ended, coverage can be extended to a full 12-month enrollment period.

Families/clients are not required to apply for Medicaid/ MIChild/Healthy Michigan Plan coverage when:

It can be documented that a family previously applied for Medicaid/MIChild/Healthy Michigan Plan coverage within 90 days prior to submission of the Income Review/Payment Agreement (MSA-0738) to CSHCS
An adult client has Medicare and falls into the $120 payment agreement category

A TEP will not be activated for the cases described above. CSHCS coverage is issued for the full 12-month enrollment period.

Most clients who have both CSHCS and Medicaid or MIChild coverage are required to enroll in a Medicaid/MIChild Health Plan or Healthy Michigan Plan.

When a client is eligible for CSHCS and is already enrolled in a Medicaid or MIChild Health Plan, or Healthy Michigan Plan, the client remains in the Medicaid/MIChild Health Plan or Healthy Michigan Plan and is automatically enrolled with CSHCS.

10.3 Partial Month Coverage

If a beneficiary enters or leaves a facility that is not a covered facility (e.g. nursing facility or intermediate care facility) during a month of eligibility, the

beneficiary remains a beneficiary for the remainder of that month. However, services provided to the beneficiary while in the facility are not covered (i.e., reimbursable) by CSHCS as these facilities are responsible for providing the medical care. (Refer to the General Information for Providers Chapter in the MPM manual **for additional information for beneficiaries who also have Medicaid coverage.)**

10.4 Incarceration or Juvenile Detention Facility

When a CSHCS client resides in an incarcerating facility or juvenile detention facility, the client remains enrolled in CSHCS. For CSHCS clients who also have Medicaid coverage, CSHCS follows Medicaid policy regarding coverage of persons who are inmates in an incarcerating facility (see the Beneficiary Eligibility Section of the Medicaid Provider Manual). For clients who only have CSHCS coverage, the client remains CSHCS enrolled but is required to access care through the authorized providers on the client's file for services to be reimbursed.

10.5 Service Delivery

The fee-for-service (FFS) system is the method of reimbursement for service delivery for some CSHCS clients. CSHCS coverage is limited to specialty health care services for the client's CSHCS qualifying diagnosis(es). Physicians, dentists, hospitals, and selected ancillary providers must be authorized on the CSHCS client's file. Providers must obtain authorization for some services (e.g. medical equipment and supplies) as required per Medicaid policy.

Clients enrolled in a Medicaid or MIChild Health Plan must contact the plan for any changes in authorized providers. For clients not enrolled in a Medicaid or MIChild Health Plan, the LHD should be the point of contact any time a family/client desires a change to the authorized provider list. The LHD notifies CSHCS of the requested change through a Notice of Action from Local Health Department (MSA-0730-B). The information submitted must include the provider name, address, phone number and specialty, provider ID number, and provider type (if known). Requests to add or change providers are forwarded to the analyst for appropriate action.

Clients with additional coverage (e.g. Medicaid, MIChild, Healthy Michigan Plan, private insurance, etc.) receive primary care, well child visits, immunizations, etc. through that source of coverage.

10.6 Renewal of Coverage

The beneficiary's coverage may be renewed as needed if all eligibility criteria continue to be met and the family completes the renewal process. Medical review reports are required according to the timeframes established based on the primary diagnosis for the beneficiary. An annual financial review is also required. If all of the criteria continue to be met for CSHCS coverage, a new coverage period is typically issued in 12-month increments. Clients required to apply for Medicaid/MIChild/Healthy Michigan Plan will receive coverage as described in the Coverage Period subsection within this section.
Renewal information may be submitted after the CSHCS coverage period has already ended.

When the information required for renewal of CSHCS coverage is submitted within one (1) year of the date CSHCS coverage ended or lapsed and the client remains eligible for CSHCS, CSHCS coverage may be renewed a maximum of two (2) months retroactively from the month renewal information is received. When the information required for renewal of CSHCS coverage is submitted more than one year after the date CSHCS coverage ended, the case is considered new and the family must re-apply for CSHCS coverage.

The LHDs assist with providing updated information to CSHCS during the annual renewal period, or any time a change occurs during the client's eligibility period. Updates may be submitted on the CSHCS Annual Information Update form, or the Notice of Action from Local Health Department form (MSA 0730-B). The LHDs may also assist families in obtaining renewal medical information and in completing the financial assessment if required for renewal of CSHCS coverage. If the client is enrolled in a Medicaid, MIChild or Healthy Michigan Plan, the LHD must coordinate with the health plan.

10.7 Medical Renewal Period

The CSHCS medical renewal period is established at one year, two years, three years, or five years, depending upon the CSHCS primary diagnosis. Medical reports for renewal of coverage (refer to the Renewal of Coverage subsection within this section) are required consistent with the time frames indicated by the CSHCS medical renewal period.

When the beneficiary has more than one CSHCS qualifying diagnosis, the diagnosis determined by MDHHS to be primary is used to determine the time

interval for required medical information to be submitted for all covered diagnoses. This results in a single periodic medical review process per beneficiary. When the medical review process results in the elimination of one of the qualifying diagnoses while maintaining another diagnosis, the new coverage period is based on the time frame associated with the new primary diagnosis.

Example: Beneficiary has three diagnoses, each related to a different medical review period. All new medical information is required according to the medical renewal time period of the primary diagnosis.

A change of primary diagnosis during the medical renewal period does not change the time period unless and until the current medical renewal period has been completed and a new one is established.

10.8 CSHCS Annual Review Process

The Public Health Code and CSHCS program policy mandate the periodic review of medical reports and financial assessment to determine ongoing program eligibility and level of financial participation. The CSHCS annual review process documents continued medical eligibility for the CSHCS program, re-establishes family/client level of financial participation for program services, and provides updated client information to the CSHCS program.

The LHD assists CSHCS in conducting the annual review of each client prior to the end date of the client's current CSHCS coverage period. The information required for the annual review may be different for each client depending on the circumstances.

The annual review process may consist of any or all of the following:

- Annual Update: **Beneficiaries are requested to provide updated information during the annual renewal of the coverage period regarding current providers, address, other insurance, etc.**
- Annual Financial Review: **Families/beneficiaries are required to provide updated financial information during the annual renewal of the coverage period to determine financial participation with the CSHCS Program. Those with Medicaid, MIChild or Healthy Michigan Plan coverage are determined complete in the annual financial review each year those**

circumstances remain true. Existing MDHHS program eligibility records are used in lieu of the financial assessment form whenever possible.

10.8-A Chronological Description of the CSHCS Annual Review Process

6th Month before CSHCS Coverage Ends

Health plans start the process for CSHCS renewal.

4th Month Before CSHCS Coverage Ends

- CSHCS system checks for Medicaid or MIChild eligibility. If any of these conditions exist on the date of the match, a new Income Review/Payment Agreement (MSA-0738) is not required for renewal of coverage.

3rd Month Before CSHCS Coverage Ends:

- LHD prints a report from the CSHCS system of all clients whose CSHCS coverage ends in three months.
- The LHD contacts every family by mail or telephone to obtain updated client information (e.g. address, insurance, providers, care needs, etc.). Updates may be submitted on a Notice of Action from Local Health Department (MSA-0730-B)
- If a copy of an annual update form is used to report changes, the LHD must highlight the areas of change before submitting to CSHCS.
- The LHD should electronically report insurance information to Third Party Liability if the information has changed.
- CSHCS sends a packet to the family/client only if income review and/or medical reports are needed. The packet may include any or all of the following:
  - Release to Obtain Medical Information (MSA-0838) for each marked diagnosis that requires review
  - Income Review/Payment Agreement (MSA-0738) and current CSHCS Payment Agreement Guide (MSA-0738-B)
  - A return envelope (only if income review is needed)

Month Before CSHCS Coverage Ends:

- LHD prints the Renewal Follow-Up Report listing clients for whom CSHCS still needs medical and/or financial information. The LHD is to follow-up with each client or family to obtain the needed information.

Month CSHCS Coverage Ends:

- CSHCS system creates a new coverage period for clients whose income review status is "complete" and whose medical eligibility status is "eligible" for at least one CSHCS qualifying diagnosis. The coverage period is typically 12 months. If a client is aging out of the CSHCS program, client coverage will only extend through the day before the client's 26th birthday
- CSHCS system generates a "Beneficiaries Not Renewed" report for the LHD. The report contains the names of clients whose CSHCS coverage ends at the end of the month and the reason(s) a new coverage period was not created. If CSHCS receives the required information within 60 days of the CSHCS coverage end date, CSHCS coverage is renewed retroactively to the coverage end date.
- CSHCS sends an Enrollment Close Out letter to the client whose CSHCS coverage expires at the end of the month and for whom a new coverage period was not created. The letter states the reason(s) CSHCS coverage was not renewed and provides information regarding appeals.
- CSHCS sends a Diagnosis Close Out letter to the client whose CSHCS coverage was renewed, but for whom one or more CSHCS qualifying diagnosis(es) were not renewed.

All coverage periods end on the last day of a month, or the beneficiary's 26th birthday if the beneficiary does not have a qualifying diagnosis that is covered beyond age 26.

10.9 Termination of Coverage

Clients enrolled in Medicaid cannot request termination of CSHCS, however, they can decline the use of CSHCS benefits. CSHCS coverage may be terminated before the current eligibility period has ended. Reasons for termination of coverage include, but are not limited to, the following:

- Family request (when the client is not enrolled in Medicaid/MIChild/Healthy Michigan Plan)
- Family moved out of state and does not meet any of the required circumstances to maintain coverage
- Client no longer meets medical eligibility criteria
- Medical information or financial information was not submitted for renewal of coverage
- Two outstanding payment agreements

- Client turned 26 years and does not have a CSHCS diagnosis that is covered beyond age 26.
- Client resides in a long-term care facility (nursing home, psychiatric hospital, intermediate care facilities for individuals with an intellectual disability, etc.)
- Client died

When CSHCS coverage is terminated (except for cases where the client has turned 26 or has died), the client receives a Close Out letter from CSHCS which includes CSHCS coverage end date, the reason for termination of coverage, and the client's right to appeal the decision.

CSHCS clients who age out of the program (reached the age of 26 years) do not receive a Close Out letter when CSHCS coverage ends. They receive a letter stating that CSHCS coverage is ending and the client should prepare for the transition.

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SECTION 11: PAPER VERIFICATION OF CSHCS ENROLLMENT

The provider must verify eligibility using the CHAMPS eligibility inquiry. Any clearinghouse vendor that the provider chooses to use can receive eligibility data from CHAMPS by enrolling in CHAMPS as a billing agent. Providers must then associate themselves with the clearinghouse vendor as the billing agent through the CHAMPS Provider Enrollment subsystem.

11.1 The Mihealth Card

The mihealth card is a plastic magnetic strip identification card issued once to each beneficiary. The front of the card contains the beneficiary's name and beneficiary ID number. When a client becomes enrolled in CSHCS, a mihealth card is issued. **The mihealth card does not contain eligibility information and does not guarantee eligibility until verified using the CHAMPS eligibility inquiry. The provider can use the mihealth card to access a beneficiary's eligibility information using the CHAMPS Eligibility Inquiry by entering the beneficiary ID number or swiping the card using a magnetic strip reader.**
If the beneficiary has lost his mihealth card, a replacement card may be issued by contacting the Beneficiary Help Line.

11.2 Client Eligibility Notice (CEN)

The Client Eligibility Notice is a paper document that is automatically generated and mailed to CSHCS clients each time a change occurs in CSHCS eligibility or provider information. The information that appears on the Client Eligibility Notice can be used to verify CSHCS eligibility using the CHAMPS eligibility inquiry.
The following information appears on the Client Eligibility Notice specifically as indicated below:

Legally Responsible Party name and address
Client name
Date of birth
Eligibility dates
County
Client ID number
Listing of CSHCS authorized hospitals, physicians, and dentists (not all provider types are required to appear on the authorized provider list)
CSHCS qualifying diagnosis the provider is authorized to treat
Provider type and specialty

Dates of provider's authorization period

Clients may receive multiple Client Eligibility Notices. Clients are encouraged to review each Client Eligibility Notice to ensure that the provider information is correct (e.g., no error made in end dating provider).

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SECTION 12: CSHCS MEDICAL SERVICES COVERAGE

CSHCS covers services that are medically necessary, related to the beneficiary's qualifying diagnosis(es), and ordered by the beneficiary's CSHCS authorized specialist(s) or subspecialist(s). Services are covered and reimbursed according to Medicaid policy unless otherwise stated in this chapter. Refer to the specific chapter of the Medicaid Provider Manual for current detailed information regarding coverage and prior authorization requirements.

NOTE: When a CSHCS enrollee also has Medicaid coverage and needs a service that is covered by both programs, the Medicaid coverage, benefits, and rules take precedence over CSHCS. Any additional benefits available to the individual through CSHCS coverage are allowed and provided according to CSHCS policy.

NOTE: All CSHCS clients without other insurance coverage are eligible for influenza and COVID-19 vaccines regardless of diagnoses.

The primary CSHCS benefits may include:

- **Ambulance**
- **Care Coordination***
- **Case Management***
- **Dental (Specialty and General)**
- **Dietary Formulas (limited)**
- **Durable Medical Equipment (DME)**
- **Emergency Department (ED)**
- **Hearing and Hearing Aids**
- **Home Health (intermittent visits)**
- **Hospice***
- **Hospital at approved sites (Inpatient/Outpatient)**
- **Laboratory Tests**
- **Medical Supplies**
- **Monitoring Devices (Nonroutine)**
- **Office Visits to CSHCS Authorized Physicians**
- **Orthopedic Shoes**
- **Orthotics and Prosthetics**
- **Parenteral Nutrition**
- **Pharmacy**
- **Physical/Occupational/Speech Therapy**
- **Radiological Procedures**

- **Respite***
- **Telemedicine**
- **Transplants and Implants**
- **Vision**

(*Refer to the information and authorization requirements stated in the Benefits section of the CSHCS chapter of the Medicaid Provider Manual.)

Private Duty Nursing (PDN) may be available for beneficiaries who also have Medicaid coverage. Questions regarding the possibility of a CSHCS client becoming Medicaid eligible through the Tax Equity and Fiscal Responsibility Act (TEFRA) should be directed to the CSHCS regional nurse.

12.1 Dental Benefits

General and specialty dental services can be covered when related to the CSHCS qualifying diagnoses for which CSHCS covers dental care. Some dental services require prior authorization. See the Dental Chapter of the Medicaid Provider Manual for coverage and prior authorization requirements.

12.1-A General Dental Benefits

General dentistry refers to services covered under the Medicaid dental benefit that may be covered for CSHCS enrollees who have a qualifying diagnosis that includes general dental services. Examples include, but are not limited to, diagnostic, preventive, restorative, endodontia, prosthodontia, and oral surgery. MDHHS may determine a beneficiary eligible for certain general dentistry services when the CSHCS qualifying diagnosis is related to conditions eligible for this coverage as identified below:

- **Chemotherapy or radiation which results in significant dental side effects**
- **Cleft lip/palate/facial anomaly**
- **Convulsive disorders with gum hypertrophy**
- **Cystic Fibrosis**
- **Hemophilia and/or other coagulation disorders**
- **Pre- and post-transplant**

To request approval as a CSHCS General Dentistry provider, dentists must contact MDHHS. (Refer to the Directory Appendix for contact information.)

NOTE: Hospital charges (e.g., general anesthesia, facility charges, etc.) may be covered for dental services provided through the inpatient or outpatient

hospital facility for beneficiaries with certain CSHCS diagnoses even though CSHCS does not cover the dental care itself.

12.1-B Specialty Dental Benefits

Specialty dentistry refers to services that are not covered under the Medicaid dental benefit but are covered for CSHCS enrollees who have a qualifying diagnosis that may include specialty dental services. Services include, but are not limited to, dental implants, orthodontia and specialty crown and bridge. All CSHCS beneficiaries do not qualify for specialty dental services. Qualification for specialty dental services is based on the specific diagnoses and treatment plan for which CSHCS covers specialty dental services**.** Eligibility criteria for orthodontic treatment, prior authorization requirements, and billing/reimbursement procedures for providers/specialists providing services to CSHCS clients are described in the CSHCS section of the Dental chapter of the Medicaid Provider Manual.

Examples of CSHCS diagnoses that may qualify for specialty dental services include:

- **Amelogenesis imperfecta, Dentinogenesis imperfecta**
- **Anodontia which has significant effect of function**
- **Cleft palate**
- **Ectodermal dysplasia or epidermolysis bullosa with significant tooth involvement**
- **Juvenile periodontosis**
- **Juvenile rheumatoid arthritis and related connective tissue disorders with jaw dysfunction secondary to temporomandibular joint arthritic involvement**
- **Post-operative care related to neoplastic jaw disease**
- **Severe malocclusion requiring orthognathic surgery**
- **Severe maxillofacial or craniofacial anomalies that require surgical intervention**
- **Traumatic injuries to the dental arches**

To request approval as a CSHCS specialty provider, dentists must contact MDHHS to initiate the process of enrolling as a Medicaid provider. If the dentist is already enrolled as a Medicaid provider, the dentist or family can contact the LHD to be authorized for a specific client. Authorization of orthodontic treatment requires a treatment plan submitted to, and approved by, Prior Authorization and the Office of

Medical Affairs separately from CSHCS medical eligibility. Please refer to the Orthodontic Services subsection of the Dental chapter of the Medicaid Provider Manual for more information.

12.2 Pharmacy Benefits Manager

MDHHS retains all decisions for policy, coverage, and reimbursement, and contracts with a pharmacy benefits manager (PBM). PBM services provided include pharmacy claims payment (paper and electronic), claims instruction, prior authorization (PA), prospective drug utilization, retrospective drug utilization, clinical consultation, provider information lines, and Maximum Allowable Cost (MAC) rate setting. The PBM is responsible for processing prior authorization requests for prescription drugs. Denials of such requests are subsequently reviewed by a CSHCS medical consultant.

The PBM website contains the:

- **Pharmacy Claims Processing Manual for Michigan Medicaid**
- **Michigan Pharmaceutical Product List (MPPL)**
- **Preferred Drug List (PDL)**
- **Drug Utilization Review (DUR) Meeting Notices**
- **Does Optimization Program**
- **Pharmacy and Therapeutics (P&T) Committee Meeting Notices**
- **Pharmacy Forms**
- **Maintenance Drug List**

Pharmacies may call the PBM with questions or concerns. Beneficiaries may call the PBM Beneficiary Helpline.

MDHHS employs a contractor to serve as the MDHHS Pharmacy Benefits Manager (PBM). CSHCS clients may obtain prescription drugs from any pharmacy enrolled with the contractor. Other contractor responsibilities include enrollment of pharmacies desiring to participate in the program, claims reimbursement, resolution of billing issues, maintaining the Michigan Pharmaceutical Product List (MPPL) and the Preferred Drug List (PDL), and reimbursement of mandatory mail order pharmacy co-pays. Pharmacies may call the PBM with questions or concerns; clients may call the PBM Beneficiary Helpline.

12.3 Diaper and Incontinence Supplies Contractor (J & B Medical)

As required by Public Act 131 of 2009, for dates of service on or after December 1, 2009, selected incontinence supplies are only available to CSHCS clients who also have Medicaid coverage. Refer to the DME Chapter of the Medicaid Provider Manual for a complete list of incontinence supplies and coverage information.

CSHCS clients who are also enrolled in Medicaid and who require catheter supplies related to the CSHCS qualifying diagnosis must obtain these items through the MDHHS contractor. The contractor conducts a nursing assessment on each new client to determine the specific product and appropriate quantity that will best meet the client's needs. The contractor is responsible for shipping the monthly supply of product to the client's home.

12.4 Vision Contractor (Classic Optical)

MDHHS employs a contractor to serve as the sole source provider for frames and lenses. CSHCS clients who have a qualifying diagnosis which includes coverage for glasses must obtain these services through the contractor. Local optical companies or optometrists may agree to complete the necessary forms for ordering frames and lenses on behalf of the client. The optical company or optometrist is paid a dispensing fee for providing this service.
Optical companies and optometrists must be added to the client's authorized provider list before billing MDHHS for the dispensing fee.

12.5 Commonly Requested Non-Covered Services

Some of the commonly requested services that are not covered by CSHCS are as follows:

Infertility treatment including sperm/ovum storage
Mental health services
Substance abuse treatment services
Experimental care (any procedure or service which is not generally accepted treatment among specialists who treat the condition)

Guidance Manual for Local Health Departments

SECTION 13: CARE COORDINATION

CSHCS Care Coordination services are provided to the client or family to promote continuity of care, appropriate use of services, and the development of independence and maximum potential.

Beneficiaries enrolled in CSHCS with identified needs may be eligible to receive Care Coordination services.

Care Coordination services may be provided by the local health department. LHD staff includes registered nurses (RNs), social workers, or paraprofessionals under the direction and supervision of RNs. Staff must be trained in the service needs of the CSHCS population and demonstrate skill and sensitivity in communicating with children with special needs and their families.

Care Coordination is not reimbursable for beneficiaries also receiving Case Management services during the same LHD billing period, which is usually a calendar quarter. In the event Care Coordination services are no longer appropriate and Case Management services are needed, the change in services may only be made at the beginning of the next billing period.

Families/beneficiaries can contact the LHD for assistance in obtaining Care Coordination services.

Local Health Departments (LHDs) must meet the following Care Coordination requirements:

- Demonstrated experience in coordinating and linking clients to community resources as required for the CYSHCN population
- An administrative capacity to ensure community accepted levels of service quality
- A financial management capacity and system that provides documentation of services and costs
- Capacity to build and maintain individual case records in accordance with state requirements and accepted standards of record retention

Guidance Manual for Local Health Departments

13.1 Requirements for Care Coordination Services

CSHCS Care Coordination is to be provided as needed and paid to only one LHD. However, certain Care Coordination services, as described in LHD contracts, are still required of the LHD and reimbursable even when the family/client is receiving Care Coordination services from a non-LHD provider. When more than one provider of Care Coordination is assisting a family, coordination of services is required.

There are two levels of CSHCS Care Coordination (Level I and Level II) that may be provided when needed and the family/client agrees to the services.

13.1-A Level I Plan of Care

The Level I plan of care is a client-specific, comprehensive care/service plan document that must be developed by a registered nurse or licensed social worker in partnership with the family/client. Input from the CSHCS program representative, the primary care provider, and other involved parties is encouraged.

The plan of care must include the following elements:

Client summary/assessment, which includes:
Client's name, date of birth, recipient ID, address, telephone, parent(s)/guardian(s) name and contact information
Client's CSHCS qualifying diagnosis(es)
All other significant health concerns or needs
Client's insurance coverage
Medical, social, educational, and functional strengths and/or needs
Date the plan of care was developed and date(s) the plan of care was updated
The Family Phone Line (FPL) number
Complete listing of current medical care providers and pharmaceuticals, and all equipment in use or intended to be acquired
Family status summary
Dated list of each problem/concern
Corresponding problem-specific goals unique to each client, with family input
Identification of appropriate interventions and designation of person who will provide each intervention, including transitions
Periodic evaluation with dated documentation of progress towards goal achievement or barriers encountered.

Elements from an external care coordinator or case manager may satisfy some of the required elements. However, the plan of care must include unique elements identified by the LHD to be considered a billable service.

The family/client signature indicates participation in, and agreement with, the plan of care. Family signature via email agreement or other electronic means is allowable. When documented good faith efforts to acquire the original or electronic signature have failed, the family/client may give verbal approval for the care coordinator to sign on their behalf.

A signed consent to release protected health information (PHI) must be obtained from the family/client in order to share the plan of care with the identified primary care provider, subspecialists, school, etc. The family/client signature area can include the agreement to release information to other providers/entities or the release can be completed separately.

The Level I plan of care is a client-specific, comprehensive care/service plan developed once within an eligibility year. Needed revisions during the year may be considered a Level II. A Level I plan may occur more often based upon the professional judgment of the registered nurse (RN) or licensed social worker who is evaluating the needs of the family/client. LHD staff must request an exception identifying the reason and circumstances that resulted in a need for an additional Level I within the same eligibility year.

A Level I may be created with a client in a Medicaid Health Plan. The LHD should collaborate and coordinate care planning with the Medicaid Health Plan. The LHD should not provide any services that are duplicative of services the family is receiving through the Medicaid Health Plan. Information from the Medicaid Health Plan care plan might satisfy some of the required elements of the LHD plan of care. A plan of care completed by the LHD that includes information provided by the Medicaid Health Plan is billable as a Level I plan of care, as long as there are unique elements in the plan of care identified by the LHD.

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13.1-B Level II Care Coordination

Level II services must be provided by a registered nurse (RN), social worker, or paraprofessional under the direction and supervision of an RN. Level II consists of interaction with the family/client and others involved in the care of the client by telephone, in-person, or in writing. Level II activities include, but are not limited to, arranging for service delivery from CSHCS qualified providers, client advocacy, assisting with social, education or other support services, facilitating transitions, assisting clients moving into or out of a Medicaid Health Plan, and assisting with applications for the Children with Special Needs (CSN) Fund. In addition, these services must:

Be substantial (greater than simple information sharing) and
Beyond the scope of base funding (See Case Management/Care Coordination Guide in Section 15 of this Guidance Manual)

Clients are eligible for a maximum of fifteen (15) Level II units per eligibility year. Any services beyond fifteen require prior approval by MDHHS by submitting a detailed request, including the rationale for additional services, to the Regional Nurse Consultant.

13.2 Payment for Care Coordination

Care coordination is paid through the Financial Status Report (FSR) system based on the "fixed unit rate" method.

Annual Level I in the home or home-like setting that requires the care coordinator to travel to a non-LHD site: $165.00

Annual Level I plan of care over the telephone or face-to-face at the LHD: $110.00

- The plan of care may only be developed and billed when the family/client participates in the process.

Level II care coordination: $33.00 per unit

- A maximum of fifteen (15) units per client per eligibility year are payable.
- Refer to Case Management/Care Coordination Guide for assistance in determining the services that are considered Level II (The Case Management/Care Coordination Guide is located in Section 15 of this Guidance Manual).

To be paid, care coordination services must be logged into the state automated system. The unit rates associated with the services rendered for both Level I and Level II Care Coordination must be detailed on the CSHCS Case Management and Care Coordination Supplemental Attachment and attached to the FSR.

Care coordination cannot be billed for clients also receiving case management services during the same billing quarter. In the event care coordination services are no longer appropriate and case management services are needed, the change in services may only be made at the beginning of the next billing quarter.

13.3 Collaboration with Other Care Coordinator or Case Manager

Some families receive CSHCS care coordination or case management through providers other than those in the LHD. The LHD should not provide any services that are duplicative of services the family is receiving through these other providers. The LHD should coordinate with the other care coordinators and case managers to assure no duplication of services occurs.

Documentation

Interaction with or on behalf of the client/family must be documented, even if included in base funding and not separately billed. Documentation of types of activities, staff involvement, and resolution must be maintained in the LHD client file. This documentation must include at a minimum:

Dates of activities
Persons involved
Activities
Resolution or follow-up plan
Staff identifier

These records must be maintained following MDHHS approved record retention guidelines and be available for review and audit/accreditation purposes. Care coordination documentation will be randomly reviewed by MDHHS to monitor overall compliance with program requirements.

13.4 Care Coordination after the Death of the CSHCS Client

In the event of the death of a person who was enrolled or eligible to enroll in CSHCS, the family can continue to receive Level II services for up to six (6) months following the death (maximum of four units). Care coordination services should be provided in conjunction with the family and other support services providers. Services may include but are not limited to:

Assistance with funeral arrangements
Notification of physicians and providers
Cancellation of appointments
Arranging for the disposition of durable medical equipment (DME) from the home
Assisting the family to arrange bereavement/counseling services
Consolidation of billing information to facilitate correct responses to billers/agency staff
Development of community support services following the departure of the many health professional services

When care coordination is continued after death, the LHD should note the client's date of death and a brief statement of the family needs in the LHD client file.

13.5 Care Coordination after CSHCS Client Ages out of CSHCS

When a client's CSHCS enrollment ends the day before the 26th birthday, the client/family can continue to receive Level II services up to six (6) months following the 26th birthday (maximum of four units). Care coordination services should be provided in conjunction with the family and other support services providers. Services may include but are not limited to:

- Assistance with billing problems
- Identification and transition to adult providers
- Assistance with transition to ancillary providers (pharmacy, DME, etc.)
- Development of community support services for adults with special health care needs

When care coordination is continued after aging out of CSHCS, the LHD should note a brief statement of the client/family needs in the LHD client file.

Guidance Manual for Local Health Departments

SECTION 14: CASE MANAGEMENT

Families/clients eligible for case management services have complex medical care and/or complex psycho-social needs (documented in the LHD client file) that would benefit from intervention, direction, and action provided by an outside, independent professional. CSHCS Case Management services are provided to the client/family to promote continuity of care, appropriate services, and development of independence and maximum potential.

Beneficiaries with either CSHCS, CSHCS and Medicaid, or Medicaid only (no CSHCS) may be eligible to receive Case Management services if they have a CSHCS medically eligible diagnosis, complex medical care needs and/or complex psychosocial situations which require that intervention and direction be provided by an outside, independent professional. LHDs or approved contractors may provide Case Management services. When there is additional training criteria required to perform a specific Case Management role based upon the service being provided (e.g., Elevated Blood Lead services), the provider of the service must be trained and certified, and services must be performed according to the training and requirements specific to that role. Case Management requires the development of a comprehensive plan of care (POC) which meets the minimum elements, as determined by MDHHS, and is monitored/revised as necessary. All services must relate to objectives/goals documented in the POC.

Case Management services address complex needs and services and include an initial in-person encounter with the beneficiary/family. Case Management requires that services be provided in the home setting or other non-office setting based on family preference. It is expected that in-person assessments are performed annually, however, the frequency should be based on the needs and circumstances of the individual/family. Subsequent units may be billed after the initial encounter when conducting follow up with the beneficiary/family, without home setting restrictions. **Beneficiaries are eligible for a maximum of six billing units per eligibility year**, to be used at any time as deemed appropriate by case manager**. Services above the maximum of six require prior approval by MDHHS. To request approval, the Case Management provider must submit an exception**

request, including the rationale for additional services, to MDHHS. Limitations on the need for and number of Case Management service units are set by MDHHS and must be provided by a specific Case Management role, in accordance with training and certification requirements and as specified by the rules within that service type.

Each case manager must be licensed to practice as a registered professional nurse in the State of Michigan and be employed by or contracted with a LHD as a Public Health nurse at the entry level or above, or be able to demonstrate to MDHHS that comparable qualifications are met.

Case Management and Care Coordination services within a specific Case Management role cannot be billed during the same LHD billing period, which is usually a fiscal quarter.

Families/beneficiaries can contact the LHD for assistance in obtaining Case Management services.

Note: The information contained below (to the sub-title Targeted Case Management Services) includes language directly from the most current Medicaid State Plan under Title XIX of the Social Security Act; Supplemental 1 to Attachment 3.1-A; Target Group D (Pages 485-489).

14.1 Targeted Case Management Services

Those eligible to receive Case Management services include persons enrolled in CSHCS or Medicaid with an identified need for case management services who are:

1. Aged 0-25 with a Michigan Department of Health and Human Services (MDHHS), Children's Special Health Care Services (CSHCS) medically eligible diagnosis, or
2. SSI-Disabled Children's Program clients 0-16, or
3. Aged 26 and over with either cystic fibrosis, coagulation defects, or hereditary red blood cell disorders commonly known as sickle cell disease

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Targeted Case Management Service Providers

1. Case Management provider organizations must be certified by the single state agency as meeting the following criteria:
   a. Currently enrolled as a MI Medicaid Provider
   b. Demonstrate a capacity to provide all core elements of case management services including:
      - Comprehensive client assessment
      - Comprehensive care/service plan development
      - Linking/coordination of services
      - Monitoring and follow-up of services
      - Reassessment of the client's status and need
   c. Demonstrated case management experience in coordinating and linking such community resources as required by the target population
   d. Demonstrated experience with the target population
   e. A sufficient number of staff to meet the case management service needs of the target population
   f. Willingness and capability to coordinate with the individual's Medicaid Health Plan, if applicable, to maximize effectiveness and avoid duplication of services.
   g. An administrative capacity to ensure quality of services in accordance with state and federal requirements
   h. A financial management capacity and system that provides documentation of services and costs
   i. Capacity to document and maintain individual case records in accordance with state and federal requirements
2. A case manager must be:
   a. Licensed to practice as a registered professional nurse in the State of Michigan and be employed by, or contracted with, a local health department at the entry level or above or
   b. Able to demonstrate to MDHHS that comparable professional qualifications are met.

14.2 Procedures for Case Management Services

The plan of care for a client receiving case management is a client-specific, comprehensive care/service plan document that must be developed by a public health nurse (or comparable professional qualifications) in partnership with the family/client. Input from the CSHCS program representative, the primary care provider, and other involved parties is encouraged.

The plan of care must include the following elements:

- Client summary/assessment
- Client's name, date of birth, recipient ID, address, telephone, parent(s)/guardian(s) name and contact information
- Client's CSHCS qualifying diagnosis(es)
- All other significant health concerns or needs
- Client's insurance coverage
- Medical, social, educational, and functional strengths and/or needs
- Date the plan of care was developed and date(s) the plan of care was updated
- The Family Phone Line number
- Complete listing of current medical care providers, pharmaceuticals and all equipment in use or intended to be acquired
- Family status summary
- Dated list of each problem/concern
- Corresponding problem-specific goal(s) unique to each client, with family input
- Identification of appropriate intervention(s) and designation of person who will provide each intervention, including transitions
- Periodic evaluation with dated documentation of progress towards goal achievement or barriers encountered

Elements from an external care coordinator or case manager may satisfy some of the required elements. However, the plan of care must include unique elements identified by the LHD to be billable. When case management services are provided to siblings, each sibling must display unique individual issues separate from whole family issues to bill case management units for each.

A Plan of Care (POC) template can be found through the CSHCS Guidance Manual website.

The family/client signature indicates participation in and agreement with the plan of care development. Family signature via email agreement or other electronic means is allowed. When documented good faith efforts to acquire the original or electronic signature have failed, the family/client may give verbal approval for the case manager to sign on their behalf.

A signed consent to release protected health information must be obtained from the family/client in order to share the plan of care with the identified primary care provider, subspecialists, schools, etc. The family/client signature area can include the agreement to release information to other providers and organizations, or the release can be done separately.

A Home Environment Needs Survey is an important tool that can be used, especially with families/clients requiring essential life support services and/or equipment for medical treatment at home.

Clients are eligible for a maximum of six (6) case management units per client eligibility year. Any services beyond six units require prior approval by MDHHS by submitting a detailed request, including the rationale for additional services, to the regional nurse consultant.

14.3 Payment for Case Management Services

Case management is paid through the Financial Status Report (FSR) system based on the "fixed unit rate" method. The fee for case management is $221.74 per set of services constituting a unit, which requires that services be provided primarily face-to-face with the initial encounter occurring in-person. Although some activities contained within the set of services will best be performed via telephone or other method, at least one (1) case management encounter per year must occur in-person in the home or other non-LHD setting, based on family preference. Case management service payment includes the cost of travel, plan of care development or update, planning, documentation, completion of the Home Environment Needs Survey, and service coordination.

To be paid, the unit rate associated with the services rendered must be included on the CSHCS Case Management and Care Coordination Reimbursement Documentation Supplemental Attachment to the Financial Status Report (FSR).

Case management cannot be billed for clients also receiving Level I or Level II Care Coordination services during the same billing quarter. If case management services are no longer required, but Level II services would be of assistance, converting from case management to care coordination is allowable at the beginning of the next billing quarter.

14.4 Collaboration with Other Care Coordinator or Case Manager

Some families receive CSHCS care coordination or case management through providers other than those in the LHD. The LHD should not provide any services that are duplicative of services the family is receiving through these other providers. The LHD should coordinate with the other care coordinators and case managers to ensure no duplication of services occurs.

Documentation

Interaction with or on behalf of the client/family must be documented, even if included in base funding and not separately billable. Documentation of types of activities, staff involvement, and resolution must be maintained in the LHD client file. This documentation must include at a minimum:

Dates of activities
Persons involved
Activities
Resolution or follow-up plan
Staff identifier

These records must be maintained following approved record retention guidelines and be available for review and audit/accreditation purposes. Case management documentation will be randomly reviewed by MDHHS to monitor overall compliance with program requirements.

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The Case Management/Care Coordination Guide is located in Section 15 of this Guidance Manual.

SECTION 15: CASE MANAGEMENT/CARE COORDINATION GUIDE
CHILDREN'S SPECIAL HEALTH CARE SERVICES

CASE MANAGEMENT/CARE COORDINATION GUIDE – 11/21/2018

BASE FUNDING	CARE COORDINATION	CASE MANAGEMENT
	Actions and activities engaged with the client/family to promote continuity of care, appropriate services, and development of independence and maximum potential. Must be substantial, and beyond the scope of base funding.	Families/clients with complex medical care and/or complex psycho-social needs (documented in the LHD client file) that would benefit from intervention, direction and action provided by an outside, independent professional. Requires development or update of a written, individualized plan of care.
OUTREACH • Provide general program information to families, providers, public, other agencies • Arrange & authorize diagnostic referrals	**OUTREACH** • Coordinating referrals for eligible services/equipment, for client and/or other family members, identified in encounters with family (e.g. dental,	**OUTREACH** • Unusual to have case management for outreach activities alone. Documentation would need to describe a complex situation and the actions taken by the LHD.

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BASE FUNDING	CARE COORDINATION Actions and activities engaged with the client/family to promote continuity of care, appropriate services, and development of independence and maximum potential. Must be substantial, and beyond the scope of base funding.	CASE MANAGEMENT Families/clients with complex medical care and/or complex psycho-social needs (documented in the LHD client file) that would benefit from intervention, direction and action provided by an outside, independent professional. Requires development or update of a written, individualized plan of care.
• Request/submit medical information for eligibility determination • Annual contact with families in writing or of short duration not requiring complex follow-up • Promote awareness of CSHCS through presentations & other networking opportunities • Provide information on the Family Center • Assist with completion of CSHCS Application & Financial Assessment	community clinics, health insurance, therapy, preschool, etc.) • Researching alternative resources for family/client • Connecting family/client community resources • Tracking lost document submissions	

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BASE FUNDING	CARE COORDINATION	CASE MANAGEMENT
	Actions and activities engaged with the client/family to promote continuity of care, appropriate services, and development of independence and maximum potential. Must be substantial, and beyond the scope of base funding.	Families/clients with complex medical care and/or complex psycho-social needs (documented in the LHD client file) that would benefit from intervention, direction and action provided by an outside, independent professional. Requires development or update of a written, individualized plan of care.
forms, in-person or over the phone.		
ADVOCACY • Answering questions & listening to concerns families have to help them advocate on their own behalf (basic information sharing)	**ADVOCACY** • Intervention at school on behalf of a child regarding their specific health issues • Working with the school/ISD to get needed school services • Attending multidisciplinary meetings, wraparound, etc. • Helping families get large equipment items	**ADVOCACY** • Same as Care Coordination but as part of written plan of care. Case management requires at least one (1) face-to-face encounter, in the home or other non-LHD setting, during a billing quarter.

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BASE FUNDING	CARE COORDINATION	CASE MANAGEMENT
	Actions and activities engaged with the client/family to promote continuity of care, appropriate services, and development of independence and maximum potential. Must be substantial, and beyond the scope of base funding.	Families/clients with complex medical care and/or complex psycho-social needs (documented in the LHD client file) that would benefit from intervention, direction and action provided by an outside, independent professional. Requires development or update of a written, individualized plan of care.
	& troubleshooting equipment delays • Intervention to obtain needed social, education or other support services • Accompanying clients to appointments	
SERVICE DELIVERY • Referral and information for service delivery • Add/delete providers as indicated	**SERVICE DELIVERY** • Arranging service delivery from providers • Discharge planning • Coordinating services with multiple agencies	**SERVICE DELIVERY** • Same as care coordination but as part of written plan of care. Case management requires at least one (1) face-to-face encounter, in the home or other non-LHD setting, during a billing quarter.

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BASE FUNDING	CARE COORDINATION	CASE MANAGEMENT
	Actions and activities engaged with the client/family to promote continuity of care, appropriate services, and development of independence and maximum potential. Must be substantial, and beyond the scope of base funding.	Families/clients with complex medical care and/or complex psycho-social needs (documented in the LHD client file) that would benefit from intervention, direction and action provided by an outside, independent professional. Requires development or update of a written, individualized plan of care.
CHILDREN WITH SPECIAL NEEDS FUND • Describe Children with Special Needs Fund & provide information	**CHILDREN WITH SPECIAL NEEDS FUND** • Assist families with Children with Special Needs Fund applications including obtaining bids and follow-up	**CHILDREN WITH SPECIAL NEEDS FUND** • Unusual to have case management for Children with Special Needs Fund activities alone. Documentation would need to describe a complex situation and the actions taken by the LHD.
TRANSPORTATION • Describe and provide information regarding CSHCS transportation assistance and other resources	**TRANSPORTATION** • Arrange for in & out of state travel including special transportation and/or lodging	**TRANSPORTATION** • Unusual to have case management for transportation activities alone. Documentation would need to describe a complex situation and

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BASE FUNDING	CARE COORDINATION	CASE MANAGEMENT
	Actions and activities engaged with the client/family to promote continuity of care, appropriate services, and development of independence and maximum potential. Must be substantial, and beyond the scope of base funding.	Families/clients with complex medical care and/or complex psycho-social needs (documented in the LHD client file) that would benefit from intervention, direction and action provided by an outside, independent professional. Requires development or update of a written, individualized plan of care.
• Provide approved forms for CSHCS Non-Emergency Medical Transportation (NEMT) assistance	• Assist in obtaining reimbursement • Assist clients with Medicaid to obtain approval for NEMT assistance through the local MDHHS office, Medicaid Health Plan or contracted transportation broker	the actions taken by the LHD.
BILLING • Add providers • Quick answers to simple questions • Referral to Beneficiary Help Line	**BILLING** • Intervention on complex billing issues such as multiple contacts with patient accounts, collection agencies and/or the state office	**BILLING** • Unusual to have case management for billing activities alone. Documentation would need to describe a complex situation and

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BASE FUNDING	CARE COORDINATION	CASE MANAGEMENT
	Actions and activities engaged with the client/family to promote continuity of care, appropriate services, and development of independence and maximum potential. Must be substantial, and beyond the scope of base funding.	Families/clients with complex medical care and/or complex psycho-social needs (documented in the LHD client file) that would benefit from intervention, direction and action provided by an outside, independent professional. Requires development or update of a written, individualized plan of care.
		the actions taken by the LHD.
TRANSITION • Mail Transition Planning guidebook • Provide transition tools at appropriate ages (e.g. Phase I and II Transition Readiness Assessment, etc.) • Identify area providers who will serve age-out population • Identify clients about to age out of CSHCS and make needed referrals	**TRANSITION** • Assist with completion of Comprehensive • Assist with goal setting (Phase I & II Transition Readiness Assessment) • Transition Readiness Tool	**TRANSITION** • Same as care coordination, but as part of written plan of care. Case management requires at least one (1) face-to-face encounter, in the home or other non-LHD setting, during a billing quarter.

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BASE FUNDING	CARE COORDINATION	CASE MANAGEMENT
	Actions and activities engaged with the client/family to promote continuity of care, appropriate services, and development of independence and maximum potential. Must be substantial, and beyond the scope of base funding.	Families/clients with complex medical care and/or complex psycho-social needs (documented in the LHD client file) that would benefit from intervention, direction and action provided by an outside, independent professional. Requires development or update of a written, individualized plan of care.
• Basic information sharing		
RESPITE • Inform families of available services or application processes • Refer families to potential resources	**RESPITE** • Help families apply for CSHCS skilled nursing respite • Research and identify other appropriate respite resources for family • Help families apply for other respite resources • Assist family in development of alternative resources (e.g. training family or	**RESPITE** • Same as care coordination but as part of written plan of care. Case management requires at least one (1) face-to-face encounter, in the home or other non-LHD setting, during a billing quarter.

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BASE FUNDING	CARE COORDINATION	CASE MANAGEMENT
	Actions and activities engaged with the client/family to promote continuity of care, appropriate services, and development of independence and maximum potential. Must be substantial, and beyond the scope of base funding.	Families/clients with complex medical care and/or complex psycho-social needs (documented in the LHD client file) that would benefit from intervention, direction and action provided by an outside, independent professional. Requires development or update of a written, individualized plan of care.
	community support system members)	
HOSPICE • Inform families of available services or application processes	**HOSPICE** • Arrange for hospice services • Follow-up on CSHCS issues created prior to hospice enrollment	**HOSPICE** • Unusual to have case management for CSHCS hospice activities alone. Documentation would need to describe a complex situation and the actions taken by the LHD.
INSURANCE PREMIUM PAYMENT PROGRAM • Inform families of available service • Answer general questions	**INSURANCE PREMIUM PAYMENT PROGRAM** • Assist with application, obtaining information from employer, and/or insurance company	**INSURANCE PREMIUM PAYMENT PROGRAM** • Unusual to have case management for Insurance Premium Payment activities alone. Documentation would

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BASE FUNDING	CARE COORDINATION	CASE MANAGEMENT
	Actions and activities engaged with the client/family to promote continuity of care, appropriate services, and development of independence and maximum potential. Must be substantial, and beyond the scope of base funding.	Families/clients with complex medical care and/or complex psycho-social needs (documented in the LHD client file) that would benefit from intervention, direction and action provided by an outside, independent professional. Requires development or update of a written, individualized plan of care.
		need to describe a complex situation and the actions taken by the LHD.
COMMUNITY SERVICES NAVIGATION (Early On, MIChild, WIC, Healthy Kids, Medicare, etc.) • Provide information & referral	**COMMUNITY SERVICES NAVIGATION** (Early On, MIChild, WIC, Healthy Kids, Medicare, etc.) • Assist with completion of applications (such as Medicaid including Home Care Children (aka TEFRA) • Completion of developmental assessment for Early	**COMMUNITY SERVICES NAVIGATION** (Early On, MIChild, WIC, Healthy Kids, Medicare, etc.) • Same as care coordination but as part of written plan of care. Case management requires at least one (1) face-to-face encounter, in the home or other non-LHD setting, during a billing quarter.

Guidance Manual for Local Health Departments

BASE FUNDING	CARE COORDINATION	CASE MANAGEMENT
	Actions and activities engaged with the client/family to promote continuity of care, appropriate services, and development of independence and maximum potential. Must be substantial, and beyond the scope of base funding.	Families/clients with complex medical care and/or complex psycho-social needs (documented in the LHD client file) that would benefit from intervention, direction and action provided by an outside, independent professional. Requires development or update of a written, individualized plan of care.
	On or Special Education • Coordinated Plan of Care with Early On IFSP • Consultation with school and family in the development of IEP • Follow-up to link families with other needed services	
PRIVATE DUTY NURSING • Answer questions	**PRIVATE DUTY NURSING** • Collaborate with private duty provider	**PRIVATE DUTY NURSING** • Collaborate with private duty nursing provider

Guidance Manual for Local Health Departments

BASE FUNDING	CARE COORDINATION	CASE MANAGEMENT
	Actions and activities engaged with the client/family to promote continuity of care, appropriate services, and development of independence and maximum potential. Must be substantial, and beyond the scope of base funding.	Families/clients with complex medical care and/or complex psycho-social needs (documented in the LHD client file) that would benefit from intervention, direction and action provided by an outside, independent professional. Requires development or update of a written, individualized plan of care.
	(if not billing case management)	• Develop care plan for case management in partnership with family • Provide in-home intervention to carry out plan of care
MEDICAID HEALTH PLAN • Share historic client information • Report the status of mutually served clients	**MEDICAID HEALTH PLAN** • Coordinate in development of joint plans of care • Transition coordination for clients into or out of a Medicaid Health Plan	**MEDICAID HEALTH PLAN** • Unusual to have case management for Medicaid Health Plan activities alone. Documentation would need to describe a complex situation and the actions taken by the LHD.

Guidance Manual for Local Health Departments

BASE FUNDING	CARE COORDINATION	CASE MANAGEMENT
	Actions and activities engaged with the client/family to promote continuity of care, appropriate services, and development of independence and maximum potential. Must be substantial, and beyond the scope of base funding.	Families/clients with complex medical care and/or complex psycho-social needs (documented in the LHD client file) that would benefit from intervention, direction and action provided by an outside, independent professional. Requires development or update of a written, individualized plan of care.
BEREAVEMENT • Fax Family Center Bereavement form to the CSHCS Family Center • Refer families to potential resources	**BEREAVEMENT** • Assist with funeral arrangements • Notify physicians and providers • Cancel of appointments • Arrange for disposition of Durable Medical Equipment from home • Assist family with obtaining bereavement/counseling services • Develop community support services following the	**BEREAVEMENT** • Same as care coordination but as part of written plan of care. Case management requires at least one (1) face-to-face encounter, in the home or other non-LHD setting, during a billing quarter.

BASE FUNDING	CARE COORDINATION	CASE MANAGEMENT
	Actions and activities engaged with the client/family to promote continuity of care, appropriate services, and development of independence and maximum potential. Must be substantial, and beyond the scope of base funding.	Families/clients with complex medical care and/or complex psycho-social needs (documented in the LHD client file) that would benefit from intervention, direction and action provided by an outside, independent professional. Requires development or update of a written, individualized plan of care.
	departure of the many health professionals	

SECTION 16: HOSPICE

The CSHCS hospice benefit provides assistance to a family/beneficiary when end of life care related to the beneficiary's CSHCS qualifying diagnosis is appropriate. Hospice is intended to address the medical needs of the beneficiary with a terminal illness whose life expectancy is limited to six months or less.

Hospice services must be prior authorized. Prior authorization requests require medical documentation from the beneficiary's enrolled CSHCS subspecialist who is authorized (i.e. listed on the beneficiary's CSHCS authorized provider file) to treat the terminal illness. The medical documentation must include all of the following:

- **A statement of the terminal diagnosis.**
- **A statement that the beneficiary has reached the terminal phase of illness where the CSHCS subspecialist deems end of life care necessary and appropriate.**
- **Documentation of the need to pursue end of life care.**
- **A statement of limited life expectancy of six months or less.**
- **A proposed plan of care to address the service needs of the beneficiary that is:**
  - **less than 30 days old;**
  - **consistent with the philosophy/intent of the CSHCS hospice benefit as described above;**
  - **clinically and developmentally appropriate to the beneficiary's needs and abilities;**
  - **representative of the pattern of care for a beneficiary who has reached the terminal phase of illness; and**
  - **signed by the CSHCS subspecialist authorized to treat the terminal illness.**

The prior authorization time period does not exceed six months. To continue hospice services beyond six months, a new prior authorization request with medical documentation must be submitted as described above.
Hospice may not be authorized and/or continued for a CSHCS beneficiary when one or more of the following is true:

- **The medical documentation no longer supports the above criteria (e.g. change in condition, change in the plan of care, etc.).**
- **The family chooses to discontinue hospice.**
- **The medical services being rendered by the hospice provider are available through another benefit.**

Requests for hospice must be made in writing to CSHCS. CSHCS responds to all prior authorization requests for hospice services in writing.

SECTION 17: RESPITE BENEFIT

Respite services provide limited and temporary relief for families caring for beneficiaries with complex health care needs when the care needs require nursing services in lieu of the trained caregivers. Services are provided in the family home by hourly skilled and licensed nursing services as appropriate. To be eligible and authorized for respite, MDHHS must determine the beneficiary to have:

- **Health care needs that meet the following criteria:**

  - **That skilled nursing judgments and interventions be provided by licensed nurses in the absence of trained and/or experienced parents/caregivers responsible for the beneficiary's care;**
  - **That the family situation requires respite; and**
  - **That no other community resources are available for this service.**
- **No other publicly or privately funded hourly skilled nursing services in the home that would be duplicated by the CSHCS respite benefit.**
- **Service needs which can reasonably be met only by the CSHCS respite benefit, not by another service benefit.**

Respite is reimbursed when provided by a Medicaid enrolled home health agency, a Medicaid enrolled registered nurse (RN) who is licensed to practice in the state of Michigan or a Medicaid enrolled licensed practical nurse (LPN) who is licensed to practice in the state of Michigan and working under supervision according to the Michigan Public Health Code. It is the responsibility of the LPN to secure the appropriate supervision and maintain documentation that identifies the supervising professional.

A maximum of 180 hours of CSHCS Respite services may be authorized per family during the 12-month eligibility period. When there is more than one respite-eligible beneficiary in a single home, the respite service is provided by one nurse at an enhanced reimbursement rate for the services provided to multiple beneficiaries. Allotted respite hours may be used at the discretion of the family within the eligibility period. Unused hours from a particular eligibility period are forfeited at the end of that period and cannot be carried forward into the next eligibility period.

Beneficiaries receiving services through any of the following publicly funded programs and benefits are not eligible for the CSHCS Respite benefit:
- **Private Duty Nursing Benefit**
- **Children's Waiver**
- **Habilitation Supports Waiver**
- **MI Choice Waiver**

Requests for respite must be made in writing to MDHHS (refer to the Directory Appendix of the Medicaid Provider Manual **for contact information) and include the following information:**

- **The health care needs of the beneficiary;**
- **The family situation that influences the need for respite; and**
- **Other community resources or support systems that are available to the family (e.g. CMH services, MDHHS services, adoption subsidy, SSI, trust funds, etc.).**

The LHDs may submit information on the Application for Periodic Respite Services for Children with Nursing Care Needs form. **MDHHS responds to all requests for respite in writing**.

SECTION 18: INSURANCE PREMIUM PAYMENT BENEFIT

Clients may lose private insurance coverage due to a change in family circumstances (loss of job, etc.) or have difficulty continuing to pay the insurance premium. **CSHCS may be able to assist in paying the beneficiary's portion of an insurance premium cost (as related to the CSHCS qualifying diagnosis) for private insurance, Medicare Part B, or Medicare Part D. Premium payment assistance may also be available when the beneficiary has lost or is about to lose insurance coverage. Depending on the timing of the event, CSHCS may be able to assist the family in reactivating or maintaining that coverage. The cost-effectiveness requirements described below always apply.**

Premium payment assistance may be available when:

- **The current cost of the premium payment is determined to be cost-effective for CSHCS. Cost-effectiveness is defined as when the cost of the insurance premium is less than the projected cost to CSHCS for covering the CSHCS-related care; and**
- **The family/beneficiary lacks sufficient financial resources to pay for the beneficiary's part of the premium. The lack of ability to pay the insurance premium is defined as follows:**
  - **When the family has an Income Review/Payment Agreement (MSA-0738) that is within the two lowest payment agreement categories, the financial need is automatically established.**
  - **When the family has an Income Review/Payment Agreement (MSA-0738) that is above the two lowest categories, the family must describe the reason for the lack of resources that is impacting the ability to pay for insurance. Examples include:**
    - **The additional out-of-pocket expenses to address only the special needs of the beneficiary(ies) is 10% or more of the gross family income. Documentation is required; or**
    - **The family income has dropped and a revised MSA-0738 still results in a payment agreement that is above the two lowest payment agreement categories but extenuating financial circumstances interfere with the family's ability to pay insurance premiums, etc. Documentation is required.**

Questions about the insurance premium payment program should be directed to the CSHCS Insurance Specialist.

18.1 COBRA

The opportunity to maintain health coverage under the provisions of COBRA exists due to various qualifying events listed below:

18-month limit of coverage:

- Layoff
- Reduction of hours
- Termination of employment

36-month limit of coverage:

- Divorce
- Employee's death
- Legal separation
- Child ceases to be a dependent

When the LHD becomes aware that a family/client is about to or has experienced one of the qualifying events listed above and is not able to take advantage of COBRA coverage due to limited resources, the LHD should initiate discussion with the family/client to determine whether a referral for the insurance premium payment benefit is appropriate.

Timeliness is especially important when the family has COBRA coverage. If a family receives a denial for the CSHCS premium payment benefit related to COBRA coverage, they can appeal that denial to the MDHHS Appeals Section. While the appeal is pending, it is important that COBRA payment(s) be made, if due, to maintain the COBRA coverage at least until a determination has been made by the MDHHS Appeals Section. If the MDHHS Appeals Section finds that the family is eligible for the premium payment benefit, but they have let the COBRA coverage time requirements expire, CSHCS will not be able to reinitiate COBRA coverage for payment.

18.2 Medicare Part B Buy-In

CSHCS offers a Medicare Part B premium payment benefit for those clients who have Medicare coverage. A client may qualify for Medicare coverage if the client has end stage renal disease or other conditions, or has received 24 consecutive months of Social Security Disability Insurance (SSDI). Medicare Part B covers physician services, outpatient hospital services, certain home health services, durable medical equipment, some preventive screening services, and some medications.

CSHCS requires submission of specific information for the Medicare Buy-In process, in addition to the Application for Payment of Health Insurance Premiums (MSA-0725) form described later in this section. The required information includes a copy of the client's Notice of Medicare Premium Payment Due that was sent to the family on behalf of the

Medicare eligible client, the client's Medicare ID number (listed on the statement), and the client's CSHCS ID number.

The Buy-In process takes approximately 120 days to complete once the approval has been initiated. The Centers for Medicare and Medicaid Services (CMS) reimburses the family for any out-of-pocket costs paid for premiums to maintain Medicare Part B coverage while the Buy-In was in process.

18.3 Insurance Premium Payment Application Process

When the LHD becomes aware that a family is experiencing financial hardship that impacts their ability to pay the insurance premium for a CSHCS client, the LHD should discuss the insurance premium payment program with the family.

To apply for CSHCS insurance premium payment assistance, the following documents are required from all applicants:

- **A completed Application for Payment of Health Insurance Premiums (MSA-0725);**
- **A copy of a billing statement from the insurance carrier or a statement from the employer or Notice of Medicare Premium Payment Due (CMS-500) that verifies the cost of the premium;**
- **Copies of previous Explanation of Benefits (EOB) statements or expenditure summaries over the past 12 months from the private health insurance carrier or Medicare; and**
- **A pharmacy report(s) documenting the cost of the prescriptions and the amount paid by the private health insurance carrier or Medicare, or written evidence that the coverage does not include a prescription benefit.**

The following additional documentation is required under two specific circumstances:

- **When the family obtained private insurance through the Federally Facilitated Marketplace (FFM) and has a subsidy, proof is required that the subsidy arrangement is the Advanced Premium Tax Credit. Any other**

subsidy through the FFM enrollment is not eligible for the insurance premium payment assistance; or

- **A Consolidated Omnibus Budget Reconciliation Act (COBRA) Election Form is required if the beneficiary lost insurance coverage within three (3) months before application due to termination of employment, death of the policy holder, divorce, etc., and may be eligible for the insurance to remain in place due to COBRA.**

The family/beneficiary may contact the Local Health Department CSHCS office to obtain and receive assistance in completing the MSA-0725.

MDHHS decisions regarding eligibility for the insurance premium payment benefit will be provided in writing. Should the family not be found eligible, information regarding their right to appeal the decision will be included. Approval letters will include the effective date that insurance premium payments will begin. Questions about the insurance premium payment program should be directed to the CSHCS insurance specialist.

18.4 Effective Date of Insurance Premium Payment Assistance

When premium payment assistance has been approved, the effective date for the coverage is the first day of the month in which the MSA-0725 was received by CSHCS. Insurance premium payments are not covered retroactively for periods before the application was received except in limited situations listed below.

NOTE: Retroactive assistance for premium payment is limited to a one-time-only event when:

- **Existing insurance coverage is still active; and**
- **The private insurance will be terminated due to non-payment; and**
- **Termination will occur within 30 days of receipt of the MSA-0725 by CSHCS.**

The assistance when approved for past coverage is applicable:

- **For the beneficiary's portion of the unpaid premium; and**
- **If those payments will make it possible for the family to pay the remainder of back-payments; and**
- **When the family can maintain the insurance policy.**

18.5 Annual Review for Renewal of Eligibility

The MSA-0725 must be submitted each year. The annual eligibility review for continuing premium payment assistance occurs after CSHCS renewal has been completed based on program requirements at that time.

18.6 Requirement to Repay CSHCS for Funds Expended on Terminated Policies

In the event that an inappropriate premium payment has been sent to the family (either directly from MDHHS/CSHCS or as a refund to the family by the insurance company), the family is required to return those funds to CSHCS. CSHCS sends the family a letter requesting these funds be submitted to the state. If the funds are not submitted within 60 days from the date on the letter, the Michigan Department of Treasury may collect the funds from the family.

SECTION 19: OUT-OF-STATE MEDICAL CARE

When a client is outside of the state of Michigan and becomes ill due to the CSHCS qualifying condition and seeks emergency or non-emergency medical treatment, CSHCS may cover the service after reviewing medical reports submitted by the out-of-state treating physician. The out-of-state provider(s) must be Michigan Medicaid enrolled to submit a claim for out-of-state services. CSHCS cannot pay for medical care if the provider is unwilling to bill for the service.

CSHCS covers out-of-state emergency medical care when services are related to the qualifying diagnosis. Emergency medical care is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, with an average knowledge

of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- **Serious jeopardy to the health of the beneficiary;**
- **Serious impairment to bodily functions; or**
- **Serious dysfunction of any bodily organ or part.**

Non-emergency medical care related to the qualifying diagnosis is defined as not meeting the definition of emergency medical care stated above. Out-of-state non-emergency medical care is covered only when the service has been prior authorized by MDHHS. Prior authorization requests for out-of-state services may be approved when all the following criteria are met:

- **The requested service is related to the CSHCS qualifying diagnosis;**
- **The request for out-of-state referral is submitted by the appropriate, CSHCS-authorized in-state subspecialist with whom the beneficiary will maintain a relationship following the out-of-state services, explaining the reason the requested service must be provided out-of-state;**
- **The in-state subspecialist and the out-of-state specialist maintain a collaborative relationship with regard to determining, coordinating, and providing the beneficiary's medical care, including a plan to transition the beneficiary back to in-state services as appropriate;**
- **Comparable care (the term "comparable care" does not require that services be identical) for the CSHCS qualifying diagnosis cannot be provided within the state of Michigan;**
- **The requested service is accepted within the context of current medical standards of care as determined by MDHHS;**
- **The service has been determined medically necessary by MDHHS because the beneficiary's health would be endangered if he were required to travel back to Michigan for services, if applicable.**

19.1 Pre-Planned Medical Services

Coverage for out-of-state care requires prior authorization by a CSHCS medical consultant. The prior authorization request should include a statement from the client's approved in-state specialist explaining the reason the service needs to be provided outside of Michigan**,** including what services have been provided in-state. The Practitioner Special Services Prior-Approval – Request/Authorization (MSA-6544-B)

should be sent to the Medical Services Administration Program Review Division. If approved, an authorization letter is sent to the out-of-state provider and family. Out-of-state providers have a responsibility to follow Michigan Medicaid policies, including the provider enrollment requirements described in the Provider Enrollment section of the Medicaid Provider Manual.

Some CSHCS clients who temporarily reside out-of-state (e.g., college students, military assignment, etc.) are allowed to maintain CSHCS coverage as described in the Residency subsection of the CSHCS Program Eligibility section in this Guidance Manual. To maintain CSHCS coverage while temporarily residing out-of-state, or to renew out-of-state provider authorizations, the CSHCS client must return to their specialty physician in Michigan at least annually. In some cases, out-of-state providers may be authorized for these clients if a referral is received from the authorized in-state specialist and information about the client's temporary residence out-of-state is noted. The out-of-state provider must be approved by the CSHCS medical consultant and must be enrolled, or agree to enroll, with Michigan Medicaid. The LHD submits the request to add the out-of-state provider(s) in the same manner as other requests. If approved, an authorization letter is sent to the out-of-state provider and family.

19.1-A Retroactive Out-of-State Medical Services

Retroactive coverage for out-of-state medical services requires documentation of extenuating circumstances. These requests are reviewed on a case-by-case basis by the CSHCS medical consultant. If the client is receiving out-of-state medical care/treatment services prior to CSHCS enrollment, continuity of care will be considered. If comparable care is available in Michigan, out-of-state medical care/treatment services may not be authorized to continue.

19.1-B Additional Information Regarding Out-of-State Medical Services

If a client receives approval to obtain a second opinion from an out-of-state provider, this approval does not also authorize continued out-of-state medical care/treatment services.
CSHCS does not authorize out-of-state providers for diagnostic evaluations.
If the client is in a Medicaid Health Plan (MHP), the MHP must approve out-of-state services for that client.

19.2 Provider Enrollment

All out-of-state providers must complete the Community Health Automated Medicaid Processing System (CHAMPS) enrollment process described in the Provider Enrollment Section of the General Information for Providers Chapter to submit claims to the MDHHS.

All out-of-state providers must complete the application process described below in order to submit claims to MDHHS, or to the MDHHS Pharmacy Benefits Manager (PBM) for payment.

Providers must complete the Michigan Medicaid on-line enrollment process through the MDHHS CHAMPS Provider Enrollment system in order to receive reimbursement for covered services.

19.3 Renewal of Out-of-State Providers

Renewing authorization for out-of-state providers is completed manually. It is not possible to automatically renew authorization letters for out-of-state services. The LHDs can access an Out-of-State Approvals report which lists clients who have out-of-state providers. Each LHD should develop a system to monitor the out-of-state needs of their clients. It is recommended that the LHD review the status of, and prior authorization requirements for, out-of-state care with their families during all contacts, including contacts required prior to the scheduled renewal or end of CSHCS enrollment.

19.4 Borderland Providers

Medical care provided in borderland areas is allowed without application of the Out-of-State Medical Care criteria if the provider is enrolled in the Michigan Medicaid program. Borderland is defined as counties outside of Michigan that are contiguous to the Michigan border and the major population centers (cities) beyond the contiguous line as recognized by MDHHS. (Refer to the General Information for Providers Chapter of the Medicaid Provider Manual for additional information.)

Indiana (city of Fort Wayne; counties of Elkhart, LaGrange, LaPorte, St. Joseph and Steuben)
Ohio (counties of Fulton, Lucas and Williams)
Wisconsin (cities of Ashland, Green Bay, Rhinelander; counties of Florence, Iron, Marinette, Forest and Vilas)

Minnesota (city of Duluth)

Borderland providers are considered in-state providers. Borderland providers who are enrolled in the Michigan Medicaid Program must adhere to the same policies as enrolled in-state providers (e.g. providers cannot bill a family/client for any difference between the provider's charges and the MDHHS payment, etc.). The LHDs may request the addition of a borderland provider to the client's authorized provider file in the same manner as other in-state providers.

The LHD CSHCS offices authorize and assist families with travel for care received in borderland areas in the same manner as for travel in state. Refer to the Non-Emergency Medical Transportation (NEMT) Assistance section of the CSHCS **chapter** of the Medicaid Provider Manual **for specific information.**

SECTION 20: NON-EMERGENCY MEDICAL TRANSPORTATION (NEMT) ASSISTANCE

CSHCS may reimburse for travel to assist beneficiaries in accessing and obtaining authorized specialty medical care and treatment (in-state and out-of-state, as appropriate) when the family's resources for the necessary travel pose a barrier to receiving care. NEMT assistance is allowed for the beneficiary and one adult to accompany the beneficiary when the beneficiary:

- **Is a minor, or**
- **Has a court-appointed guardian and /or**
- **Has a medical condition that supports the need for a caregiver**

The treatment must be related to the qualifying medical condition and provided by a CSHCS approved provider. The NEMT benefit is not intended to assume the entire cost for the expenses incurred.

20.1 In-And Out-of-State Travel

Requests for NEMT assistance must be made as follows:

- **Beneficiaries who are not covered by Medicaid must request NEMT assistance through the LHD.**
- **Beneficiaries who have Fee-For-Service Medicaid and live in Wayne, Oakland or Macomb County must request NEMT assistance from the contracted transportation broker.**
- **Beneficiaries who have Fee-for-Service Medicaid, and live outside of Wayne, Oakland or Macomb county must request NEMT assistance from their local MDHHS Office. When NEMT assistance from the local MDHHS office is unavailable, beneficiaries can request NEMT assistance through the LHD.**
- **Beneficiaries who are Medicaid Health Plan (MHP) members must request NEMT from their health plan. MHPs may have different prior authorization and documentation requirements from those described in this chapter.**

To be eligible and authorized for CSHCS NEMT travel assistance, the beneficiary must be determined by MDHHS to meet the following criteria:

- **The beneficiary has CSHCS coverage at the time of the travel;**
  - **NEMT assistance may be authorized for individuals who do not have CSHCS but need NEMT assistance to participate in a diagnostic evaluation that is performed for the purpose of determining CSHCS eligibility.**
  - **There must be verification that no other resources are available and the individual is otherwise unable to access the site of the diagnostic evaluation.**
- **The NEMT assistance is for obtaining CSHCS specialty medical care and treatment from a CSHCS approved provider for the CSHCS medically-eligible condition;**
- **The family/beneficiary lacks the financial resources to pay for all or part of the travel expenses;**
- **Other travel/financial resources are unavailable or insufficient;**

- **The mode of travel to be used is the least expensive and most appropriate mode available.**

The following are additional criteria for out-of-state NEMT assistance:

- **Comparable medical care is not available to the beneficiary within the State of Michigan or borderland areas;**
- **Prior approval for the out-of-state medical care and treatment was obtained from MDHHS before the NEMT assistance was requested.**

Travel to borderland providers is considered the same as travel to in-state providers and follows the same requirements and rules.

CSHCS strongly encourages the use of Medicaid travel assistance for any client who also has Medicaid coverage, even in situations where travel is related to the CSHCS qualifying condition. Families cannot be reimbursed by both Medicaid and CSHCS for the same service.

Medicaid Health Plans provide non-emergency travel assistance, unless the client is requesting travel assistance for a medical treatment, service, or medication for which the Medicaid Health Plan is not responsible. See Section 20.10, MHP Exceptions, in this Guidance Manual for additional information.

A beneficiary with Medicaid may require LHD assistance/advocacy in obtaining needed NEMT assistance from their MHP or local MDHHS office.

Medicaid's NEMT policy can be found in the Non-Emergency Medical Transportation chapter of the Medicaid Provider Manual.

Questions regarding CSHCS NEMT assistance may be directed to the CSHCS Transportation Analyst.

CSHCS travel reimbursement rates are available online.

20.2 Non-Emergency Medical Transportation Reimbursement Process

In-state NEMT assistance for beneficiaries who do not have Medicaid, or who are receiving non-Medicaid eligible services, does not require prior

authorization. Out-of-state NEMT assistance requests may be initiated by the LHD and must be authorized by the CSHCS state Office.

Reimbursement is made according to the allowable amount established by MDHHS. Rates are reviewed at least annually and published on the MDHHS website. (Refer to the Directory Appendix in the Medicaid Provider Manual **for website information.)**

Reimbursement for beneficiaries with Medicaid coverage who request NEMT assistance from their local MDHHS office is provided in accordance with the Medicaid/MDHHS Non-Emergency Medical Transportation policy.

Beneficiaries who are authorized for CSHCS NEMT assistance must request reimbursement by submitting the completed Client Transportation Authorization and Invoice form (MSA-0636) and Addendum according to the General Instructions. Receipts are required for all reimbursable expenditures except mileage. Meal expenditures are not reimbursable. Requests for NEMT reimbursement must be received by MDHHS within 90 days following the authorized month of travel to be considered for payment. New enrollees may be reimbursed retroactive to the date of CSHCS enrollment when applicable.

The LHD authorizes NEMT assistance using the CHASS system. When the LHD is aware that travel will involve multiple trips, the NEMT request may be prior authorized to include all NEMT assistance for one calendar month. Any unusual circumstances should be documented in the "Notes" area of the prior authorization. This includes any approved request for a policy exception.

The Client Transportation Authorization and Invoice form (MSA-0636) serves as the family's invoice and must be submitted to MDHHS within 90 days following the month authorized for reimbursement. The family/client must complete Section 2 and provide receipts, if required. The family/client signature certifies that the information is correct. The LHD may assist with the completion of Section 2 if requested to do so.

MDHHS issues reimbursement within six to eight weeks after receiving an invoice. Incomplete or incorrect information on the Client Transportation Authorization and Invoice form, or failure to submit required receipts, may result in a delay in reimbursement.

Families should keep a copy of the forms for their records. The LHD makes copies for the family/client when requested to do so.

NEMT assistance reimbursement is not intended to cover the full cost of travel, but to provide assistance to defray the cost of travel for medical care related to the CSHCS qualifying condition for the family.

Lodging facilities that bill MDHHS directly are not required to consider the MDHHS allowable amount as payment in full, which may leave the family with a balance. The family may not request additional reimbursement from MDHHS when a facility has billed directly for these services.

20.2-A Allowable Expenditures – Ground Transportation

- **Mileage by private car to and from the health care service. Mileage is reimbursed according to the rate established by MDHHS.**
- **Car rentals, parking costs, and highway, bridge, and tunnel tolls require receipts.**
- **Bus, taxi, ferry or train fare, when it is the least expensive, most appropriate mode of transportation available and supported by receipts.**

Prior authorization for car rental initiated by the LHD through the CHASS system must be authorized by the CSHCS Transportation Analyst. When approved, car rentals are for standard size car base-rental fees only. Authorization and reimbursement do not include any additional taxes or fees charged by car rental companies. Refer to the CHASS User Manual for additional information.

Parking fees charged by a lodging facility are not covered.

MDHHS/CSHCS does not have a minimum mileage requirement.

20.2-B Allowable Expenditures – Air Travel

- **The family cannot be reimbursed for airline tickets unless prior approval to purchase the tickets was obtained from MDHHS/CSHCS. Receipts are required for reimbursement.**

- **Baggage charges, etc. require receipts**

Prior authorization for air travel initiated by the LHD through the CHASS system must be authorized by the CSHCS Transportation Analyst.

Air travel authorization is for the client and one accompanying adult. CSHCS will cover baggage charges up to one bag per person authorized for air travel reimbursement. Receipts are required.

Clients living on one of Michigan's island communities do not require prior authorization from the MDHHS CSHCS Transportation Analyst (e.g. families/clients living on Beaver Island traveling to Charlevoix). In these instances, the family/client must contact their LHD for prior authorization for NEMT assistance for in-state travel. The LHD must document this type of air travel within the client chart.

20.2-C Allowable Expenditures – Lodging

- **The beneficiary must be required to stay overnight to obtain in-patient or out-patient treatment related to the CSHCS covered condition, performed by a CSHCS approved provider and at a CSHCS approved medical facility, in order for the family to be reimbursed for lodging.**
- **Inpatient Requirements: Reimbursement is for the accompanying adult as needed.**
- **Outpatient Requirements: Reimbursement is for the beneficiary and the accompanying adult as needed.**
- **MDHHS reimburses lodging up to the allowable amount established by MDHHS, regardless of cost. Receipts are required.**

Lodging assistance (for one room) can be authorized for the caregiver(s) when the client is admitted as an inpatient. CSHCS may cover lodging for an outpatient visit when an overnight stay is required due to travel distance. NEMT assistance for lodging with a facility that bills MDHHS directly must be pre-authorized separately from other NEMT assistance.
An additional copy of the Client Transportation Authorization and Invoice form may be faxed directly to the lodging facility or provided to the family/client to give to the facility. The family/client should be instructed to take the copy(ies) of the authorization form with them to present to the facility if requested to do so.

20.3 Non-Medical Transportation

Families who request transportation assistance for non-medical services, such as for conferences or trainings, etc. should contact the Family Phone Line.

20.4 Non-Emergency Ambulance Transportation

CSHCS follows the same policies and procedures regarding non-emergency ambulance transportation coverage as the Medicaid Program. Refer to the Ambulance section in the Medicaid Provider Manual for additional information. Please also refer to section 22.7, Adding Providers to a CSHCS Client's Authorized Provider List, in this guidance manual for more information regarding adding transportation providers for reimbursement.

20.5 Inappropriate Use of Transportation Benefits

Family/client transportation invoices are reviewed and audited for correction of errors. If a family/client is found to be utilizing transportation benefits inappropriately, transportation assistance benefits may be temporarily denied. In addition, the attorney general's office may be consulted.

20.6 Additional Guidance for Out-of-State Non-Emergency Transportation

Families may call the LHD or the MDHHS CSHCS Transportation Analyst through the Family Phone Line for assistance with out-of-state NEMT requests. Once authorized, the MDHHS CSHCS Transportation Analyst, or the LHD, will print and mail to the family the Client Transportation Invoice.

Out-of-state NEMT assistance will not be authorized prior to the client's enrollment in CSHCS and without prior approval of out-of-state medical care by a CSHCS medical consultant. Clients who are in the process of completing CSHCS enrollment are not eligible for out-of-state NEMT assistance.

20.7 Commercial or Non-Profit Transportation Provider (Non-Ambulance)

Beneficiaries may be eligible for NEMT through a commercial or non-profit provider (e.g., Ambu-Cab, Medi-Van, vans operated by medical facilities or

public entities, etc.) when at least one of the following conditions is met. Beneficiary is:

- **Wheelchair dependent; or**
- **Bed bound; or**
- **Medically dependent on life sustaining equipment which cannot be accommodated by standard transportation; or**
- **Unable to access public or private transportation for the purpose of obtaining medical care.**

CSHCS NEMT provided by a commercial or non-profit transportation provider must be prior approved by the LHD on the Non-Emergent Medical Transportation Authorization and Verification form (MSA-0709). Payment is made directly to the commercial or non-profit transportation provider by MDHHS. The family/beneficiary should not pay the provider directly since the family/beneficiary cannot be reimbursed.

The LHD must verify the commercial or non-profit provider is compliant with all provider enrollment background and screening requirements as required by the Medicaid program. (Refer to the General Information for Providers Chapter in the Medicaid Provider Manual for additional information).

Requests for NEMT assistance through a commercial transportation provider must be authorized by the LHD per the NEMT policy. Authorization may be given for clients who do not have the physical limitations indicated yet are unable to access any other private or public mode of transportation for the purpose of obtaining medical care. When the LHD determines that the client meets the above criteria for transportation by a commercial provider, the LHD completes the Non-Emergent Medical Transportation Authorization and Verification form (MSA-0709) to allow the provider to be reimbursed for services. The Non-Emergent Medical Transportation Authorization and Verification form is divided into four sections as follows:

- Section 1 is completed by the LHD and contains client information and the authorizing LHD information. Upon completion of Section 1, the form may be mailed to the family and a copy faxed to the provider, if requested.
- Section 2 must be signed by the family. The LHD should explain to the family, either in-person or by telephone, that the transportation must be verified by the

physician, clinic, or other provider, or the family will be responsible for payment to the transportation provider. If the LHD is working with the family in-person, the LHD should obtain the family signature for this section.

- Section 3 must be completed by the physician, clinic or medical provider to verify that the client was seen on the stated date. If Section 3 is not completed, the transportation provider will not be reimbursed by MDHHS. The family keeps a copy of section 3 for their records.
- Section 4 is completed by the transportation company. The transportation company sends the original authorization, an itemized invoice that includes the provider's federal tax ID number, and a copy of the provider's W-9, if not on file with MDHHS, to the address stated on the form.

The commercial transportation provider is responsible for ensuring Sections 2, 3, and 4 of the Non-Emergent Transportation Authorization and Verification form (MSA-0709) are completed correctly or payment may be delayed or denied.

Occasionally, the LHD may become aware of a client who requires on-going regular treatment (e.g. dialysis, radiation, etc.) and requires transportation accommodation to travel to the treatment appointments. If the LHD determines that the circumstances are appropriate to authorize non-emergency transportation through a commercial or non-profit provider, the LHD completes Section 1 of the Non-Emergent Transportation Authorization and Verification (MSA-0709). For on-going treatment, the form may be completed by the LHD weekly or monthly. Multiple trips are indicated by entering the number of trips per week and the duration (e.g. M-W-F for one week; three times weekly for one month, etc.) in the "Date" portion of Section 1. Upon completion of Section 1, the LHD proceeds as above to allow the provider to be reimbursed for services.

When two or more beneficiaries from the same family are being transported at the same time in one vehicle, CSHCS will reimburse for one beneficiary only. This reimbursement is for one trip, regardless of the number of beneficiaries in the family being transported. The LHD should request reimbursement under the name of one beneficiary, and list any others with their name and ID number.

20.8 Emergency and Special Transportation Coverage

CSHCS follows the same policies and procedures regarding emergency and special medical transportation coverage as the Medicaid Program. Coverage must be related to the CSHCS qualifying condition. (Refer to the Ambulance Chapter of the Medicaid Provider Manual **for additional information.)**

An additional person, such as a donor related to the medical care of the beneficiary, may be considered for NEMT assistance when approved by a MDHHS medical consultant. The treating specialist must provide CSHCS with documentation of the relationship between the beneficiary and the additional person.

20.9 Special Considerations for Non-Emergency Medical Transportation

- NEMT assistance is available to a client's primary care physician only when the visit is for a pre-surgical or pre-operative exam required prior to surgery for the qualifying condition.
- NEMT assistance is available for Physical/Occupational/Speech therapy when it is required for the qualifying condition. The therapy must be ordered by an authorized provider. NEMT assistance may not be authorized for travel to and from a school facility or school-based services.
- NEMT reimbursement is only available when the client is being transported, unless the client's medical need does not require the presence of the client to receive services. Examples:
  - Medication pick-up at the pharmacy
  - DME deliveries or repairs which do not require the client's participation
  - Training for the caregiver(s) to provide physical/medical care for the client
  - One vehicle traveling to/from the hospital when the client is inpatient
    - Travel authorization is for one round-trip for one vehicle to/from the hospital per day. MDHHS/CSHCS does not reimburse for multiple trips for caregivers to/from the hospital in one day or for multiple vehicles.
    - Mileage reimbursement, while lodging has been authorized, is only available for the initial trip to the hospital at admission, and the return trip from the hospital at discharge for one vehicle.
    - If lodging has been authorized while the client is inpatient, mileage for ongoing trips may not be authorized, even for another caregiver. There is no additional coverage for making trips to and from the hospital when lodging has been authorized.

When two or more beneficiaries from the same family are being transported at the same time in one vehicle, CSHCS will reimburse for one beneficiary only. This reimbursement is for one trip, regardless of the number of beneficiaries in the family being transported. The LHD should request reimbursement under the name of one beneficiary, and list any others with their name and ID number.

20.10 MHP Exceptions

Certain services are excluded from the Medicaid Health Plan's responsibilities. Clients receiving the following services should contact their LHD or MDHHS as described below to access non-emergency medical transportation.

- Dental / Orthodontia
  - The LHD CSHCS office may assist with NEMT as orthodontic treatment is a benefit available only under CSHCS
  - The MHP is not responsible for dental care or related services (with the exception of Healthy Michigan Plan and in relation to pregnancy)
  - Clients with Healthy Kids Dental should contact their local MDHHS office for dental services other than orthodontia

- Factor for clients with blood coagulation disorders
  - Factor, administered through an infusion clinic, hospital, etc., is the responsibility of the Medicaid Health Plan.
  - Factor received directly by the client for self-administration is not the responsibility of the Medicaid Health Plan, but it is covered by Medicaid fee-for-service. The family should contact their local MDHHS caseworker for NEMT assistance.

- In-State Approved Intensive Feeding Clinics
  - Medicaid Health Plans are not responsible for in-state approved Intensive Feeding Clinic services. The family should contact their local MDHHS caseworker for NEMT assistance.

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SECTION 21: CHILDREN'S MULTI-DISCIPLINARY SPECIALTY (CMDS) CLINICS

Children's Multi-Disciplinary Specialty (CMDS) clinic services **provide a coordinated, interdisciplinary approach to the management of specified complex medical diagnoses. Services are provided as a comprehensive package by a team of pediatric specialty physicians and other appropriate health care professionals.**

CSHCS reimbursements for **CMDS clinic services are reserved for those beneficiaries who have CSHCS and have at least one of the conditions for which the CMDS clinics are available. Additional clinic information is available on the MDHHS website. (Refer to the Directory Appendix for website information.)**

21.1 CMDS Clinic Requirements

CMDS clinics are required to operate under the authority of hospitals or medical universities. Hospitals or medical universities requesting CMDS clinic designation must adhere to the requirements as stated in this policy and acquire approval and oversight from the CSHCS program. Hospitals and medical universities that administer CMDS clinics require a separate National Provider Identified (NPI) number with which to enroll and submit claims specifically for the CMDS clinic fee.

CSHCS-approved organizations with responsibility for CMDS clinics must enroll through the online MDHHS CHAMPS Provider Enrollment (PE) subsystem to be reimbursed for clinic fees for services rendered to eligible CSHCS beneficiaries. Each CMDS clinic must operate under the unique CMDS National Provider Identifier (NPI) held by the organization responsible for those CMDS clinics and must identify the providers who render the services in the CMDS clinic as affiliated providers. All affiliated providers whose services are directly reimbursable per MDHHS policy must be separately enrolled in CHAMPS and must also receive a beneficiary-specific authorization from CSHCS prior to the clinic billing for the clinic fees.

Refer to the General Information for Providers chapter in the Medicaid Provider Manual **for additional provider enrollment information.**

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21.2 Explanation of Services

In addition to medical services, CMDS clinics provide:

- **A single place and extended appointment for the family to be seen by their team of pediatric specialty providers as well as other appropriate health care professionals during each appointment**;
- **An environment where the providers come to the family for the single appointment at the clinic as opposed to the family needing to set separate dates and times to go to each provider as in the usual service methodology;**
- **Same day, face-to-face care coordination by all of the providers who saw the beneficiary at each appointment allows for immediate discussion, negotiation, coordination and duty assignment. The family does not need to interpret information from one provider to the next which risks misunderstanding as in the usual service methodology;**
- **Development and upkeep of a coordinated and comprehensive plan of care (POC) and treatment for beneficiaries including clear statements of current comprehensive assessment and ongoing treatment plans available to the entire team;**
- **Facilities that are tailored to the needs of children and their families; and**
- **Opportunity for the parent/beneficiary to participate in treatment planning, allowing for timely feedback and discussion of concerns with specialists and other health care professionals simultaneously when needed.**

Services are provided as a comprehensive package by a team of pediatric specialty physicians and other appropriate health care professionals. CMDS clinic fees are not intended for sporadic users of the services available through CMDS clinics such as support services only. CMDS clinic fees are intended for the comprehensive, coordinated and integrated services that CMDS clinics provide to beneficiaries who return for and continue to use this full package of services.

21.3 CMDS Clinic Staff Requirements

Medical Director	**A Medicaid-enrolled and CSHCS-approved physician currently licensed to practice under Michigan state law, with special training and demonstrated clinical experience related to the diagnoses followed by the specific CMDS clinic type. Physicians are expected to remain familiar with current developments and standards of treatment in their respective fields. If the medical director is not a pediatrician, a board certified pediatrician must be available and function within the scope of current medical practice.**
Physician	**A Medicaid enrolled and CSHCS-authorized pediatric subspecialist, or adult subspecialist physician when serving adults, currently licensed to practice under Michigan state law with special training and demonstrated clinical experience related to the diagnoses treated by the specific CMDS clinic type. Physicians are expected to remain familiar with current**

	developments and standards of treatment in their respective fields. Refer to the CMDS Clinic Guide, tables I and II, for subspecialty designations. The CMDS Clinic Guide is available on the MDHHS website.
Registered Nurse	**A Registered Nurse (RN) currently licensed to practice under Michigan state law and having a minimum of two years of pediatric nursing experience or adult nursing experience when serving adults. Certain CMDS clinics are exempt from this requirement (e.g., the Metabolic Diseases CMDS clinics) as long as they have the appropriate additional staff as required in the CMDS Clinic Guide.**
Registered Dietitian	**A Registered Dietitian (RD) in possession of a master's degree in human nutrition, public health, or a health-related field with an emphasis on nutrition, and two years of pediatric nutrition experience or adult nutrition experience when serving adults in providing nutrition**

	assessment, education and counseling.
Social Worker	**A Licensed Master Social Worker (LMSW) or professional staff member in possession of a master's degree in social work and two years of experience in counseling and providing service to children/youth, adults and their families.**
Parent/Guardian and/or Beneficiary	**The parent/guardian and/or the beneficiary must be an actively participating team member in the development of the beneficiary's comprehensive POC.**
Additional Required Staff	**Additional staffing requirements are based on clinic diagnosis type. Refer to the CMDS Clinic Guides on the MDHHS website for staffing requirements. (Refer to the Directory Appendix** of the Medicaid Provider Manual **for website information.)**

21.4 CMDS Clinic Visit Types

Beneficiaries with multiple, complex diagnoses may receive CMDS coordinated services from more than one CMDS clinic. The CMDS clinics must document clinic visit levels to include the following:

- **Support services must be indicated in the CMDS Plan of Care (POC) developed at a CMDS clinic Comprehensive Initial or Basic Evaluation visit or Management/Follow-up visit.**

- **The CMDS clinic must collaborate with other CMDS clinics the family/beneficiary may be using.**

21.4-A Initial Comprehensive Evaluation

The initial Comprehensive Evaluation is performed during the CSHCS beneficiary's first visit to the CMDS clinic. The medical team integrates assessments and recommendations and works with the family/beneficiary in the development of a coordinated and comprehensive POC and treatment for the beneficiary. The CMDS POC is required to be recorded. The CMDS clinic will communicate the written CMDS POC to the appropriate health care providers and the family/beneficiary. Written CMDS POCs may be provided to other appropriate health care providers for whom the parent/guardian/beneficiary has signed a medical release form. A copy of the CMDS POC is to be submitted to CSHCS medical consultants for review.

An Initial Comprehensive Evaluation visit must include the following:

- The entire CMDS team, including **physician specialist(s) and non-physician professionals examination or assessment of the beneficiary and submission of an established/confirmed diagnosis(es), identification of strengths and needs, and with family/beneficiary input, development of a course of action or plan for treatment;**
- **Integration of findings and recommendations at team conferences;**
- **Discussion of the medical findings and treatment recommendations with family/beneficiary in language the family/beneficiary can comprehend;**
- **Designation of identified staff to teach the family/beneficiary how to assist in the management of the beneficiary's health problems if appropriate; and**
- **Compilation of an integrated CMDS POC from the findings of the various health care providers that includes:**
    - **relevant history;**
    - **medical findings by specialty;**

- **problem areas that may develop and for which the beneficiary should receive care;**
- **recommendations and prescriptions for braces, shoes, special equipment, medications, etc.;**
- **referral to physical therapy, speech-language therapy, occupational therapy, public health nurse, CMDS support services; and**
- **a description of how the CMDS POC will be implemented.**

Reimbursement for the Initial Comprehensive Evaluation fee occurs only once per beneficiary per lifetime, regardless of the number of diagnoses and/or CMDS clinics from which the beneficiary may be receiving services. Medical services continue to be billed as usual.

21.4-B Basic and Ongoing Comprehensive Evaluation

Basic and ongoing comprehensive evaluation is conducted with established CMDS patients. The evaluation(s) may include the entire CMDS clinic staff composition or as deemed appropriate by each CMDS clinic Medical Director per visit and is documented in the CMDS POC. Every effort should be made to include all staff identified in the CMDS plan of care as recommended by the CMDS clinic Medical Director.
A basic and ongoing comprehensive evaluation may include the following activities:

- **Comprehensive beneficiary assessment;**
- **Evaluation and identification of the beneficiary's needs;**
- **Coordination of the beneficiary's multi-disciplinary needs;**
- **Review and modification of the comprehensive CMDS POC;**

- **Assured implementation and follow-up; and**
- **Referrals to other professionals, resources, and services as applicable.**

Reimbursement for the Basic and Ongoing Comprehensive Evaluation clinic fee is provided for a maximum of three (3) visits per beneficiary, per 12-month CSHCS eligibility year regardless of the number of diagnoses or CMDS clinics the beneficiary may have. Medical services continue to be billed as usual.

21.4-C Management/Follow-up Visits

Management/follow-up visits to a CMDS clinic may be provided if they are recommended in the CMDS POC. In addition, a referral may be recommended based on a tertiary hospital inpatient discharge plan that was written within the previous 12 months of the referral. Every effort should be made to include all staff identified as participants in the CMDS POC or as recommended by the CMDS clinic Medical Director.

The management/follow-up visit may include:

- **A physical exam by a pediatrician and/or physician subspecialist(s);**
- **Assessment by at least two of the clinic staff (in addition to the clinic physicians) designated for the clinic type;**
- **Follow-up on all components identified in the CMDS POC by appropriate staff;**
- **Update of condition and treatment, and revision of the CMDS POC; and**
- **Communication with the family/beneficiary, other providers, and other designated health care providers, including provision of copies of the CMDS POC to the family/beneficiary.**

Reimbursement for the management/follow-up visit clinic fee is provided for a maximum of three (3) visits per beneficiary, per 12-month CSHCS eligibility

year, regardless of the number of diagnoses or CMDS clinics the beneficiary may have. Medical services continue to be billed as usual.

21.4-D Support Service Visits

CMDS clinics may provide support services. Services consists of counseling, specialized training, transition assistance and/or treatment. Support services must be ordered as part of the CMDS POC developed at a CMDS clinic Initial Comprehensive Evaluation, Basic and Ongoing Comprehensive Evaluation, and/or Management/Follow-up visit.

CMDS clinic support services may be provided by any combination of one or more of the non-physician basic CMDS clinic staff to the family/beneficiary as outlined in the CMDS POC. Support Services may be conducted by professional members of the team (i.e., nurses, dietitians, certified diabetes counselors, social workers or other clinical professional staff as appropriate). The presence of a physician is not required.

- **The clinical encounter must be substantive with clinical information gathered, treatment recommendations provided, transition needs addressed and an update to the CMDS POC.**

- **The clinical content of the encounter is documented in the CMDS POC.**

CMDS support service visits include and provide two different methods of delivery:

- **Face-to-Face meetings between the appropriate clinic professional and the family/beneficiary; or**

- **Telephone meetings between the appropriate clinic professional and the family/beneficiary.**

Reimbursement for support services clinic fees can be provided up to a maximum of ten (10) visits per beneficiary as a single method or as a combination of methods, per 12-month CSHCS eligibility year, regardless of the number of diagnoses or CMDS clinics the beneficiary may have. Medical services continue to be billed as usual.

21.5 Additional Responsibilities

The CMDS clinics must establish and maintain an agreement with each Medicaid and MIChild Health Plan for health plan enrolled beneficiaries to ensure coordinated care planning and data sharing.

- **CMDS clinics must establish a process for clinical staff to communicate with health plan staff on a regular basis to identify health plan enrollees using the CMDS clinic(s), review testing/assessment/screening results, treatment plans, CMDS POCs, and status of mutually served beneficiaries.**

- **CMDS clinics must collaborate with health plans on the development of referral procedures and effective means of communicating the need for beneficiary-specific referrals. For beneficiaries enrolled in a health plan, CMDS clinics must bill the Medicaid Health Plan (MHP) for medical services rendered according to the health plan billing rules.**

The CMDS clinic fee is billed as a FFS claim through CHAMPS regardless of health plan status.

21.6 CMDS Clinic Fee Billing Instructions

CMDS Clinic fees must be billed according to instructions contained in the Billing and Reimbursement for Professionals Chapter of the Michigan Medicaid Provider **Manual. CMDS Clinics must bill clinic fees following Uniform Billing (UB) guidelines on the professional CMS-1500 claim format or the electronic Health Care Claim Professional (837) ACS X12N Version 5010 information. CHAMPS NPI claim editing will be applied to the billing, rendering, supervising, attending, servicing and referring providers as applicable for payment.**

The following Healthcare Procedure Coding System (HCPCS) codes should be used to bill for the clinic fees associated with CMDS Clinic visits:

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CMDS Clinic Visit	CPT/HCPCS Code	Modifier	Periodicity	Reimbursement
Comprehensive Initial Visit	S0315		Once per client	$350
Comprehensive Basic Evaluation	S0316		3/12-month CSHCS eligibility year	$170
Management/Follow-up Visit	S0317	TS	10/12-month CSHCS eligibility year for any combination of support services	$50
Telephone Support Services	98967	TS		$25

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SECTION 22: PROVIDER PARTICIPATION WITH CSHCS

CSHCS authorizes hospitals, physician specialists, and clinics to diagnose and treat CSHCS clients as authorized providers using the criteria established below. Other provider types reimbursed by the program include, but are not limited to, dentists, pharmacies, medical suppliers, audiologists, speech/physical/occupational therapists, and hearing aid dealers. Providers who become formally and/or involuntarily excluded from participation in programs of Federal and State agencies are also excluded from participation in the CSHCS Program.

Providers enrolled in Medicaid/CSHCS are not required to render services to every client seeking care. Providers may accept CSHCS clients on a selective basis. When assisting a family, the LHD should ascertain the provider's willingness to accept the client's CSHCS coverage or advise the family to confirm the provider's acceptance of the client's CSHCS coverage prior to obtaining services. Authorized providers, when treating the eligible diagnosis, must accept payment from CSHCS as payment in full and cannot request additional payment from the family/client.

If a CSHCS client is told and understands that a provider is not willing to accept them as a CSHCS client, and the client agrees to be private pay, the provider may charge the client for services rendered. The provider should maintain written documentation of this agreement in the client's file. Similarly, if a client needs a medical service that is not covered by Medicaid/CSHCS, the client must be informed, prior to rendering the service, that the service is not covered. If the client chooses to receive the non-covered service, the provider and client must make their own payment arrangements. The provider should maintain written documentation of this agreement in the client's file.

Note: **Hospitals must provide emergency services as required by the Emergency Medical Treatment and Active Labor Act (EMTALA), 42USC 1395dd.**

22.1 CHAMPS Online Provider Enrollment

Providers interested in rendering services to CSHCS clients must first be enrolled as Medicaid providers. Providers must complete the Medicaid on-line enrollment process through the CHAMPS Provider Enrollment (PE) system in order to receive reimbursement for covered services.

All out-of-state providers must complete the Community Health Automated Medicaid Processing System (CHAMPS) enrollment process described in the Provider Enrollment Section of the General Information for Providers Chapter to submit claims to MDHHS.

22.2 Providers: Participating/Authorized/Not Required to be Authorized

An approved provider is not the same as an authorized provider.

An approved provider (physicians and hospitals) has been subject to a review of credentials by the CSHCS and deemed to be an appropriate provider to treat the special needs of CSHCS clients.
An authorized provider is a provider that CSHCS has determined to be an appropriate provider of care for a specific client, as indicated on the Client Eligibility Notice or in the CHAMPS eligibility inquiry.

In addition to enrollment with the Michigan Medicaid Program, physicians and hospitals serving beneficiaries must meet criteria to serve as a CSHCS specialty care provider. The criteria are detailed in the CSHCS Approved Providers subsection below.
All providers must comply with Medicaid policies, requirements, including prior authorization requirements described elsewhere in the Medicaid Provider **manual.**

22.3 CSHCS Approved Providers

22.3-A Physicians

Physicians desiring to be CSHCS approved specialty providers must:

- **Be licensed to practice as a doctor of medicine (MD) or osteopathy (DO) by the state where the service is performed.**
- **Have successfully completed medical residency.**
- **Be enrolled in the Michigan Medicaid program (Refer to the General Information for Providers Chapter of** the Medicaid Provider Manual **for additional information.)**
- **Possess Specialty Board Certification. (Board eligible physicians in the process of completing certification requirements may be provisionally approved.)**
- **Have clinical privileges in a CSHCS approved hospital/facility.**

- **Have documented clinical training or experience with children who have diagnoses eligible for CSHCS services. A physician not having experience treating infants and young children may be conditionally approved to supervise the care of children over 12 years of age.**

22.3-B Hospitals

Hospitals desiring to be CSHCS approved must:

- **Be enrolled in the Michigan Medicaid program (refer to the General Information for Providers Chapter of** the Medicaid Provider Manual **for additional information)**
- **Have an organized Pediatrics Unit with an average daily census of six (6) or greater; and**
- **Have a Pediatrics Department identified in the medical staff structure. Exceptions:**
    - **Local laboratory and/or local imaging services ordered by the CSHCS subspecialist during the hospital visit and emergency care are not required to meet the organized Pediatrics Unit requirement, as stated above.**
    - **Emergency services do not require an order by the CSHCS subspecialist.**

22.4 CSHCS Authorized Providers

The following requirements apply only to providers serving CSHCS beneficiaries who do not also have Medicaid/MIChild/Healthy Michigan Plan coverage:

- **An authorized provider is an approved physician and/or hospital that is specifically identified on the CSHCS system as a provider for a specific beneficiary. (Refer to the CSHCS Approved Providers subsection for participation requirements.)**

- **CSHCS authorization of a provider is the step that allows for reimbursement for medical services rendered that are related to the CSHCS qualified condition(s).**

- **To become CSHCS authorized for a specific beneficiary, the family or the provider contacts the county health department in which the beneficiary lives.**

Providers serving beneficiaries with CSHCS who also have Medicaid/MIChild/Healthy Michigan Plan coverages do not need to be authorized.

22.5 Providers Who Do Not Need to be CSHCS Authorized

Non-physician providers typically do not need CSHCS authorization to render services to a beneficiary (except for hospital-owned ambulances and hospice agencies). This can apply, but is not limited to, the following provider types:

- Anesthesiologists
- Home health agencies
- Independent clinical laboratories
- Medical suppliers/durable medical equipment
- Pathologists
- Pharmacies
- Physician Assistants
- Prosthetists
- Radiologists

These providers may render services (and be reimbursed) when ordered or prescribed by a CSHCS authorized provider and the services are related to the beneficiary's CSHCS qualifying diagnosis.

The National Provider Identifier (NPI) number of the CSHCS authorized ordering or prescribing provider must be entered in the appropriate field on the claim.

22.6 Verifying Provider Authorization and Diagnosis Information

Authorized provider and diagnosis information can be obtained from the beneficiary's Client Eligibility Notice (CEN). **The CHAMPS Eligibility Inquiry and/or HIPAA 270/271 transaction will also indicate if the inquiring provider NPI number is authorized to render CSHCS services to the beneficiary on that**

date of service. Providers will receive the Benefit Plan ID of CSHCS along with one of the following messages in the eligibility response:

- **This NPI is listed. See CSHCS guidelines.**
- **This NPI is not listed. See CSHCS guidelines.**

If the client is not CSHCS eligible, providers receive the following message:

- Recipient is not eligible for CSHCS on the Date of Service (DOS)

The NPI of the CSHCS authorized ordering or prescribing provider must be entered in the appropriate field on the claim.

Refer to Chapter 3, Beneficiary Eligibility, of the Medicaid Provider Manual for additional information.

22.7 Adding Providers to a CSHCS Client's Authorized Provider List

The LHD should be the point of contact any time a family/client desires a change to the authorized provider list. The LHD notifies the CSHCS Customer Support Section of the requested change using the Notice of Action from Local Health Department (MSA-0730-B). A specific and valid reason for adding the provider as related to a qualifying diagnosis must be part of the request.

If the provider is already enrolled as a Medicaid provider, the provider or family can contact the LHD to be authorized for a specific client. If not already enrolled as a Medicaid provider, the provider must contact MDHHS to initiate enrollment. Requests to add or change providers are forwarded to the assigned analyst for appropriate action. When requesting to add a physician or other provider, the information submitted must include:

- Provider name and specialty (if applicable)
- NPI
- Address
- Phone number
- Date(s) of service
- The CSHCS diagnosis(es) the provider is treating

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22.7-A Adding Physicians and Other Providers

Primary care physicians are not routinely authorized. Exceptions can be made to allow the participation of the primary care provider in a treatment plan directed by a specialist. Pediatricians (for younger children) and internists (for older teens) are preferable to family physicians because of their extended training an expertise. Exceptions are determined by CSHCS medical consultants.

Primary care physicians are added to the date of service (DOS) only when approved by the CSHCS medical consultant. Examples of conditions primary care providers may be authorized as part of the specialist's treatment plan include, but are not limited to:

- Infants discharged from neonatal intensive care units (NICU) with specific diagnoses
- Infants with cleft lip or cleft lip/palate who have difficulty feeding and are at risk for otitis media
- Children in the upper peninsula (UP) or other rural areas where the primary physician is coordinating long distance with the specialists
- Children for whom the specialist(s) require regular checks for weight, head circumference or blood pressure; or for those requiring lab work, injections or for symptom monitoring between visits
- Children who require a physical exam as a prerequisite to CSHCS covered surgery

When requesting to add a physician or other provider, the information submitted must include:

- Provider name and specialty (if applicable)
- NPI
- Address
- Phone number
- Date(s) of service
- The CSHCS diagnosis(es) the provider is treating

22.7-B Adding Hospitals

Requests to add an in-state hospital or out-of-state borderland hospital enrolled as a Michigan Medicaid provider must include the following information:

- Client name and ID number
- Hospital name and NPI

- Whether the need for the hospitalization is inpatient or outpatient
- Date(s) of service
- CSHCS diagnosis that was being treated
- Short description/summary of treatment needed

CSHCS is unable to add a provider that is not enrolled with Michigan Medicaid.

22.8 Eligibility Verification

It is the provider's responsibility to verify a client's CSHCS eligibility prior to rendering service. Eligibility should be verified once each calendar month at a minimum, and preferably for each date of service (DOS). CSHCS coverage dates occasionally end mid-month (family request, client reached the age of 26, etc.)

CSHCS enrolled clients are issued a mihealth card and Client Eligibility Notice (CEN). These documents do not guarantee CSHCS eligibility until the eligibility information is verified on the CHAMPS eligibility inquiry, HIPAA 270/271 transaction, or web-DENIS.

22.8-A Eligibility Verification System (EVS)

The CHAMPS eligibility inquiry and/or the HIPAA 270/271 transaction will indicate when a client is enrolled in CSHCS for the DOS entered in the inquiry. It will also identify the CSHCS Benefit Plan and whether the provider NPI number is authorized to render CSHCS services for the client on that DOS. Providers receive one of the following messages in the eligibility response:

- **This NPI is listed. See CSHCS guidelines.** This message means the NPI is authorized by CSHCS to render services to this beneficiary on the specified date(s) of service. Services must be related to the beneficiary's CSHCS qualifying diagnosis.
- **This NPI is not listed. See CSHCS guidelines.** This message means the NPI is not authorized to render services to a CSHCS beneficiary on the specified date(s) of service. Some providers can render services to a CSHCS beneficiary without being authorized. Refer to the Authorized Provider subsections.

If the client is not enrolled in CSHCS, providers receive the following message in the eligibility response:

Recipient is not eligible for CSHCS on DOS

The provider should request that the client present a mihealth card or Client Eligibility Notice to access information on the CHAMPS eligibility inquiry to verify CSHCS eligibility before rendering any service. If the client does not have a mihealth card or Client Eligibility Notice, the provider can also access eligibility information with the following additional search methods:

Client identification number
Client social security number and date of birth
Client name and social security number or date of birth

The ten-digit client identification number obtained from the eligibility response must be used when billing MDHHS for services rendered. For CSHCS clients who also have Medicaid coverage, providers are encouraged to check for changes of enrollment status (usually for a Medicaid Health Plan versus fee-for-service) prior to billing MDHHS if the services rendered are not related to the CSHCS qualifying diagnosis(es).

22.8-B Other Billing Contractors (Netwerkes)

In addition to the CHAMPS eligibility inquiry and HIPAA 270/271 transaction, MDHHS provides eligibility information to other billing contractors (e.g. Netwerkes). Client eligibility information can be accessed by using the same search methods as described above for the CHAMPS eligibility inquiry, and providers will receive the same eligibility messages. The LHDs may not be able to determine whether a specific provider is authorized for a client through the billing contractor.

22.8-C Web-DENIS

MDHHS and Blue Cross Blue Shield of Michigan (BCBSM) have collaborated to make Medicaid eligibility information available for verification through BCBSM's secure, browser-based internet site called web-DENIS. Providers, including LHDs, can verify eligibility for CSHCS, Medicaid, Maternity Outpatient Medical Services (MOMS), and MIChild. The response can be printed for use as documentation of eligibility. Providers who do not have access to web-DENIS can refer to the BCBSM website for sign up information, including the web-DENIS application and agreement forms. Upon receipt of the completed forms, BCBSM will assign a user ID and password.

22.9 Prior Authorization

Some services for CSHCS clients may require prior authorization. CSHCS follows Medicaid policy for prior authorization requirements and processes. Complete coverage

details and prior authorization requirements can be found in the Medicaid Provider Manual, in the chapter specific to the service requiring prior authorization. For questions/assistance with the prior authorization process, providers may call the Program Review Division.

All requests for prior authorization need to be submitted to the Program Review Division by the provider using the Practitioner Special Services Prior Approval – Request/Authorization (MSA-6544-B). LHDs can assist (but are not required to do so) by completing the top portion of the form and sending that to the rendering provider. Otherwise, it is up to the rendering provider to complete and submit the form.

22.10 Provider Reimbursement

Information in this section is not specific to the LHDs but may be useful in discussions with providers.

Claims for CSHCS clients are processed through the Community Health Automated Medicaid Processing System (CHAMPS). The billing rules and rates of reimbursement for services rendered by providers to CSHCS clients are the same as those established for the Medicaid program and are available on the MDHHS website. Providers who are experiencing billing problems or other barriers to reimbursement should contact provider inquiry for assistance.
Federal regulations require that all identifiable financial resources be utilized prior to expenditure of Medicaid funds for most health care services provided to CSHCS clients. MDHHS is considered the payer of last resort.

The term "other insurance" refers to an insurance plan or carrier (e.g. individual, group, employer related, self-insured, or self-funded plan), commercial carrier (e.g. automobile insurance and workers' compensation), or program (e.g. Medicare) that has liability for all or part of a client's medical coverage. The term is used to mean any payment source, other than MDHHS, that has a financial obligation for health care coverage. Providers must utilize other payment sources to the fullest extent prior to filing a claim with MDHHS. Billing MDHHS prior to exhausting other insurance resources may be considered fraud if the provider is aware that the client had other insurance coverage for the services rendered.

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MDHHS' payment liability for clients with private commercial health insurance is the lesser of the client's liability (including co-insurance, co-payments, or deductibles), the provider's charge or the maximum Medicaid fee screen, minus the insurance payments and contractual adjustments. As clarification, a contractual adjustment is an amount established in an agreement with a third-party payer to accept payment for less than the amount of charges. CSHCS clients must use the highest level of benefit available through their other insurance carrier.

Providers may enter into agreements with other insurers to accept payment that is less than their usual and customary fees. Known as "Preferred Provider" or "Participating Provider" agreements, these arrangements are considered payment-in-full for services rendered. Neither the client nor MDHHS has any financial liability in these situations.

Providers must secure responses(s) from other insurances (e.g. explanation of benefits or denials) prior to billing MDHHS except for fixed co-pay amounts or payments for non-covered services. In these cases, providers must have the explanation of benefits documentation in the client's file. When billing, this documentation must be included with the claim.

If payments are made by another insurance carrier, the amount paid and whether it is paid to the provider or the client, must be reflected on the claim. It is the provider's responsibility to obtain the payment from the client if the other insurance pays the client directly. It is acceptable to bill the client in this situation. Providers may not bill a CSHCS client unless the client is the policy holder of the other insurance. Failure to repay, return, or reimburse MDHHS may be construed as fraud under the Medicaid False Claim Act if the provider has received payment from a third-party resource after MDHHS has made a payment.

CSHCS does not reimburse families directly for payments made to providers.

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SECTION 23: CSHCS COORDINATION WITH OTHER HEALTH CARE COVERAGE

Beneficiaries may have coverage through CSHCS and another program simultaneously.

23.1 Medicaid

Beneficiaries may have both Medicaid and CSHCS coverage. The beneficiary must comply with Medicaid requirements.

23.2 MIChild

Beneficiaries may have both MIChild and CSHCS coverage. The beneficiary must comply with MIChild requirements. CSHCS is not considered health insurance for purposes of MIChild eligibility.

23.3 Transitional Medical Assistance (TMA)

Beneficiaries may have both TMA and CSHCS coverage. For services not covered by CSHCS and covered by TMA, the beneficiary must comply with TMA requirements.

23.4 Maternity Outpatient Medical Services (MOMS)

Beneficiaries may have both MOMS and CSHCS coverage. The beneficiary must comply with MOMS requirements.

23.5 Healthy Michigan Plan

Beneficiaries may have both the Healthy Michigan Plan and CSHCS. The beneficiary must comply with the Healthy Michigan Plan requirements.

23.6 Court-ordered Medical Insurance

CSHCS cannot be used as court-ordered medical insurance.

23.7 Medicare

Beneficiaries may have both Medicare and CSHCS. The beneficiary must comply with Medicare requirements.

Medicaid beneficiaries may apply for Medicare at any time and are not limited to open enrollment periods. Beneficiaries may be eligible for Medicare if they are:

- **65 years of age or older.**
- **A disabled adult (entitled to SSI or RSDI due to a disability).**
- **A disabled minor child.**

Beneficiaries are encouraged to enroll in Medicare Part B as soon as they are eligible to do so. A beneficiary's representative can apply for Medicare Part B benefits on behalf of the beneficiary.

CSHCS may cover the out-of-pocket pharmacy costs related to the CSHCS covered diagnoses for CSHCS beneficiaries enrolled with a Medicare Part D Pharmacy Drug Plan. These out-of-pocket costs include copays, co-insurance and deductibles specific to the Medicare Part D pharmacy benefit. Providers and beneficiaries should contact CSHCS for additional information regarding the reimbursement of out-of-pocket pharmacy costs.

Refer clients who have Medicare and are enrolled in a Part D Prescription Drug Plan to the CSHCS resolution and reimbursement specialist.

23.8 Other Insurance

Clients may have both CSHCS and other health insurance coverage. CSHCS follows Medicaid in that, if a **beneficiary is enrolled in a commercial health insurance plan or is covered by a traditional indemnity policy or military/veteran insurance, the rules for coverage by the commercial health insurance, traditional indemnity policy, or military/veteran insurance must be followed. This includes, but is not limited to:**

- **Prior authorization (PA) requirements.**
- **Provider qualifications.**
- **Obtaining services through the insurer's provider network.**

Beneficiaries must use the highest level of benefits available to them under their policy. CSHCS follows Medicaid in that it **is not liable for payment of services denied because coverage rules of the primary health insurance were not followed. For example,** it **does not pay the point of service sanction amount for the beneficiary electing to go out of the preferred provider network.** CSHCS is**, however, liable for Medicaid-covered services that are not part of the primary health insurance coverage.**

If the other insurance plan does not have an appropriate in-network provider available to serve the client, or if other extenuating circumstances exist (e.g. continuity of care, etc.), it is the responsibility of the family/client to obtain agreement from their primary insurance carrier to pay the provider for the out-of-network services. If the other insurance denies the request, the family/client should pursue the other insurance carrier's appeal process.

23.8-A Co-Insurance/Deductibles and/or Copayment

MDHHS **pays the appropriate coinsurance amounts, copayment amounts, and deductibles up to the beneficiary's financial obligation to pay or the Medicaid allowable amount (less other insurance payments), whichever is less. If the other insurance has negotiated a rate for a service that is lower than the Medicaid allowable amount, that amount must be accepted as payment in full and Medicaid cannot be billed.**

23.8-B Services Not Covered by Another Insurance

If the other insurance does not cover a service that is a covered service, MDHHS **reimburses the provider up to the Medicaid-allowable amount if all the coverage rules are followed.**

23.8-C Changes in Other Insurance Coverage

When the LHD becomes aware that a client has a change in other insurance coverage, they must submit those changes through the online Insurance Coverage Request Form.

Do not send more than one notice to Third Party Liability. Third Party Liability staff makes every attempt to process insurance changes submitted within 7-10 business days after receiving the information, depending on staff availability. If insurance changes have not been made to CHAMPS within fifteen (15) business days, or if the LHD has further questions about coordination of benefits issues, contact the CSHCS insurance specialist. When insurance changes create access to care issues that require immediate attention (e.g. client unable to obtain medication from the pharmacy), contact the CSHCS insurance specialist or the CSHCS billing resolution specialist for assistance.

Do not send copies of insurance cards to CSHCS with annual update information. All changes in other insurance coverage should be directed to the MDHHS Third Party Liability section (see Appendix B).

23.9 Private Insurance Mail-Order Pharmacy Coordination of Benefits Contractor (Magellan Medicaid Administration, Inc.)

If the client has private insurance coverage that includes a mandatory mail-order pharmacy benefit, or the pharmacy contractor is not enrolled as a Medicaid Provider, the mail-order benefit must be utilized. If the mail-order pharmacy requires a co-payment/deductible from the client, MDHHS will coordinate benefits with the mail-order pharmacy by paying the client's co-payment through the pharmacy coordination of benefits (COB) contractor.

The client must submit the prescription order to the mail-order pharmacy according to the process required by the mail-order pharmacy. At the time of the order, the client must report CSHCS coverage and provide the mail-order pharmacy with the CSHCS client identification number for billing purposes. The mail-order pharmacy will then bill the MDHHS pharmacy COB contractor for the co-payment amount at the point of sale. There is no out-of-pocket expense for the client and the client receives the mail-order prescription with no additional delay beyond the pharmacy's usual time frame. MDHHS pays the full co-payment amount (as opposed to the Medicaid allowable amount) for prescriptions covered through a mail-order pharmacy benefit. For medications that are covered by the mail-order pharmacy, but require prior authorization by MDHHS, prior authorization requirements are waived only if the mail-order pharmacy is only billing for the co-payment/deductible amount. All excluded drug categories remain excluded from this benefit. Any client who receives a bill for his/her co-payment from a participating or non-participating mail-order pharmacy provider should call Magellan Medicaid Administration, Inc. for assistance in coordinating benefits.

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23.9-A Pharmacy Mail Order Copay Reimbursement

Mail-order pharmacy co-pays/deductibles are processed through the Pharmacy Contractor Magellan Medicaid Administration. The Mail-Order Copay Submission Forms and Instructions are found on the Magellan Website. Beneficiary inquiries regarding mail-order co-pay submission may contact the Magellan Customer Service at 1-877-681-7540.

23.9-B Durable Medical Equipment (DME) Mail Order Reimbursement

CSHCS will manually reimburse co-pays/deductibles for diabetic supplies, such as diabetic strips, lancets, keto test strips etc. when a client's primary insurance mandates that coverage for medical supplies must be obtained through their pharmacy benefit manager that does not coordinate benefits with Michigan Medicaid. The following information is required for processing:

- Client name and beneficiary identification number
- Name and address of the person or entity being reimbursed (payee)
- Payee ID (Social Security Number)
- Copy of invoice or statement from the mail-order pharmacy that shows the date of service, prescription number, description of item, quantity, and co-pay amount

For questions, contact the CSHCS billing resolution specialist
Information must be submitted to:

MDHHS – CSHCS (Fax: 517-241-0796)
PO Box 30734
Lansing, MI 48909
Attn: CSHCS Reimbursement Resolution Specialist

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SECTION 24: CHILDREN WITH SPECIAL NEEDS (CSN) FUND

24.1 History and Mission

Mission

The Children with Special Needs (CSN) Fund provides family-centered support for children in Michigan with special health care needs when other funding sources are not available by assisting with the purchase of equipment that promotes the child's mobility and optimal health. The Fund collaborates with other programs to support services that promote the development and independence of children with special needs.

History of the Fund

The Children with Special Needs Fund (formerly the Crippled Children's Fund) was created in 1944 when Dr. James T. Pardee, co-founder of Dow Chemical, made a generous bequest of Dow Chemical Company stocks to the Crippled Children's Commission to support children with special needs. In 1965, the Crippled Children's Commission was transferred to the Department of Public Health, which is now known as the Michigan Department of Health and Human Services. While Pardee's gift comprises the major portion of the Fund, many other organizations, businesses, individuals, and families have contributed over the years, making it a privately funded program. One of the guiding principles of the CSN Fund is for it to function as the grantor/payor of last resort. It cannot be used as a substitute for available state or federal health programs.

The CSN Fund Advisory Committee was formed to provide support in meeting the mission of the CSN Fund by gathering information, identifying needs, and providing recommendations for improving the Fund's ability to serve children with special health care needs. The committee consists of individuals who represent parents of children with special health care needs, community-based agencies, professionals from various fields, and community members. They volunteer their time to give thoughtful input and guidance into the policies and grant-making activities of the Fund. These individuals are familiar with the challenges that families of children with special health care needs face and offer a variety of views and expertise related to support for families of children with special health care needs.

Today, the CSN Fund is a program within the Michigan Department of Health and Human Services (MDHHS) Children's Special Health Care Services (CSHCS) Division. Because the Fund is comprised of private donations, families/caregivers requesting

grants from the CSN Fund must first apply to the child's private/commercial insurance, and other state or federal programs with whom the child is enrolled. Families unable to obtain funding for certain equipment can make their request to the Fund by submitting an application along with other required documentation. The application is reviewed by a team to determine the eligibility of the child and the equipment or service being requested. The decision to approve, deny, or request more information is conveyed to the family and the local health department, and the preferred vendor is notified if the request is approved. Vendors are paid directly after the service or equipment has been provided.

24.2 CSN Fund Application and Brochure

Families and individuals can submit their request for CSN Fund assistance by completing an application. Applications are processed within four to six weeks.

The CSN Fund application package consists of an application and program guide and the following forms:

- Children with Special Needs Fund Application (DCH-1239)
- Children with Special Needs Fund Financial Assessment (DCH-1273), required for children not enrolled in CSHCS
- Children with Special Needs Fund Documentation of Assistance (DCH-2423)
- Children with Special Needs Fund Landlord Agreement (DCH-2424), for requests regarding modification of rental units (electrical upgrades or wheelchair ramps)

Families requesting CSN Fund assistance must complete the appropriate forms as determined by the item being requested. Refer to Section 24.4, CSN Fund Covered Items, to determine the appropriate forms and additional documentation required for each request.

The CSN Fund Application is available to print from the CSN Fund Website.

CSN Fund Brochure

The CSN Fund publishes the Children with Special Needs Fund brochure, which provides an overview of the Fund and eligible equipment and services. Copies of this publication may be ordered by contacting the CSN Fund at (517) 241-7420 or e-mail at

csnfund@michigan.gov. Brochures can also be ordered from the Health Promotions Clearinghouse.

24.3 CSN Fund Eligibility Criteria

A child must meet all the criteria below to qualify for CSN Fund assistance. The criteria listed in this section are used by CSN Fund staff to determine eligibility.

24.3-A Medical Eligibility

The child for whom the family is seeking financial assistance from the Fund must be enrolled in, or medically eligible to enroll in, CSHCS. A signed letter of medical necessity that is no older than one (1) year, signed by the child's physician or licensed medical professional that is no older than one (1) year must be submitted with the application. This letter should explain the child's diagnosis and the direct medical benefit of the item/equipment requested for the child.

Adults 21 years and older are not eligible for funding from the CSN Fund, including those who may qualify for the CSHCS program.

24.3-B Enrollment in Other Programs

Children enrolled in Community Mental Health (CMH) services and/or Adoption Medical Subsidy must apply to those programs first. A letter of denial from these programs is required to be submitted with the application for the request to be considered. The denial letter must be on official agency letterhead and include a specific explanation of the denial. Acceptable reasons for denial can include those due to written policy that states coverage is not available, or lack of available funding. CSN Funds cannot be used to substitute available state health program services.

Children enrolled in the Children's Home and Community–Based Services Waiver (CWP), Habilitation Support Waiver (HSW), or any other waiver program, are not eligible for funding through the CSN Fund. Waiver programs are responsible for providing necessary home- and community-based services for enrolled children.

24.3-C Income Eligibility

There are no income eligibility restrictions for CSN funding. Applications for children not currently enrolled in CSHCS must include the Children with Special Needs Fund Financial Assessment Form DCH-1273.

If/when there is a period of decreased revenue, budget shortfalls, or other funding constraints for the CSN Fund, applications may be subject to income eligibility restrictions based on household income and family size.

24.3-D Citizenship/Residency

The individual, or parent of a minor, or court-appointed guardian of the individual must be a citizen of the U.S., a non-citizen lawfully admitted for permanent residence, or a lawfully admitted migrant farm worker (i.e., temporary agricultural worker). Any individual born in the United States who meets all other program eligibility criteria is deemed eligible regardless of the citizenship status of the parents/court-appointed guardian.

The individual, parent, court-appointed guardian, or foster parent of the individual must be: A Michigan resident(s); or working or looking for a job in Michigan and living in Michigan (including migrant status); or in Michigan with the clear intent to make Michigan their home.

24.4 CSN Fund Covered Items

24.4-A Adaptive Recreational Equipment

The CSN Fund may approve funding for recreational equipment including, but not limited to, floatation devices, adaptive toys/switches, swings, and bike trailers. Requests are reviewed on a case-by-case basis. When possible, three (3) quotes are required for the requested item. The CSN Fund will approve the lowest quote up to the maximum allowed. If a family chooses a vendor that is not the lowest bidder, the preferred vendor must be indicated on the application. However, the CSN Fund only approves the amount of the lowest bid up to the maximum allowed, and the family is responsible for any remaining balance. No duplicate requests allowed within five years.

The following documents must be submitted for adaptive recreational equipment applications:

- A completed Children with Special Needs Fund Application for Assistance (DCH-1239)
- A completed Children with Special Needs Fund Financial Assessment (DCH-1273) if the child is not enrolled in CSHCS
- A letter from the child's parent/guardian explaining the reason for the request
- A letter of medical necessity from the child's specialty physician
- A completed Children with Special Needs Fund Documentation of Assistance (DCH-2423)
- Three (3) quotes for the equipment
- One (1) quote for toys/switches

24.4-B Air Conditioners/Central Air Conditioning

The CSN Fund may approve funding for a portable or window air conditioning unit (or partial funding towards central air conditioning) for children with documented medical diagnosis of severe and persistent asthma, respiratory distress, or other medical conditions exacerbated by heat and humidity, as determined by the CSHCS medical consultant.

Quotes are not required for portable or window air conditioner requests as the units are ordered directly from the manufacturer (currently Home Depot Supply) at a discounted price and shipped directly to the child's home. Central air requests only require one quote. The CSNF will approve the maximum amount allowed for the air conditioning unit or central air conditioning.

The CSN Fund does not cover installation of home central air conditioning in a rental property. Air conditioner and central air conditioning requests are limited to one approval per family per lifetime.

The following documents must be submitted for air conditioner applications:

- A completed Children with Special Needs Fund Application for Assistance (DCH-1239)
- A completed Children with Special Needs Fund Financial Assessment (DCH-1273) if the child is not enrolled in CSHCS

- A letter from the child's parent/guardian explaining the reason for the request
- A letter of medical necessity from the child's specialty physician
- A completed Children with Special Needs Fund Documentation of Assistance (DCH-2423)
- One (1) quote if requesting central air conditioning

24.4-C Ceiling and Stair Lifts

The CSN Fund may approve funding for a ceiling track system or stair lift to transfer the child safely and securely inside of the home for necessary tasks such as transfer from bed to chair, chair to toilet/shower, etc. Approval of ceiling or stair lifts is subject to the availability of special grant funding. Exceptions may be made for a platform lift inside the home if it is the least expensive option. Funding is not available for ceiling, stair, or platform lifts on rental property.

Due to the limited amount of funding available for lifts, applications will be reviewed by the Advisory Committee twice per year. To be considered, applications must include all required documents and be received by deadlines set each calendar year. Applicants who are not approved for funding may re-apply if all required documentation is current. Ceiling and stair lifts are limited to one approval per family per lifetime.

The following documents must be submitted for ceiling and stair lift applications:

- A completed Children with Special Needs Fund Application for Assistance (DCH-1239)
- A completed Children with Special Needs Fund Financial Assessment (DCH-1273) if the child is not enrolled in CSHCS
- A letter from the child's parent/guardian explaining the reason for the request
- A letter of medical necessity from the child's specialty physician, physical therapist, or occupational therapist
- A completed Children with Special Needs Fund Documentation of Assistance (DCH-2423)
- Three (3) quotes for the ceiling, stair, or platform lift accompanied with a diagram of the proposed installation from each vendor.

24.4-D Electrical Service Upgrade

The CSN Fund may grant funding to install dedicated circuits that will accommodate proper functioning of medical equipment for an eligible child. Electrical upgrades are not intended to correct existing code violations in the beneficiary's home.

If a family lives in a rental unit, a complete Landlord Agreement Form DCH-2424 must be submitted with the application package. This signed agreement absolves the CSN Fund of any responsibility regarding restoration of the property to its original condition in case of damages or if the occupants relocate.

Two (2) quotes are required for electrical service upgrade applications. The CSN Fund will approve the lower bid up to the maximum allowed. If a family chooses a vendor that is not the lowest bidder, the preferred vendor must be indicated on the application. However, the CSN Fund only approves the amount of the lowest bid up to the maximum allowed, and the family is responsible to pay for any remaining balance. Electrical Service upgrades are limited to one approval per family per lifetime.

The following documents must be submitted for electrical service upgrade applications:

- A completed Children with Special Needs Fund Application for Assistance (DCH-1239)
- A completed Children with Special Needs Fund Financial Assessment (DCH-1273) if the child is not enrolled in CSHCS
- A letter from the child's parent/guardian explaining the reason for the request
- A letter of medical necessity from the child's specialty physician
- A completed Children with Special Needs Fund Documentation of Assistance (DCH-2423)
- Two (2) quotes for the service upgrade
- A signed Children with Special Needs Fund Landlord Agreement (DCH-2424) for rental units only

24.4-E Therapeutic Tricycles

The CSN Fund may grant funding for an adaptive therapeutic tricycle or therapeutic recreation equipment that will promote independence, exercise, and mobility for the eligible child.

The medical evaluation report submitted must indicate that the child is able to ride the requested tricycle or use the adaptive equipment. If requesting a Rifton tricycle, a Rifton Tricycle Order Form (DCH-1342) must be completed by a licensed health professional, preferably an Occupational/Physical Therapist, who has assessed the child for the appropriate tricycle size and accessories.

Quotes are not required for Rifton tricycle applications because they are ordered online directly from the manufacturers at a discounted price. Applications for AMTRYKE tricycles require one (1) quote. Any other adaptive recreation equipment or tricycle must follow CSN Fund guidelines and include three quotes with the application. Families will be notified of any balance they owe if the total cost of the tricycle exceeds the maximum amount that the CSN Fund will cover. Payment of balance owed must be sent by check or money order to the CSN Fund before the tricycle can be ordered from Rifton. Tricycles are limited to every 2-5 years.

The following documents must be submitted for therapeutic tricycle applications:

- A completed Children with Special Needs Fund Application for Assistance (DCH-1239)
- A completed Children with Special Needs Fund Financial Assessment (DCH-1273) if the child is not enrolled in CSHCS
- A letter from the child's parent/guardian explaining the reason for the request
- A letter of medical necessity from the child's specialty physician
- An assessment for the tricycle completed by a physical/occupational therapist
- A completed Children with Special Needs Fund Documentation of Assistance (DCH-2423)
- Three (3) quotes for all equipment except Rifton or AMTRYKE tricycles
- One (1) quote for AMTRYKE tricycles
- A completed Rifton Tricycle Order Form (DCH-1342) for Rifton tricycles only

24.4-F Transit Options

The CSN Fund may approve funding for transit options, such as loop mounts, for the purpose of securing a wheelchair inside a family vehicle. Only one transit option will be approved per child. A second request may be considered if the child's wheelchair has been replaced.

The following documents must be submitted for transit option applications:

- A completed Children with Special Needs Fund Application for Assistance (DCH-1239)
- A completed Children with Special Needs Fund Financial Assessment (DCH-1273) if the child is not enrolled in CSHCS
- A letter from the child's parent/guardian explaining the reason for the request
- A letter of medical necessity from the child's specialty physician, physical therapist, or occupational therapist
- A completed Children with Special Needs Fund Documentation of Assistance (DCH-2423)
- One itemized quote listing each wheelchair/seating component, including the transit option, with retail price and dealer/vendor price.

24.4-G Vehicle Accessibility Devices

The CSN Fund may approve funding for vehicle accessibility devices to transfer the child safely and securely into and out of the family vehicle. The Fund may contribute toward the installation of tie-downs, a wheelchair lifter, assistive seating (such as a Turney Seat), reverse swing doors, restraint systems, or a van ramp or lift. The Fund may also approve funding for the van lift portion of a ready-made wheelchair accessible van.

Three (3) quotes are required for vehicle accessibility device applications. Quotes must be itemized to reflect the separate cost of the vehicle, conversion, lift, tie downs, and other components. The CSN Fund will approve the lowest bid up to the maximum allowed. If a family chooses a vendor who is not the lowest bidder, the preferred vendor must be indicated on the application. The CSN Fund only approves the amount of the lowest bid up to the maximum allowed, and the family is responsible for any remaining balance.

There are no restrictions on tie-down systems, they are replaced as needed. All other vehicle accessibility devices will be considered no more than twice per child until the age of 21. A second request may be submitted after five (5) years have elapsed since the first device was approved.

The CSN Fund may:

- Provide funding toward the van lift portion of a ready-made wheelchair accessible van.
- Provide funding toward the transfer of a functioning lift (paid for by the CSN Fund)

to another vehicle if the old vehicle is damaged beyond repair and/or insurance will not cover the cost of transfer. (Documentation must be provided showing insurance will not cover transfer).
- Provide funding towards the installation of a van lift during a vehicle modification such as van conversion.

The CSN Fund will not cover:

- Routine maintenance or van repair
- The purchase or lease of vehicles
- Remote car starters and custom interiors, etc.

The following documents must be submitted for vehicle accessibility device applications:

- A completed Children with Special Needs Fund Application for Assistance (DCH-1239)
- A completed Children with Special Needs Fund Financial Assessment (DCH-1273) if the child is not enrolled in CSHCS
- A letter from the child's parent/guardian explaining the reason for the request
- A letter of medical necessity from the child's specialty physician, physical therapist, or occupational therapist
- A completed Children with Special Needs Fund Documentation of Assistance (DCH-2423)
- Three (3) quotes for the vehicle accessibility device. Quotes must be itemized to reflect the separate cost of the vehicle, conversion, lift, tie-downs, and other components.

Families living in Michigan's Upper Peninsula (UP) need only submit two (2) quotes. For applicants who do not live in the Upper Peninsula but cannot obtain more than two (2) quotes due to lack of local vendors/resources, please contact the Children with Special Needs Fund.

24.4-H Weighted Blankets, Vests

The CSN Fund may approve funding for weighted blankets and vests for the purpose of improving the quality of life of a child. Three (3) quotes are required for weighted blanket/vest applications. The CSN Fund will approve the lowest bid up to the maximum allowed. If a family chooses a vendor who is not the lowest bidder, the preferred

vendor must be indicated on the application. The CSN Fund only approves the amount of the lowest bid up to the maximum allowed, and the family is responsible for any remaining balance. Weighted blankets or vests will be considered no more than twice per child until the age of 21. A second request may be submitted after five (5) years have elapsed since the first blanket/vest was approved.

24.4-I Wheelchair Ramps

The CSN Fund may approve funding for a permanent or portable home wheelchair ramp to transfer the child safely and securely into and out of the home.

If a family lives in a rental unit, a complete and signed Children with Special Needs Fund Landlord Agreement Form (DCH-2424) must be submitted with the application package. This signed agreement absolves the CSN Fund of any responsibility regarding restoration of the property to its original condition in case of damages or if the occupants relocate.

Three (3) quotes are required for wheelchair ramp applications. Each quote must be accompanied with a diagram of the proposed structure. The CSN Fund will approve the lowest bid up to the maximum allowed. If a family chooses a vendor who is not the lowest bidder, the preferred vendor must be indicated on the application. However, the CSN Fund only approves the amount of the lowest bid up to the maximum allowed, and the family is responsible for any remaining balance. A copy of the building permit must accompany the invoice whenever construction is involved.

Note: A platform lift may be considered if the property will not accommodate a wheelchair ramp that meets Americans with Disabilities Act (ADA) guidelines and any city, state, or federal ordinances that apply. A home evaluation report must be submitted to show that a platform lift is the better option. Funding is not available for platform lifts on rental property.

Wheelchair ramps and platform lifts are limited to one approval per family per lifetime.

The following documents must be submitted for wheelchair ramp and platform lift applications:

- A completed Children with Special Needs Fund Application for Assistance (DCH-

1239)
- A completed Children with Special Needs Fund Financial Assessment (DCH-1273) if the child is not enrolled in CSHCS
- A letter from the child's parent/guardian explaining the reason for the request
- A letter of medical necessity from the child's specialty physician, physical therapist, or occupational therapist
- A completed Children with Special Needs Fund Documentation of Assistance (DCH-2423)
- Three (3) quotes for the wheelchair ramp or platform lift accompanied with a diagram of the proposed structure
- A signed Landlord Agreement Form DCH-2424 (for rental units) for wheelchair ramps

Note: Genesee and many other counties have a ramp builders associations and charitable organizations that will donate manual labor. Families who live in counties that provide donated manual labor services may only request funding for the cost of materials. Local resources for donated services include: United Way of Genesee County, Disability Services Resource Center, and Michigan Council of Carpenters. When available, these resources/vendors are CSN Fund preferred vendors because labor is supplied free of charge for construction and their quote will always be the lowest when compared to other vendors who charge for labor and material.

Families living in Michigan's Upper Peninsula (UP) need only submit two (2) quotes. For applicants who do not live in the Upper Peninsula but cannot obtain more than two (2) quotes due to lack of local vendors/resources, please contact the Children with Special Needs Fund.

24.4-J Other Requests

Requests other than those listed above will be reviewed by the Medical Consultant and/or the CSN Fund Advisory Committee. When requests are outside the scope of traditional CSN Fund coverage, the reviewers and/or committee may request that the family to submit additional information. In this case, families are advised that it may take longer than 4 – 6 weeks for a decision to be made.

Three (3) quotes are required for "Other Request" applications. The CSN Fund will approve the lowest bid up to the maximum allowed. If a family chooses a vendor who is not the lowest bidder, the preferred vendor must be indicated on the application.

However, the CSN Fund only approves the amount of the lowest bid up to the maximum allowed, and the family is responsible for any remaining balance.

The following documents should be submitted for "Other Requests" applications:

- A completed Children with Special Needs Fund Application for Assistance (DCH-1239)
- A completed Children with Special Needs Fund Financial Assessment (DCH-1273) if the child is not enrolled in CSHCS
- A letter from the child's parent/guardian explaining the reason for the request
- A letter of medical necessity from the child's specialty physician, physical therapist, or occupational therapist
- A completed Children with Special Needs Fund Documentation of Assistance (DCH-2423)
- Three (3) quotes for the item being requested
- A signed Children with Special Needs Fund Landlord Agreement Form (DCH-2424) for requests involving rental property
- Additional information may be required/requested

24.5 Non-Covered Items

The CSN Fund does not cover the following items:

24.5-A Home Modifications

The CSN Fund does not cover:

- Fencing, widening of doorways, modification of bathroom facilities, elevators, installation of plumbing systems, roof repair, sidewalks, driveways, heating, garages, raised garage doors, storage, and organizers etc.
- Hot tubs, whirlpool tubs, swimming pools, landscaping, and general home repairs
- Items routinely found in a home (e.g., bed linens, carpeting, mattress, pillow, vacuum cleaner, blender etc.)
- Safety devices routinely found in a home (e.g. fire extinguishers, home security systems, and storage cabinets etc.)

Any adaptation or improvements to the home that are considered to be standard housing obligations of the beneficiary's parent/caregiver and are not of direct medical or remedial benefit to the child are not covered by the CSN Fund.

24.5-B Assistive Technology

Assistive technology is an item or set of items for communication-impaired individuals that enable the individual to perceive, control, or communicate with the environment.

The CSN Fund does not cover:

- iPads/computers
- Sensory integration equipment
- Communication devices and aids including FM systems
- Special care items that accommodate the child's disability (e.g. reachers, full-spectrum lamps)
- Prostheses necessary to ameliorate negative visual impact of serious facial disfigurements and/or skin conditions
- Ancillary supplies and equipment necessary for proper functioning of assistive technology items
- Repairs to covered assistive technology

24.5-C Specialty Services

Specialty services are part of physical health care plans and arrangements related to mental health and developmental disability services, as well as certain covered substance abuse services.

The CSN Fund does not cover:

- Music Therapy
- Recreation Therapy
- Art Therapy
- Massage Therapy
- Memberships to health fitness clubs

24.5-D Personal Care/Household Items

The CSN Fund does not cover:

- Infection control, allergy control supplies or services
- Foot Care, massagers, and relaxation products
- Incontinence supplies
- Eyeglasses, hearing aids, braces and dentures

- Mattresses/beds
- Strollers and car seats
- Generators
- Blenders
- Humidifiers, dehumidifiers and purifiers
- Other personal care & household item not listed

24.5-E Reimbursement/Replacement of Equipment

The CSN Fund does not cover:

- Vendor reimbursements or reimbursements to families for items/equipment or services purchased/provided for or paid for by another source.
- Vendor reimbursements or reimbursements to families for items/equipment or services purchased/provided without CSN Fund approval.
- The CSN Fund will not replace items damaged from misuse/abuse by the beneficiary or caregiver.

24.6 Processing CSN Fund Applications

LHD staff provides assistance to families during the application process by helping them to:

- Complete the CSN Fund application
- Check for completeness of required documents
- Locate vendors in the community

It is not the role of the LHD to:

- Determine if a request will be approved or denied
- Gather estimates on behalf of families for equipment

24.7 Notification of Decisions

After the CSN Fund receives a request, CSN Fund staff and/or a clinical review team/medical consultant reviews the application. This review process yields one of the following decisions: approval, denial, or more information needed. The CSN Fund is privately funded and all funding decisions are at the discretion of the CSN Fund Advisory Committee. Should a beneficiary receive a denial with which they disagree, they should contact the CSN Fund for information on how to re-apply.

24.7-A Approval Notifications

Vendor – The CSN Fund will a send a promissory notification letter to the vendor stating the specific equipment and the amount of funds authorized to the approved vendor upon completion of work.

Family/individual – The CSN Fund will send an approval notification letter to the responsible party that states the specific equipment and the amount of funds authorized for the approved vendor upon completion of work. The letter includes information regarding any delivery information for equipment ordered on their behalf, or the family's responsibility to contact the approved vendor.

Local Health Department staff – The CSN Fund will send a copy of both vendor and family letters to the requestor's county LHD when the LHD submitted the application, or upon the family's request.

24.7-B Denial Notifications

Family/individual – The CSN Fund will send a denial notification letter to the responsible party that states the request has been denied, and the reason for the denial.

Local Health Department staff – The CSN Fund will send a copy of the denial letter to the requestor's county LHD when the LHD submitted the application, or upon the family's request.

24.7-C More Information Notifications

Family/individual – The CSN Fund will send a notification letter to the responsible party listing the documents that are required to complete the application.

Local Health Department staff – The CSN Fund will send a copy of the notification letter listing the documents that are required to complete the application to the requestor's county LHD when the LHD submitted the request, or upon the family's request.

Guidance Manual for Local Health Departments

SECTION 25: LEGAL MATTERS

25.1 Appeals

CSHCS clients have the right to appeal decisions made by MDHHS. Examples of decisions which may be appealed include, but are not limited to:

Denial of Medical eligibility
Financial participation (payment agreements)
Denial of Services requiring prior authorization or that have been reduced, changed or terminated.

All clients have the right to request an appeal. The client is informed in writing of the action taken and the right to appeal. Appeals are conducted by telephone. Administrative Hearings can be held in-person when requested by the client.

The LHD may assist or represent the family as requested during the appeal process. All appeal requests must be in writing and mailed to the Appeals Section for the MDHHS. If an original request for an appeal is received by the LHD, it must be faxed or mailed to the Appeals Section.

25.2 Department Reviews

Beneficiaries without Medicaid coverage are entitled to appeal MDHHS negative actions, and to a Department Review when they have been denied CSHCS eligibility or services, or when established CSHCS services have been reduced, changed or terminated. The beneficiary will be notified in writing of the negative action and the right to appeal. CSHCS follows the same appeal and request for hearing policies and procedures as established by MDHHS for all MDHHS programs.

To request a department review, the client must complete and return a Request for a Department Review (DCH-0892) within 90 days of the date of the written notification. The request for department review is usually included with the client's written notification of the change in services. The client has the right to be assisted or represented by a person of his/her choice during this process. Requests for Department Review must be made in writing and signed by the client or the client's representative. Department reviews are informal appeals conducted by an MDHHS appeals review officer. The family is informed of the decision in writing, and copies of the decision are

provided to CSHCS and any party representing the family at the review. Further questions about the appeals process can be directed to the MDHHS Appeals Section.

25.3 Administrative Hearings

Beneficiaries who also have Medicaid coverage, have a right to an administrative hearing when services have been denied, reduced, changed or terminated. The beneficiary will be notified in writing of the negative action and the right to appeal. The beneficiary may receive an administrative hearing if the circumstances suggest that Medicaid reimbursement is involved in the coverage or service in question. The beneficiary may receive a department review if the circumstances indicate that Medicaid reimbursement is in no way involved in the coverage or service in question. The Michigan Office of Administrative Hearings and Rules (MOAHR) determines which hearing is appropriate once a beneficiary has requested a hearing.

To request an administrative hearing (also referred to as a fair hearing), the client must complete and return a Request for Hearing (DCH-0092) within 90 days of the date of the written notification. The Request for Hearing form is usually included with the client's written notification of the change in services. The client has the right to be assisted or represented by a person of his/her choice during this process. Any requests for a hearing must be made in writing and signed by the client or the client's representative. Hearings are formal appeals conducted by an MDHHS Administrative Law Judge (ALJ). The family is informed of the decision in writing and copies of the decision are provided to CSHCS and any party representing the family at the hearing. Further questions about the appeals process can be directed to the MOAHR.

25.3-A Failure to Appear

A family or representative who is unavailable at the scheduled time of appeal will be issued a notice of failure to appear. Failure to appear results in closure of the appeal process and affirmation of the MDHHS decision.

25.3-B Withdrawal of Appeals

The client or a representative may withdraw the appeal request at any time during the process. To withdraw an appeal, the client or client's representative may complete the

Request for Withdrawal of Appeal (DCH-0093) and return it to the MOAHR. The client or client's representative may also withdraw an appeal by calling the MOAHR.

25.4 Subpoenas

Occasionally, the CSHCS office in the LHD may be served with a subpoena requiring the presentation of a CSHCS client's records (medical or financial) in court.
LHDs served with subpoenas are required to:

Record the date, time, and the name of the server in the client's case file.
Forward copies of the court order or subpoena, released bills, and any additional information to the CSHCS Customer Support Section. The Customer Support Section is responsible for obtaining specific information from the client's case file.
If a provider other than the LHD is served with a subpoena or court order, copies of the released information described above should be sent directly to the MDHHS Third Party Liability section.
Original documents are not to be relinquished.

25.5 Court Originated Liability Cases

A court originated liability case (formerly known as a "casualty" case) is defined as a case with the potential for recovery of MDHHS expenditures made on behalf of a client seeking medical attention as the result of an auto accident, personal injury, medical malpractice, or birth trauma. MDHHS funds may be recoverable from an outside responsible entity such as an insurance company, lawsuit settlement, or estate.
When an application for CSHCS, or conversation with a potential client indicates or suggests that the potential client's health problem is related to an accident or birth injury (e.g. an auto insurance company listed in the insurance information section or statements made indicating the words attorney, adjuster, case, or legal action), forward a copy of the application to the MDHHS Third Party Liability section.
Third Party Liability will review the information on the application and complete a follow-up with the client or family as necessary. Questions regarding court originated liability cases should be directed to Third Party Liability.

25.6 HIPAA: Confidentiality of Protected Health Information

MDHHS complies with HIPAA privacy requirements and recognizes the concern for the confidential relationship between the provider and the client. MDHHS protects this

relationship by using records and information only for purposes directly related to the administration of CSHCS and/or Medicaid.

All records are of a confidential nature and should not be released, other than to a client or his/her representative, unless the provider has a signed release from the client. The Authorization to Disclose Protected Health Information (DCH-1183) or Release to Obtain Medical Information (MSA-0838) are available for completion. Providers are bound to all HIPAA privacy and security requirements as federally mandated.

Occasionally the LHD may be contacted by another agency (e.g. SSI office) with a request to release client medical information. The LHD should forward all requests of this nature to the CSHCS Customer Service Section for response. If the LHD or provider has questions regarding the appropriateness of releasing protected health information, the LHD or provider is encouraged to seek legal counsel before doing so.

Guidance Manual for Local Health Departments

SECTION 26: TRANSITION ASSISTANCE

As children enrolled in the CSHCS program become young adults, their health care needs begin to change. Health care transition is the process of preparing young adults to transfer their health care from pediatric providers to adult providers. It should also ensure that a child develops necessary skills needed to maintain their health and health insurance coverage.

During childhood, parents and caregivers usually help with medical needs. As youth get older, managing their medical needs becomes their responsibility. Although this transition can be exciting and challenging, it can also be particularly difficult for youth enrolled in CSHCS due to complex medical needs. LHDs have a unique opportunity to help create a smooth transition by providing guidance and support to youth and families throughout this process.

Each LHD is expected to have a Transition Policy. LHDs are encouraged to begin transition planning prior to the age of 14. CSHCS has provided materials, resources, and guidance for LHDs, clients, and families to effectively transition to adult health care, including a transition readiness assessment and plans of care. These are primarily billable care coordination services which are tracked through the MDHHS automated system. Additional materials and resources can be found on the CSHCS website under Transition to Adulthood.

During this time, youth will be preparing for other transitions as well. Some examples include evaluating housing options, considering job opportunities, and learning how to manage their money and other resources. The LHD serves an important community-based role by providing referrals and resources to state or local agencies that directly relate to these topics.

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SECTION 27: BEREAVEMENT

27.1 LHD Bereavement Procedure

Complete a Notice of Action (NOA) advising the analyst of the child's death and upload to DMP, or fax to the CSHCS Customer Support Section if DMP is unavailable. A referral should be made to the Family Center only if the family requests additional bereavement resources.

27.2 CSHCS Analyst Procedure

The analyst will update the CSHCS database and notify the Family Center. Any remaining balance due on a payment agreement will be waived. CSHCS coverage will not be issued to a Medicaid-enrolled client who died prior to the CSHCS start date.

27.3 Family Center Bereavement Procedure

Upon notification from the analyst that a death has occurred, the Family Center will send a bereavement letter to the family. A sample bereavement letter is included at the end of this section. This sample is included for reference only and is sent to families by the Family Center.

Guidance Manual for Local Health Departments

STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

GRETCHEN WHITMER
GOVERNOR

Elizabeth Hertel
DIRECTOR

July 6, 2023

The xxxxx Family
Xxxx xxxxxxx St.
xxxxx, MI xxxx

Dear xxxxx Family,

The staff of the Family Center and Children's Special Health Care Services would like to express our heartfelt sympathies on the recent passing of xxxxx. While words are so often inadequate, we hope that you will accept our expression of sorrow.

We do not want you to feel alone during this difficult time. If the need arises and you would like to speak with another parent who has experienced the loss of a child, please do not hesitate to contact us through the CSHCS Family Phone line at 800-359-3722 or email cshcsfc@michigan.gov.

Once again, you and your family have our deepest condolences. Please remember that the Family Center staff, and many other parents, are here to help.

Sincerely,

Jane Pilditch
Manager of Family Center for Children and Youth
with Special Health Care Needs
Children's Special Health Care Services
Michigan Departm of Health and Human Services

400 S.PINE ST. PO BOX 30815.LANSING, MICHIGAN 48909
www.michigan.gov/mdhhs - 517-373-3740

MDHHS Michigan Department of Health & Human Services | Children's Special Health Care Services

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Michigan Department of Health and Human Services (MDHHS)
Please note if needed, free language assistance services are available.
Call 800-359-3722 (TTY users call 711).

Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-359-3722 (TTY: 711).
Arabic	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 800-359-3722 (رقم هاتف الصم والبكم:-TTY:711).
Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 800-359-3722（TTY:711）
Syriac (Assyrian)	ܙܘܗܪܐ: ܐܢ ܐܢܬܘܢ ܟܐ ܡܡܠܠܝܬܘܢ ܠܫܢܐ ܐܬܘܪܝܐ، ܬܡܢ ܝܬܘܢ ܕܦܠܚܬܘܢ ܡܢ ܬܫܡܫܝܬܐ ܕܗܝܪܬܐ ܒܠܫܢܐ ܡܓܢܢܝܬܐ. ܩܪܘܢ ܥܠ ܡܢܝܢܐ 800-359-3722 (TTY:711)
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 800-359-3722 (TTY:711).
Albanian	KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 800-359-3722 (TTY:711).
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-359-3722 (TTY:711)번으로 전화해 주십시오.
Bengali	লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১-800-359-3722 (TTY ১-711)
Polish	UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 800-359-3722 (TTY:711).
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer 800-359-3722 (TTY:711).
Italian	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 800-359-3722 (TTY:711).
Japanese	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。800-359-3722（TTY:711）まで、お電話にてご連絡ください
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800-359-3722 (телетайп 711).
Serbo-Croatian	OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 800-359-3722 (TTY Telefon za osobe sa oštećenim govorom ili sluhom 711).
Tagalog	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 800-359-3722 (TTY: 711).

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The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability. Further, MDHHS:

- Provides free aids and services to people with disabilities to communicate with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats); and
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need the above services, contact the MDHHS Section 1557 Coordinator.

If you believe that MDHHS has failed to provide the above services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: MDHHS Section 1557 Coordinator. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the MDHHS Section 1557 Coordinator is available to help you.

MDHHS Section 1557 Coordinator
Compliance Office, 4th Floor
P.O. Box 30195
Lansing, MI 48909
517-284-1018 (Main), TTY users call 711, 517-335-6146 (Fax),
MDHHS-ComplianceOffice@michigan.gov

You can also file a civil rights complaint with the responsible federal agency.

If your grievance or complaint is about your Medicaid application, benefits or services you can file a civil rights complaint with the U.S. Department of Health and Human Services at https://bit.ly/2pBS4YG, or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 800-368-1019, 800-537-7697 (TDD) Complaint forms are available at https://bit.ly/2IKsHMS.	If your grievance or complaint is about your application for or current food assistance benefits, you can file a discrimination complaint with the U.S. Department of Agriculture (USDA) Program by: Completing a Complaint Form, (AD-3027) found online at: https://bit.ly/2g9zzpU or at any USDA office, or write a letter addressed to USDA at the address below. In your letter, provide all information requested in the form. To request a copy of the complaint form, call 866-632-9992. Send your completed form or letter to USDA by mail: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, SW Washington, D.C. 20250-9410 Fax: 202-690-7442; or Email: program.intake@usda.gov

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