MATHEMATICA Policy Research

URBAN INSTITUTE

REPORT

FINAL REPORT

Congressionally Mandated Evaluation of the Children's Health Insurance Program: Michigan Case Study

November 1, 2012

Sheila Hoag

Cara Orfield

Submitted to:

U.S. Department of Health and Human Services

Office of the Assistant Secretary for Planning and Evaluation

200 Independence Avenue, SW

Washington, DC 20201

Project Officer: Rose Chu

Contract Number: HHSP23320095642WC/HHSP23337021T

Submitted by:

Mathematica Policy Research

220 East Huron Street

Suite 300

Ann Arbor, MI 48104-1912

Telephone: (734) 794-1120

Facsimile: (734) 794-0241

Project Director: Mary Harrington

Reference Number: 06873.702

This page has been left blank for double-sided copying.

ACKNOWLEDGEMENTS

The authors would like to thank the many state officials and stakeholders in Michigan who gave so freely of their time and insights during our site visit; this case study would not have been possible without their assistance. We would also like to sincerely thank the community-based agencies that assisted us with focus group recruitment, as well as the Meijer Corporation, which generously supported our efforts to conduct a focus group with some of its employees. We are indebted to the many parents who took the time to participate in our focus groups, tell us of their experiences, and share their honest opinions about how well *MIChild, Healthy Kids,* and employer-sponsored insurance programs in the state are meeting the needs of their children. We acknowledge the contributions of staff at Mathematica, in particular Vivian Byrd, who facilitated the focus groups. Finally, we are grateful to our Federal project officers, Rose Chu and Wilma Robinson at ASPE/DHHS, as well as Beth Hadley of ASPE/DHHS, for their ongoing guidance, assistance, and advice.

This page has been left blank for double-sided copying.

CONTENTS

This page has been left blank for double-sided copying.

TABLES

This page has been left blank for double-sided copying.

FIGURES

This page has been left blank for double-sided copying.

I. BACKGROUND AND RECENT HISTORY

Michigan operates a combined Children's Health Insurance Program (CHIP), featuring a larger separate CHIP component coupled with a smaller Medicaid expansion; together, the two programs cover children from families with incomes up to 200 percent of the Federal poverty level (FPL). The separate CHIP component (S-CHIP), *MIChild*, currently covers about 37,000 children each month. The M-CHIP component, *Healthy Kids*, is small in size—covering about 7,000 children ages 16 through 18 from families with incomes from 101 to 150 percent of the FPL on average each month. As with most Medicaid expansions, the M-CHIP portion is viewed throughout the state as a component of the Medicaid program (also called *Healthy Kids*).[1] Although both programs are administered by the Michigan Department of Community Health (DCH), eligibility for *Healthy Kids* is determined by another state agency, the Department of Human Services (DHS).

Michigan was an early innovator in *MIChild* and continues to permit many simplifications that make enrolling and remaining in the program easier for families, including self-declaration of income and residency and a 12-month continuous coverage policy. It has kept costs low for families—at premiums of $10 per family per month, regardless of the number of children in the family, Michigan's premium charge is among the lowest in the nation (among states that charge premiums) and uses no other cost-sharing in the program.[2]

As a result of modeling *MIChild* on private coverage—for example, enrollees receive an insurance card with their plan's name on it and nothing identifying *MIChild*—the program appears to be popular among stakeholders, families, and providers. Perhaps because of its popularity, as well as the relatively small size of the program compared to Medicaid, it has not been a target for state budget cuts, despite the difficult Michigan economy in the past decade. Most stakeholders think access in *MIChild* is good; in fact, the biggest access problem identified was with *Healthy Kids* dental access in certain areas of the state (particularly large urban areas, such as Detroit), where dental benefits are provided through fee-for-service arrangements rather than managed care, and few dentists will accept it.

The number of uninsured children, in particular low-income uninsured children (family incomes less than 200 percent of the FPL), has declined over the past several years in Michigan. Published data analyses of the American Community Survey find that the number of uninsured children from low-income families in the state has fallen from about 86,000 in 2008 to about 60,000 in 2010; from 2008 to 2009, children's participation in public coverage has increased from 90.8 to 92.1 percent in the state, making it the fifth highest in the Nation in terms of public coverage rates in 2009 (Kenney et al. 2011; Lynch et al. 2010; Center for Children and Families 2011). Although many factors, including the weak state economy, contribute to increasing public coverage rates, stakeholders give

[1] When we use the term *Healthy Kids* throughout the remainder of this report, we are referring to both the larger Medicaid program as well as the M-CHIP component, as these are administered as a single program.

[2] This is among States that charge premiums in their S-CHIP programs (10 States with S-CHIP programs charge no premiums, but even those States have cost sharing in the form of copayments for prescriptions, primary care office visits, or both) (Hoag et al. 2011). A review of 2010 data on premium and cost-sharing indicates that among States that charge premiums, only Colorado, North Carolina, and Texas's premiums are lower than Michigan's, and all three of these States charge copayments (Hoag et al. 2011).

much of the credit to the *MIChild* program. Informants report that for every five children screened for *MIChild* eligibility using the joint application form, four are found eligible for *Healthy Kids*.

Coordination between *MIChild* and *Healthy Kids* has improved in recent years, due in large part to a new information system to determine eligibility for *Healthy Kids* (and public programs other than *MIChild*) implemented in 2009. Beginning in September 2010, this system for the first time permitted electronic referrals from *Healthy Kids* to *MIChild*; before this, referrals could only be made by sending a paper application. After implementation of the new system, referrals from *Healthy Kids* to *MIChild* increased by 30 percent. Although narrowing, gaps remain for families transitioning between the programs, however. For example, there is not complete overlap in the participating health plans, so switching from *MIChild* to *Healthy Kids* might disrupt care provision for children, requiring a plan change and possibly a provider change. Administratively, the state is missing opportunities for more efficiencies between the two programs. For example, every application transferred from one program to another ends up being processed twice, once by the transferring agency and once by the receiving agency, adding time and resources to the eligibility determination process, and possibly lengthening the time to coverage for families.

In terms of policy, the CHIP Reauthorization Act (CHIPRA) had a small effect on Michigan's CHIP program primarily because the state already had generous policies in place before CHIPRA's passage. The state did make some policy adjustments, such as implementing the citizenship documentation requirement in *MIChild* and modifying the dental services benefits to comply with CHIPRA rules. It only recently implemented a prospective payment system for federally qualified health centers (FQHCs) and rural health clinics (RHCs), which was required by October 1, 2009; Michigan is working on this new payment system and will have to reconcile with centers retroactively back to the October 1, 2009 deadline.[3] The most significant impact of the CHIPRA legislation has been financial, with Michigan's Federal allocation for CHIP increasing 50 percent, combined with CHIPRA performance bonuses of nearly $20 million and more than $2 million in CHIPRA outreach grants.

With nearly $1 million in Federal exchange grant planning monies, Michigan is actively preparing for health reform, although the legislature is slowing the planning process. The governor supports the implementation of a new health care marketplace for Michigan, and the state has used its initial grant to actively pursue a state-based exchange. Once the exchange is enacted, CHIP would likely be one of many options available in the exchange, although the CHIP and Medicaid plan selection process may remain independent of the exchange. Efforts to pass exchange legislation have been delayed by the Michigan House of Representatives, which has postponed voting on exchange legislation in this election year (it has already passed the state Senate). In addition, the House of Representatives has refused to appropriate a nearly $10 million new grant from the Federal government to build and implement a new information system to support the exchange. The state continues to use the predecessor Federal grant so that the planning process for reform can continue, but the money from this grant is almost completely spent. Although other reforms, such as basic health plan (BHP), have been promulgated—for example, the Senate sponsored a BHP bill—the administration has deferred its consideration on such issues until the exchange authorization is complete. At the time of our visit, informants reported that no final decisions would be made about

[3] Michigan's State Plan Amendment for PPS payments to FQHCs and RHCs was approved in April 2012, and payments have begun being processed.

health reform or the state-based exchange until after the Supreme Court decision. In the aftermath of the Supreme Court's ruling, a posting on the Governor's website in early July indicated his continued support for implementing a state-based exchange, although the Legislature still has not acted on exchange legislation (Snyder 2012). At the time of our visit, given how little time was left to plan a state-based exchange, some key informants suggested the state might pursue a state-federal partnership exchange. As of August 23, 2012, Michigan remains undecided as to whether it will participate in the Affordable Care Act's Medicaid expansion (American Health Line 2012).

This case study is primarily based on a case study conducted in Michigan in May 2012 by staff from Mathematica Policy Research.[4] Michigan was one of 10 states selected for study in the second congressionally mandated evaluation of CHIP, authorized by CHIPRA and overseen by the Assistant Secretary for Planning and Evaluation (ASPE). The report highlights changes to Michigan's programs that have occurred since 2006, with a particular focus on state responses to provisions of CHIPRA. In addition to interviewing 39 key informants (listed in Appendix A) in Lansing, East Lansing, Detroit, Ann Arbor, Southfield, and Farmington Hills, researchers conducted three focus groups for the study: one with parents of children currently enrolled in *MIChild* in Lansing, one with parents of children who had been disenrolled from *MIChild* in Detroit, and one with lower-income parents whose children were enrolled in their employer-sponsored insurance (ESI) in Lansing.[5] In all, 16 parents participated in these focus groups. Findings from these focus groups are included throughout the report and serve to augment information gathered through stakeholder interviews.

The remainder of this report will describe recent *MIChild* and *Healthy Kids* program developments and their perceived effects in the key implementation areas of eligibility, enrollment, and retention; outreach; benefits; service delivery, quality, and access; cost-sharing; crowd-out; financing; and preparation for health care reform. The report concludes with cross-cutting lessons learned about the successes and challenges associated with administering Michigan's CHIP program.

II. ELIGIBILITY, ENROLLMENT, AND RETENTION

Michigan was an early innovator in *MIChild*, offering 12-months of continuous eligibility since the program's inception and initially implementing a passive renewal process (changed to an active renewal process in 2006).[6] Most stakeholders believe that *MIChild* has played an important role in outreach for *Healthy Kids*: for every five children screened for *MIChild* eligibility, four are found eligible for *Healthy Kids*. In this section, we review eligibility rules and processes, enrollment and application processes, enrollment trends, and retention policies and practices in Michigan's CHIP and Medicaid programs.

[4] Our site visit was conducted before the Supreme Court ruled on the constitutionality of the Affordable Care Act. This case study report largely reflects Michigan's CHIP program and policy developments prior to the ruling, although relevant updates have been made to the extent possible.

[5] Mathematica conducted a focus group with parents of children enrolled in ESI, but whose incomes might have otherwise qualified them for *MIChild*, in part to understand lower-income family experiences with nonpublic coverage.

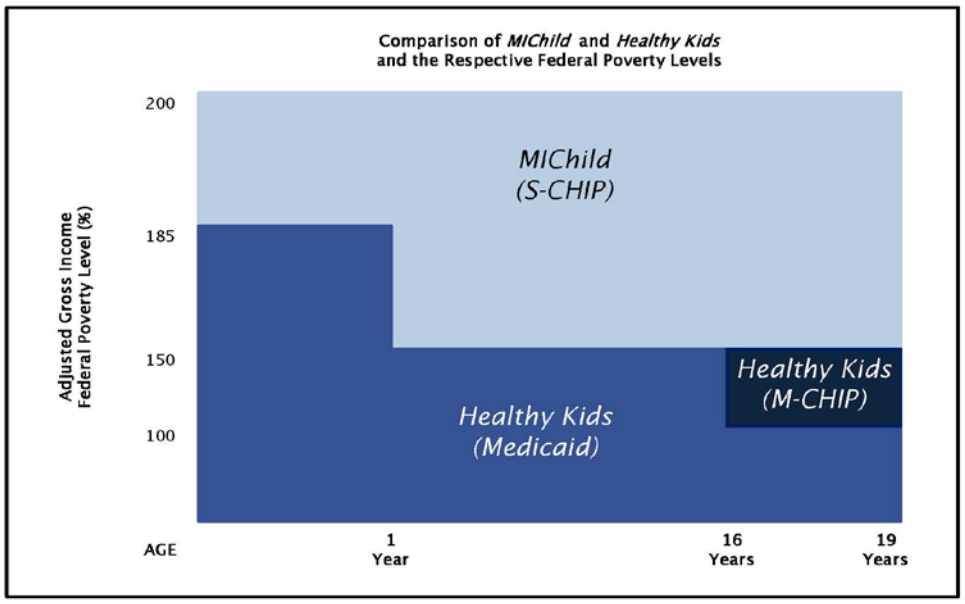
[6] Michigan changed from a passive to an active renewal process due to concerns about data accuracy and program integrity.

A. Eligibility

In Michigan, two different public health insurance programs provide insurance to low-income families (see Figure 1).

1. *MIChild* is the separate CHIP (S-CHIP) program in Michigan, funded through Title XXI. *MIChild* covers children ages birth to 1 whose families have incomes between 186 and 200 percent of the FPL, and children ages 1 through 19 whose families have incomes between 151 and 200 percent of the FPL. The Michigan Department of Community Health (DCH) administers all aspects of *MIChild,* including eligibility determination. DCH utilizes a single administrative contractor (MAXIMUS) for many *MIChild* administrative duties, such as eligibility determination, staffing a customer call line, and premium processing, among others.[7]
2. *Healthy Kids* includes children's Medicaid and Michigan's M-CHIP. The Title XIX Medicaid program in Michigan covers children ages birth to 1 whose families have incomes up to 185 percent of the FPL, ages 1 through 15 whose families have incomes up to 150 percent of the FPL, and ages 16 through 19 whose families have incomes up to 100 percent of the FPL. The Title XXI M-CHIP component covers children ages 16 through 19 whose families have incomes between 101 and 150 percent of the FPL. The Michigan Department of Human Services (DHS) is responsible for making *Healthy Kids* eligibility determination decisions, whereas DCH administers the program.

Figure 1. Eligibility Standards, Michigan's *MIChild* and *Healthy Kids* Programs



Source: Michigan Department of Community Health 2010.

Note: Children can be enrolled in either program until they turn 19. They are disenrolled on the last day of the month they turn 19 (Michigan Department of Community Health 2010).

[7] In Michigan, MAXIMUS receives and screens all initial joint applications, makes eligibility determinations for *MIChild,* refers *Healthy Kids*-eligible cases to DHS, operates the call center, collects *MIChild* premiums, processes *MIChild* renewals and disenrollments, and responds to all requests for outreach materials.

Beyond age and income, Michigan requires that all *MIChild* and *Healthy Kids* enrollees be citizens or qualified, documented aliens. As CHIPRA mandated, citizenship documentation is required for all applicants, although enrollment in *MIChild* is not permitted to be delayed or denied while awaiting citizenship verification. Some legal immigrants are not eligible for *MIChild* for the first five years of residency.[8] Applicants must be residents of Michigan, although migrant workers are permitted *MIChild* coverage provided all other eligibility requirements are met. Other individuals ineligible for *MIChild* include children eligible for *Healthy Kids;* those who have other comprehensive health insurance; those have been criminally adjudicated and are in a correctional facility; children admitted to an institution for the mentally disabled; those eligible for health insurance coverage on the basis of a family member's employment by a state, county, or city government agency in Michigan; or children covered by court-ordered medical insurance.[9]

Michigan's *MIChild* program income eligibility limits have not changed in the past six years. Despite a difficult state budget environment, there have been no threats to existing coverage levels. Key informants attributed this to the relatively small number of *MIChild* enrollees, and thus the smaller budget compared to *Healthy Kids,* which faces much more budget pressure. Because program eligibility levels were not threatened, the CHIP maintenance of effort (MOE) requirements were less critical in Michigan.[10] Expanding the program beyond the current eligibility levels has received no serious consideration.

Michigan's current eligibility policies for *MIChild* and *Healthy Kids* are largely similar (Table 1). Both programs have 12 months of continuous eligibility, do not require an asset test, do not use Express Lane Eligibility (ELE), require proof of citizenship, and have a redetermination frequency of 12 months. The main difference is that *Healthy Kids* eligibility rules are more generous: *Healthy Kids* provides enrollees with 3 months of retroactive coverage and has presumptive eligibility. The presumptive eligibility rules allow children who apply for *Healthy Kids* through a qualified application assistance agency, such as a county health clinic or other Medicaid provider, 60 days of presumptive eligibility while the full eligibility determination is made.[11]

---

[8] Legal immigrants who are eligible in their first five years of residency include refugees under Section 207, Cuban/Haitian entrants, and Iraqi and Afghan special immigrants.

[9] Michigan also offers a small coverage program for very low-income adults using its S-CHIP funding. The program, begun as a Health Insurance Flexibility and Accountability (HIFA) Section 1115 waiver in 2004, allowed Michigan to use its excess Federal S-CHIP allotment from its early program years to pay coverage for childless adults with very low incomes. CHIPRA eliminated HIFA waivers, but CMS allowed Michigan to convert its program to an 1115 Adult Benefits Waiver. This 1115 waiver program covers approximately 42,000 childless adults with incomes up to 35 percent of the FPL. Although there is no enrollment cap, there is an allocation cap that effectively caps enrollment, as the program is often closed to new enrollment because of limited funds. In addition to the adult benefit waiver, Michigan has county health plans that operate as quasi-public and quasi-managed care plans and provide medically-necessary health care to adults with incomes under 150% of the FPL.

[10] The Affordable Care Act stipulated that States must maintain minimum eligibility and enrollment standards (known as MOE requirements) in CHIP (as well as in Medicaid) that are at least as generous as those in place when the legislation was enacted on March 23, 2010 (PL 111-148).

[11] DCH trains and certifies two types of agencies to assist families applying for coverage using the online application: assisting agencies (AA) and qualified agencies (QA). There are about 400 such agencies in the State. AAs receive training but are unable to offer presumptive eligibility; organizations must be Medicaid providers in order to be certified as a QA and to offer presumptive eligibility. MAXIMUS reported that approximately 25 percent of all *MIChild* applications are submitted with help from an agency (either AA or QA).

Michigan considered adopting ELE using the National School Lunch Program (NSLP) as its partner agency. However, Michigan school districts are administered independently, meaning their data are not gathered and stored in a uniform manner. Several school districts were approached about the policy, but they were not interested in sharing information with DCH. The issue was dropped due to a lack of funding and what were seen as insurmountable data issues.

Children with special health care needs can apply for the Children's Special Health Care Services (CSHCS) program, administered by DCH, regardless of their family's income or eligibility for *MIChild* or *Healthy Kids*. To be eligible for CSHCS, a child must be diagnosed with at least one of over 2,600 health conditions.[12] CSHCS only covers medical services or treatments directly related to the member's eligible diagnosis, and thus does not cover primary care services, well-child visits, or services related to non-eligible health care conditions. Families of any income are eligible for CSHCS, and private health care coverage does not preclude CSHCS eligibility. Families that have coverage from *Healthy Kids*, *MIChild*, or Women, Infants, and Children (WIC) do not have any CSHCS cost-sharing burden. Families not covered by these programs are required to undergo a financial assessment as part of the application process to determine their level of cost-sharing. Key informants reported the fees to be nominal, at $2,600 a year at most. In calendar year 2010, average monthly enrollment in the program was 31,170.

Table 1. Eligibility Policies

Policies	*MIChild* (S-CHIP)	*Healthy Kids* (Medicaid/M-CHIP)	Details
Retroactive Eligibility	No	Yes	Unlike S-CHIP, M-CHIP and Medicaid automatically issue 3 months of retroactive coverage
Presumptive Eligibility	Yes	Yes	60 days of presumptive eligibility is provided when an application is filed at a trained and qualified application assistance agency
Continuous Eligibility	Yes	Yes	12 months
Asset Test	No	No	
Income Test	Adjusted gross income	Adjusted gross income	
Express Lane Eligibility	No	No	
Citizenship Requirement	Yes	Yes	Citizenship verification is not required for children born to Medicaid recipients
Redetermination Frequency	12 months	12 months	

B. Enrollment and Application Processes

The joint application for *MIChild* and *Healthy Kids* asks for demographic information on the family; income information (such as wages, self-employment, and other income); and income deductions (such as child support, guardian expenses, and day care) (a copy of the application can be

[12] In addition to meeting the medical condition requirement, individuals must be Michigan residents, U.S. citizens (some non-citizens may be eligible), and under age 21 (except for persons with certain blood clotting disorders or cystic fibrosis).

found in Appendix B).[13] Signing the application electronically serves as the family's legal signature. Table 2 summarizes current application requirements and procedures for Michigan's *MIChild* application.

Table 2. Current CHIP Application Requirements and Procedures

Initial Application	Details
Form	
Joint Application with Medicaid	Yes
Length of Joint Application	4 pages: 3 pages of application, 1 page of waiver and signature
Languages	English only: a telephone number for interpreter services is listed on the application in Spanish and Arabic
Verification Requirements	
Age	Yes, self-declared
Income	Yes, self-declared
Deductions	Yes, self-declared
Assets	No asset test
State Residency	Yes, self-declared
Immigration Status	Yes, self-declared and matched with Social Security Administration database
Social Security Number	Yes, self-declared with administrative verification
Enrollment Procedures	
In-Person Interview	No
Express Lane Eligibility	No
Mail-In Application	Yes
Telephone Application	No
Online Application	Yes
Hotline	Yes
Outstationed Application Assistors	Yes
Community-Based Enrollment	No, centralized enrollment

The joint application is relatively short and, although it is available only in English, a telephone number for interpreter services available through the state's call center (operated by MAXIMUS) is listed on the application in both Spanish and Arabic. Michigan is a no-documentation state, meaning families can self-declare age, income, deductions, state residency, immigration status (matched with the Social Security Administration [SSA] database) and their Social Security number. No asset test or in-person interview is required. Families can submit the application online or by mail and more than 400 community-based application assistors are available throughout the state to help families complete and submit the form (see footnote 8 for additional information on application assistance).

Table 3 shows that most families apply for coverage online (61.4 percent of applications in 2011). When a family applies online, an initial eligibility determination is made in real time. Someone whose income makes his or her child *MIChild*-eligible is immediately asked several follow-up questions, including whether he or she has access to health insurance, whether that insurance is comprehensive, and whether he or she voluntarily dropped employer-based health insurance in the past six months. After answering these additional questions, the family sees a screen showing the

[13] Michigan offers a joint, online application for CHIP and Medicaid, but a separate application is also available for families applying only for Medicaid or for Medicaid and other assistance programs.

programs for which members of the family are eligible (either *MIChild, Healthy Kids, Plan First!,*[14] or *Maternal Outpatient Medical Services* [MOMS])[15].

Table 3. Joint Applications Received, by Source: January 2011 to December 2011

Source of Application	Count	Percentage
Internet Application	92,786	61
DHS Interface (electronic referral from Medicaid)	43,190	29
Renewal Application	7,758	5
Paper Application	7,344	5
Paper Application Forwarded from DHS	118	<1
Total Applications Received	151,196	100
Number of Children and/or Pregnant Women Listed on the Applications	488,526	

Source: MAXIMUS, *MIChild* calendar year 2011 report. January 1, 2011 to December 31, 2011.

After Internet application, the next largest share of *MIChild* applications is from the DHS interface referral system (28.6 percent). This group represents families who applied to DHS for *Healthy Kids,* were determined ineligible, and are electronically referred to *MIChild.*[16] Very few paper applications are received (4.9 percent of 2011 applications), although key informants reported that paper applications could be found at many providers' offices, school-based health clinics, and county offices. Paper applications are submitted to MAXIMUS, whose staff members enter them into the online system. After that additional step, paper applications are processed in the same way as online applications.

The last step in the online application for families eligible for *MIChild* is to select both health and dental plans. Families are permitted to change their plans within the first 90 days. Families with children determined *MIChild*-eligible also receive coupons for paying their $10 per family per month premiums. Coverage under *MIChild* begins on the first of the month following acceptance into the *MIChild* program, unless the approval occurs in the last five business days of the month, in which case coverage does not start until the first of the following month. Enrollment does not hinge on receipt of the $10 family premium or on the citizenship verification process (discussed later in this profile).

Unlike in *MIChild*, additional steps are involved in getting *Healthy Kids* children enrolled in a health plan. For *Healthy Kids*, DHS sends a letter to the family informing them of the eligibility determination decision and also sends MAXIMUS a daily update file with information on new and revised *Healthy Kids* cases. MAXIMUS then sends a letter to new *Healthy Kids* families instructing

[14] *Plan First!* is a family planning service for women ages 19 to 44 who are not pregnant. The program has no monthly premiums or copayments and is administered by DHS.

[15] *MOMS* provides immediate prenatal care coverage for pregnant woman and provides a guarantee of payment letter while Medicaid coverage is pending. It uses CHIP funding for immigrant pregnant women, covering the baby until he or she is born. The program has no monthly premiums or copayments and is administered by DCH.

[16] Families applying for benefits through the DHS office can submit a 1171 application form, which is the combined application for all DHS-administered programs. If the family indicates it wants to apply for public health insurance programs and the applicant has children, DHS conducts the eligibility determination for *Healthy Kids*. If the applicant is not eligible for *Healthy Kids,* DHS send the application electronically to MAXIMUS via an electronic interface, where an eligibility determination for *MIChild* is made.

them to call to make a health plan selection, or to visit their local field agency.[17] Beginning July 15, 2012, *Healthy Kids* enrollees will be able to make their health plan selection online, and stakeholders see this as an important simplification.

Michigan employs an open-and-chase policy, which means all *MIChild* cases are opened immediately, despite the potential need for additional documentation regarding citizenship. Although *MIChild* does not require applicants to submit any type of documentation initially, citizenship verification is required. If a child's Social Security number is provided at the time of application, MAXIMUS will send an electronic file to DCH Vital Records within the first 10 days of the first month of eligibility. About 65 percent of new applicants have their citizenship verified through this process and do not have to provide any additional documentation. If the state is unable to verify the live birth because the child was born elsewhere or because the family does not provide a Social Security number for the child, the family may be asked to send a birth record. If the documentation is not received after multiple requests, the case is closed at the end of the fourth month. If the applicant came to *MIChild* through a DHS referral and DHS had separately verified the child's citizenship or identity, MAXIMUS accepts that verification.

For online applicants whose children appear eligible for *Healthy Kids*, the system informs them that it appears likely they are *Healthy Kids*-eligible but their application will be sent to DHS for a final determination. MAXIMUS then sends the application to DHS via an electronic interface for the formal *Healthy Kids* eligibility determination. This transfer happens for roughly a third of the applications MAXIMUS receives, and key informants pointed out the limitation of needing to screen these *Healthy Kids* applications twice (once at MAXIMUS and once at DHS), but current legislation does not permit MAXIMUS to determine eligibility for *Healthy Kids*.

Focus Group Findings: Eligibility and Enrollment

Most focus group participants said that applying for *MIChild* was relatively easy, though a few noted difficulties with the application itself. Some participants mentioned a language barrier, particularly for those speaking different Spanish dialects.

I didn't qualify for Medicaid, so my caseworker tried MIChild and they did it right on the computer.

I didn't even know that my kids could get MIChild … I was pleasantly surprised and went for it.

I could see how people have a hard time getting through that [application] or need help. It is a long application.

Sometimes people can't understand the application because the Spanish is in one dialect and they can't understand that dialect.

Families with ESI coverage cited affordability and peace of mind as the main reasons for enrolling their children in insurance coverage. Most said it was easy to enroll.

When my son was born, I just put him on my [insurance] because I wanted to … I don't have a cell phone and just recently got a laptop … I've gone without extras because insurance to me is something you need to have, versus the cell phone [which] is a luxury.

I feel a lot better having [insurance]. I know some people that wound up in intensive care for 100 days at $10,000 a day. If I walked out of the hospital with that kind of bill for my family … How could you do it?

It's really easy [to enroll]. Most of it, you can do on the computer. I just changed mine over.

[17] MAXIMUS contracts with the Michigan Community Practice Action Association (MCPAA), which subcontracts to community action agencies (CAAs) to track down *Healthy Kids* families that have not selected a health plan.

The timeline for eligibility determination is much shorter for *MIChild* than *Healthy Kids*. For *MIChild*, DCH requires MAXIMUS to process paper applications in eight days or fewer (it typically takes MAXIMUS two days) and to make real-time determinations for online applications. For *Healthy Kids*, eligibility determinations can take up to 45 days as allowed by Federal law. Although it does not always take this long, some informants reported that it can take much longer to determine *Healthy Kids* eligibility compared to *MIChild* because of a new assets test for food assistance implemented in late 2011 was slowing the process for families applying for food assistance and *Healthy Kids*. DHS uses a separate eligibility system called the Bridges Integrated Automated Eligibility Determination System or BRIDGES, which enables case workers to conduct eligibility determinations for a number of different programs simultaneously, including *Healthy Kids*. DHS offices can try to make families aware of other benefits for which they might be eligible, which can slow down the process.[18]

The only major eligibility and enrollment process change reported as a result of CHIPRA is a new electronic interface with DCH Vital Records to satisfy CHIPRA requirements regarding citizenship verification. Michigan has received CHIPRA performance bonuses in all three years that they have been available; all five of its qualifying policies (continuous eligibility, liberalization of asset requirements, elimination of in-person interview, same application and renewal form, and presumptive eligibility) were in place before CHIPRA. Since Federal fiscal year (FY) 2009, the state has received nearly $20 million in CHIPRA performance bonus funds. Although several key informants reported a desire to use the CHIPRA performance bonus for a special project, thus far, the performance bonuses have simply been used to plug holes in the *MIChild* budget.

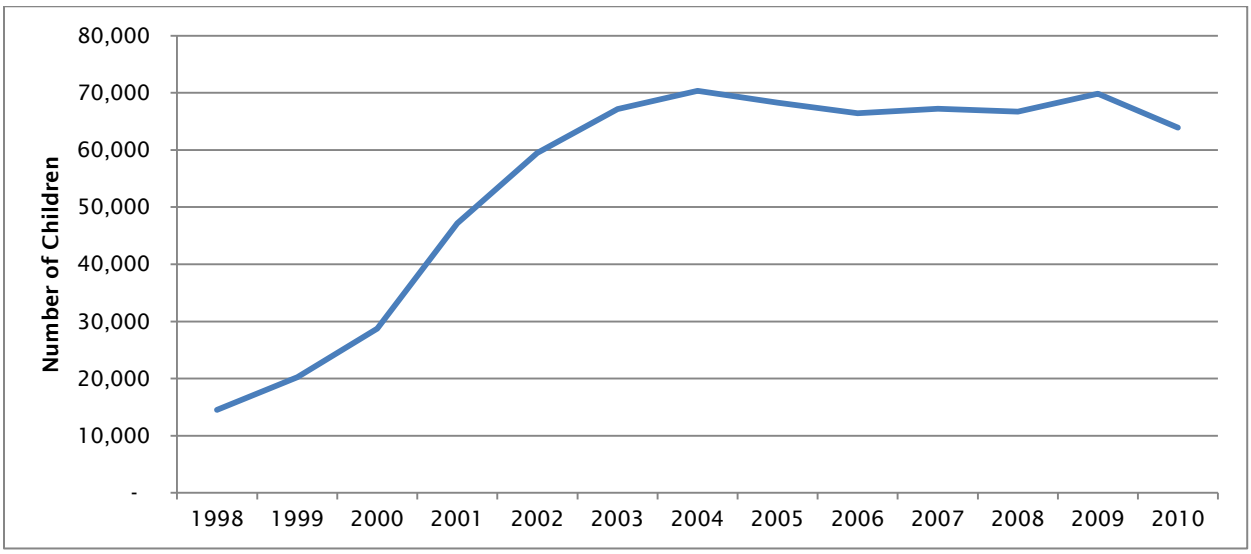
C. Enrollment Trends

Figure 2 shows the number of children ever enrolled in Michigan's M-CHIP and S-CHIP programs from Federal FYs 1998 through 2010. CHIP enrollment grew fairly steadily from 1998 through 2004. Enrollment in the program dropped slightly in 2005 and 2006 before plateauing in 2007 and 2008. Enrollment peaked in 2004 with 70,341 children ever enrolled that year. Several possible reasons can explain the enrollment drop between 2004 and 2006, including the switch from a passive to active renewal process in January 2006, and the weak and worsening state economy, making more children eligible for Medicaid than for CHIP (and in fact, Medicaid enrollment was increasing in the period [data not shown]). CHIP enrollment increased slightly through 2009 and dropped slightly in 2010.

Enrollment in the *MIChild* (S-CHIP) component was originally projected to be 200,000 children; *MIChild* has never reached this level. Monthly enrollment currently hovers around 37,000 children per month; monthly enrollment in the M-CHIP component of *Healthy Kids* is about 7,000 per month. Informants say part of the problem is that most children qualify for *Healthy Kids* (either Medicaid or M-CHIP) rather than S-CHIP.

[18] Families applying to DHS for *Healthy Kids* are considered for other programs only if they indicate they want to be considered for them.

Figure 2. Enrollment, Both Michigan CHIP programs, Federal FYs 1998-2010



Source: Personal communication with B. Keisling, October 29, 2012.

Note: Data include both the separate CHIP and Medicaid expansion programs. M-CHIP data from Federal FYs 1998-2005 are estimates. These individuals were not specifically coded in the state's system prior to 2006.

D. Renewal

Table 4 shows Michigan's renewal procedures for these programs, which are very similar. Enrollees in both *MIChild* and *Healthy Kids* receive 12 months of continuous eligibility. Both programs require active renewal and do not conduct ex parte or rolling renewal. In general, no documentation is required at renewal for *MIChild* or *Healthy Kids* because citizenship is verified during the initial application and does not have to be reverified at renewal. The one exception is for children with a visa; immigration documentation may be checked at redetermination to verify the visa has not expired. Although health plans are aware when a family is due for renewal in *MIChild* and *Healthy Kids*, they play no role in reaching out to families at this juncture.

Table 4. Renewal Procedures in Michigan's *MIChild* and *Healthy Kids*

	MIChild (S-CHIP)	*Healthy Kids* (Medicaid and M-CHIP)
Passive/Active	Active	Active
Ex Parte	No	No
Rolling Renewal	No	No
Same Form as Application	Yes	Yes if the only thing being redetermined is *Healthy Kids*. If completing a redetermination form for other assistance programs, a different application is used
Preprinted/Populated Form	No	No
Mail-In or Online Redetermination	Yes: can submit by mail or online	Yes, can submit by mail or online[a]
Income Verification Required	No, self-declared	No, self-declared
Administrative Verification of Income	No, self-declared	No, self-declared
Other Verification Required	NA	NA

[a] Medicaid beneficiaries can also renew their benefits in person at their local DHS offices

NA = not applicable.

MIChild enrollees receive a letter from MAXIMUS 50 days before their coverage expires informing them that they will lose their coverage if they fail to renew. The letter includes a blank paper application—unlike procedures used in most states, the *MIChild* program uses the same form for both applications and renewals—that families can fill out and submit to MAXIMUS, but they are encouraged to reapply online because it speeds the process. Families are asked to include their case number when renewing, which helps MAXIMUS identify the child as a renewal. In the past, Michigan sent prepopulated forms to families, but the state stopped doing this because of concerns that families may not update their information. If MAXIMUS does not receive a renewal application within 15 days of the initial notice, the family is sent a reminder notice. If there is still no response, the child is disenrolled at the end of the 12-month period.

MAXIMUS conducts follow-up telephone surveys with a sample of families who fail to reapply to *MIChild*. In March 2012, of the 50 families that responded to the survey, 47 percent that failed to renew were covered by other insurance, 21 percent forgot to renew, 9 percent did not receive the form, and the rest listed other reasons for failing to renew. After the survey telephone call, MAXIMUS reported that some families decide to renew. There is no penalty for failing to renew right away, but the child does experience discontinuous coverage.

For children enrolled in *Healthy Kids,* DHS initiates the redetermination process through the BRIDGES system. In the 11th month of *Healthy Kids* eligibility, DHS mails a redetermination packet and advises families that they must complete and submit the form to maintain ongoing eligibility. Families can return the form by mail or they can go into a local DHS office to renew. If the family does not return the packet, the child's *Healthy Kids* case does not automatically close; rather, case workers must close the case manually. Key informants reported that manual closures of *Healthy Kids* cases do not happen very often, because most families complete the redetermination process so as not to lose their coverage.

Focus Group Findings: Redetermination

Focus group participants were generally pleased with the redetermination process for MIChild, finding it easier than the initial enrollment process. Given that the State uses the same forms for both, this might indicate that the form is more familiar and thus easier to complete.

I just filled out the form that they sent [for renewal], and it was easy.

Reapplying is easier than the first time [you apply]

Some focus group participants expressed discontent that they never received their *MIChild* redetermination notices and their children lost coverage as a result.

[My daughter] had the insurance for awhile … This last time that they cut it has been the third time that they cut it … They don't tell me why … They just send a note that I have to reapply.

[Regarding reenrollment] they told me that they were going to call and they didn't … I didn't get a letter in the mail, I found out like two months later when I took my daughter to the doctor … My daughter went almost five months without health insurance … I never got the phone call for redetermination and they just cut me off.

E. Discussion

Michigan's *MIChild* program has adopted many best-practice eligibility and enrollment policies, making the program easily accessible to Michigan families. The online application is utilized widely throughout the state, and the documentation burden has been almost entirely removed from families

(except in cases in which there is no DCH Vital Records match to determine citizenship status). MAXIMUS seems to be an efficient and effective enrollment broker for Michigan, and state audits find that MAXIMUS is making quick and accurate eligibility and redetermination decisions.

The electronic interface between DHS and MAXIMUS, which permits referrals between *MIChild* and *Healthy Kids,* is a huge improvement over the prior system, in which cross-program referrals were made by sharing paper applications. Informants said that after DHS fully implemented the BRIDGES electronic interface (including the referral system) in September 2010, referrals from *Healthy Kids* to *MIChild* increased 30 percent. Opportunities for improvement remain. For example, applications transferred from one program to the other are processed twice: joint applications that are *Healthy Kids*-eligible are processed first by MAXIMUS and then again by DHS, and applications sent directly to DHS that are not eligible for *Healthy Kids* are processed first by DHS and then again by MAXIMUS. If MAXIMUS and DHS were permitted to accept each other's eligibility decisions it would reduce this duplicative screening and potentially speed eligibility determinations. In addition, Michigan could take steps to pick up additional children in its BRIDGES system; families that apply for food or cash assistance, for example, are not automatically screened for health insurance eligibility (the family must check a box saying that it wants to be assessed for health insurance).

The renewal process for *MIChild* could also be enhanced. Families are currently required to reapply to the program using the same application form they completed at initial enrollment. The application form is streamlined, but some of the information collected remains the same year after year; moreover, it might be confusing that families are applying for something they already have, rather than completing a form that clearly states they are renewing coverage. Michigan ended the process of sending prepopulated forms to families due to audit concerns, although other states have continued this process. Similar to sending prepopulated forms, allowing clients to log in to their existing account information and make adjustments to the information submitted the previous year could ease the redetermination burden on families. Also, Michigan's current practice of sending one renewal notice and only one reminder is somewhat less than other states: of the 46 states reporting that they sent notices in Federal FY 2010, 20 states (43 percent) indicated that they usually sent three or more notices (Hoag et al. 2011).

Michigan received CHIPRA performance bonuses every year they were available, identifying the state as a high performer in trying to simplify its coverage programs for children. The state used its performance bonus payments to plug holes in the CHIP budget.

III. OUTREACH

The state of Michigan currently does not conduct formal outreach for *MIChild* or *Healthy Kids* (outreach funds were eliminated from the budget in 2002).[19] Before passage of CHIPRA, most of the outreach that occurred was sponsored by MAXIMUS and the health plans participating in

[19] When CHIP was first initiated, Michigan undertook a large outreach campaign with Federal funds. Key informants described the campaign as state-of-the art, involving collaboration with many different stakeholders (for example, advocacy groups, community-based organizations, and providers) and utilizing multiple forms of media (for example, television, print and radio). Michigan also employed a bounty payment system that gave organizations $25 per successful enrollee. When Federal funding ran out in 2002 and the State's budget situation declined, the outreach program was eliminated, although *Healthy Kids* and *MIChild* caseloads continued to grow.

MIChild. MAXIMUS continues to employ an outreach specialist who promotes *Healthy Kids* and *MIChild* at health fairs, exhibits, and school/community activities, among other locales, and it provides brochures and applications to school and community groups, churches, government agencies, and anyone else who requests them. *MIChild* participating health plans are also very active in promoting *MIChild*. Health plans reported funding occasional television and radio spots, hosting so-called park parties that include events and information, partnering with local schools, and attending health fairs. Because of the downturn in the economy, some health plans reported conducting presentations at workplaces experiencing downsizing to alert the recently uninsured of the program. In addition, DCH has always provided materials such as brochures and applications to community-based organizations, schools, advocates, and other organizations involved in community support work. Michigan requires MAXIMUS to conduct data collection efforts at the MAXIMUS call center. The results of their most recent survey reveal that most families learn about Michigan's child coverage programs through friends or family (29 percent), DHS (21 percent), the *MIChild* call center (10 percent), a medical provider (6 percent), the Internet (6 percent), the news media (4 percent), or other sources (24 percent). [20]

Since CHIPRA's passage, CHIPRA outreach grants have been the largest single source of outreach funding in the state. The YMCA of Greater Grand Rapids received a CHIPRA outreach grant in Cycle I ($293,040), which funded marketing, education, and a one-on-one enrollment assistance program primarily targeted at the Hispanic population in the Grand Rapids region. The Michigan Primary Care Association (MPCA), an association of community health centers, received CHIPRA outreach grants in both Cycle I ($915,079) and Cycle II ($814,801).[21] MPCA's first outreach grant focused on reducing barriers to enrollment by using a community navigator approach to find potentially eligible families. Community navigators (AmeriCorps volunteers) look at FPL estimates within counties and use that information to identify target neighborhoods that might contain pockets of uninsured families. Within those neighborhoods, community navigators look for established community organizations that could be good partners in their efforts to locate eligible but uninsured children. From there, the community navigators adapt to the particular surroundings and reach out to families in the environment in which the family is most comfortable. The outreach program started in September 2009 and will run through September 2012. As of May 2012, the MPCA reports that community navigators have enrolled more than 2,000 children in *Healthy Kids* and *MIChild*. Key informants reported that the grant program provided a lot of capacity-building; the AmeriCorps program will continue after the CHIPRA outreach grant ends, so many of the training and concepts behind the community navigator program will continue. The state has sought guidance from MPCA on what the navigator program could look like under the Affordable Care Act.

During the Cycle I grant, community navigators found that many of the people they were enrolling had previous experience in public insurance programs, and they identified failure to renew coverage as a systematic issue in need of repair. To address this issue in a sustainable manner, MPCA's Cycle II outreach grant is being used to implement a text message reminder system alerting families of the need to renew their coverage and informing them of ways to obtain assistance with

[20] When families contact the *MIChild* call center for any reason, they are asked how they learned about the *MIChild* program, which permits the State to collect some data on outreach.

[21] The director of the outreach grants at MCPA was recognized with the CMS Excellence in Children's Health Outreach and Enrollment in 2011, one of nine recipients nationally that year.

reapplying, if needed. For initial program roll-out, MPCA selected eight health centers in seven cities across Michigan that serve 90,000 children. The state authorized the Michigan Public Health Institute (via an existing data use agreement) to conduct data matching to identify children's redetermination dates.[22] MPCA sends text reminders and voice calls a month before redetermination, alerting families to look for specific information. A second reminder is sent during the redetermination month. Both use text and voice messages to reach families that have both land lines and cell phones, and MPCA sends emails and regular mail reminders to families with no telephone number on file. The renewal reminder system began in December 2011. In March 2012, MPCA found retention rates for families included in the program were almost 10 percent higher than overall state numbers.

In partnership with the Michigan Health and Hospital Association and the Middle Cities Education Association, MPCA is also involved in another outreach effort, Enroll Michigan. This program is designed to spread awareness about children's coverage programs at back-to-school time; in 2011, the group reported a 21 percent increase in the number of applications for children's health coverage (MPCA 2011).

Overall, key informants saw the lack of outreach funding and the patchwork approach to outreach as hurdles in the state. At the same time, published data find that more children are participating in public coverage in Michigan, and that the number of low income uninsured children in the state has fallen in recent years (Kenney et al. 2011; Center for Children and Families 2012). Due to the high insurance penetration rates, informants think that the network of community-based organizations, MAXIMUS, and the health plans do a fairly good job reaching out to families.

Focus Group Findings: Outreach

Families in focus groups reported hearing about *MIChild* both through formal and informal channels.

I've always had a child advocate [for my daughter] … I told her when we were cut off of Medicaid, and she pulled out the form and said this is MIChild and filled it out.

My mom worked at a doctor's office, so she told me about it and helped me get enrolled in it.

Working at the clinic … as I went through the training on how to sign up other people, I signed up myself … I have two children who have ADD, each medicine is $300 a month. If it wasn't for the State, I wouldn't be able to pay it and they wouldn't be able to get the good grades they are getting in school.

IV. BENEFITS

Key informants and focus group participants view the medical benefits package for children enrolled in *MIChild* and *Healthy Kids* as generous. Children enrolled in *MIChild* receive the same benefits package provided to state employees. There is no limit on medical services. Whereas many states had to expand their behavioral health and substance abuse benefits as a result of CHIPRA parity rules, Michigan already had the necessary coverage in place in *MIChild* before CHIPRA. Children enrolled in *Healthy Kids* receive the benefits package required under Federal Medicaid law for medical, behavioral health, and dental coverage.

[22] In addition to the data use agreement, MPCA put the project through an Institutional Review Board review, executed new Memorandums of Agreement, and entered into HIPAA Business Associate Agreements for data security.

The *MIChild* dental benefits package was updated to bring the benefits into compliance with CHIPRA. *MIChild* dental benefits are provided using the state-defined benefits package and periodicity schedule. This package covers medically necessary services, including orthodontia. There is a $1,500 benefit maximum per child per year, with the ability to obtain higher benefits if determined medically necessary. Orthodontic services are subject to a $4,000 lifetime benefit maximum (separate from the $1,500 annual cap for all other dental services). The *Healthy Kids* dental benefit benefits comply with Medicaid early periodic screening, diagnosis, and treatment (EPSDT) rules for dental services.

Focus Group Findings: Benefits

Focus group participants spoke highly of the benefits covered under *MIChild,* including access to specialists and behavioral health care.

I think [the benefits are] excellent – I don't know what I would do without it, I'm just really grateful for it.

I just recently started using the mental health for my daughter. They cut out a portion of it so it is just at one clinic. She goes about once a week for a therapist … She actually comes to our home.

I had to use it to take her to a sexual abuse expert and I was really grateful because they are expensive. I didn't think that [specialists] were covered … I was grateful that they took it.

One focus group participant expressed difficulty with the pharmacy benefit (all prescription drugs are covered with $0 copays; supplements may not be covered).

Some of the things are not covered. At one time [my daughter] had low iron and they wanted her to take iron supplements and they gave me a prescription for it and it wasn't covered. I had to pay $30 for it … But mostly they covered everything.

V. SERVICE DELIVERY, QUALITY, AND ACCESS TO CARE

The intention of all coverage programs is not only to get and keep children enrolled, but to ensure they can and do access services they need, and that the care is high quality. In this section, we review three related topics: service delivery, quality, and access.

A. Service Delivery

Table 5 summarizes how Michigan provides medical, behavioral, and dental health care in *MIChild* and *Healthy Kids*. Most *MIChild* participants—currently about 83 percent or 30,000 members—are enrolled in Blue Cross Blue Shield of Michigan's PPO for their medical and pharmacy services. Blue Cross is the only statewide plan available in *MIChild;* the other nine plans are regionally focused and represent a mix of for-profit and nonprofit managed care organizations (MCOs). MCO plan enrollments vary widely, ranging from a plan with fewer than 200 enrollees to another with nearly 2,000.

Table 5. Service Delivery Arrangements in *MIChild* and *Healthy Kids*

	MIChild	Healthy Kids
Managed Care Contracting	Yes	Mostly managed care, with fee-for-service for people with an exemption due to medical needs
Number of Plans Serving Program	10 8 overlap with *Healthy Kids*[23]	14 8 overlap with *MIChild*

[23] Blue Cross only became an overlap program between *MIChild* and *Healthy Kids* recently. Blue Cross withdrew from Medicaid in 2001, but it recently purchased a small Medicaid product.

Table 5 *(Continued)*

	MIChild	Healthy Kids
Services Plans Are Responsible for	Medical, pharmacy	Medical, pharmacy
How Are Mental Health and Substance Abuse Services Provided?	Comprehensive carve-out to community mental health service programs	Up to 20 outpatient visits allotted through health plans; everything else is a comprehensive carve-out
How Are Dental Services Provided?	State carves out dental to three separate managed care dental plans, one of which is statewide	State carves out dental to one separate managed dental plan, which is not statewide; children living in counties not served by the plan can receive dental services through fee-for-service

From *MIChild's* inception, Blue Cross has always been the dominant *MIChild* plan, just as it is the dominant plan in Michigan overall.[24] One of the reasons *MIChild* was viewed favorably from inception was that Blue Cross' involvement in the program made it seem more like private coverage and assured that no public program stigma would be attached to *MIChild*. In addition, Blue Cross was a statewide plan, making it easier to implement *MIChild* quickly. Blue Cross was also an attractive partner because it was willing to subsidize the program (that is, take a loss on it) to meet its non-profit mission, but only to a certain extent. Currently, its agreement with Michigan is that it will subsidize *MIChild* up to $15 million. Because of this agreement, the state conducts a cost settlement with Blue Cross at the end of each fiscal year to pay Blue Cross a settlement for claims above the $15 million subsidy amount. The other participating MCOs do not receive any settlement: any plan that meets certain state requirements (such as provider access standards, financial integrity, and encounter data reporting, among others) and is willing to accept the same rate as Blue Cross can participate. The current average per member per month rate is $78; key informants said this rate has not changed in at least the past eight years.[25]

Over the past few years, health plans have entered *MIChild* at a rate of one or two new plans a year. Stakeholders think this has more to do with the passage of the Affordable Care Act, with health plans wanting to have a hand in both *Healthy Kids* and *MIChild* so that they are well positioned for various reform options, including participating in Michigan's health insurance exchange if it is implemented. Currently, eight of the *MIChild* plans also participate as *Healthy Kids* managed care plans, including Blue Cross.

Families determined eligible for *MIChild* are expected to select a health plan online immediately, although there is an auto-assignment process if no plan is selected.[26] Children enrolled in both CSHCS and *MIChild* are automatically enrolled in Blue Cross, because it is the only *MIChild* plan not at risk for care (it has the end of year settlement with the state). Auto-assignment in *MIChild* does not use a complicated algorithm; it is simply rotated through the plans available in each county. *MIChild* participants not enrolled in Blue Cross are also asked to select a primary care provider

[24] In large part, this was because Blue Cross had run a predecessor program, Caring Program for Children, which provided a limited benefit package to children from families with incomes up to 185 percent of the FPL beginning in 1992 that was folded into *MIChild* (Ellis et al. 2007).

[25] Rates vary by age and geographic region, but all plans receive the same rates.

[26] Even families that use a paper application are supposed to select a plan (even before they enter any demographic information). If families send in a paper application without a selection, they select a plan after receiving a packet of information instructing them to call and make a selection.

(PCP); those enrolled in Blue Cross's PPO are able to visit any provider within the Blue Cross network and do not select a PCP. All *MIChild* enrollees receive an insurance card that is indistinguishable from an insurance card for a private insurance plan. Key informants reported that a major advantage of the Blue Cross arrangement is that children have virtually no problems seeing physicians or dentists; they are treated the same as any other Blue Cross enrollee. Others see the PPO program as a disadvantage in that the plans do not have an incentive to manage an enrollee's care by getting them in for well visits, for example, or linking them to a particular gatekeeper PCP.

Michigan's *Healthy Kids* program has more than 15 years of experience in mandatory managed care. *Healthy Kids* enrollees are enrolled in Health Maintenance Organizations (HMOs), unless there is an exemption due to medical needs that prevents them from obtaining care from their primary or specialist medical providers. In these cases (or if the family receives care through presumptive eligibility before selecting a health insurance plan), benefits are paid through a fee-for-service arrangement. Approximately 70 percent of the *Healthy Kids* population is in managed care, with more specialty populations moving in this direction. For example, children enrolled in both CSHCS and *Healthy Kids* will transition to managed care as of October 1, 2012. Fourteen plans currently participate in *Healthy Kids*, representing a variety of commercial, for-profit, and nonprofit plans.

The procurement process for becoming a *Healthy Kids* health plan is quite complex. Among other requirements, plans must be licensed HMOs, accredited by the National Committee for Quality Assurance (NCQA), and meet strict solvency and capital requirements. *Healthy Kids* contracts are granted for three years, plus three one-year optional extensions. For each service region within the state, *Healthy Kids* uses quality measures (rather than rates) to select participating health plans. DCH begins by determining how many health plans are needed in a given region based on current capacity and projected expansion. At least two plans are required in every region (except the Upper Peninsula, a rural area, which has only one plan). After DCH sees which plans are interested in bidding in a particular region, the plans are ranked based on their quality scores. DCH then awards the prescribed number of contracts to the top-ranked health plans. Some health plans are nearly ubiquitous in *Healthy Kids*; for example, Meridian participates in all but three counties in the Lower Peninsula. Blue Cross Blue Shield of Michigan (the dominant player in *MIChild*, as described earlier) withdrew from *Healthy Kids* in 2001, although it recently purchased a small Medicaid product. Many of the plans have expanded into new service regions in recent years, but, in general, plan participation has been stable.

As described earlier, after a family is determined eligible for *Healthy Kids*, it receives a packet of information asking it to select a health plan. Families must call in to make their health plan selection or go to a local DHS office. Beginning on July 15, 2012, families will be able to select their health plans online. Although MAXIMUS is not permitted to help members choose a health plan, key informants reported that the call center staff are able to advise families on elements they might want to consider and can provide families with information that enables them to make sound decisions. Multiple attempts are made to contact families so they can select a health plan, but approximately 30 percent of *Healthy Kids* enrollees are auto-assigned to a plan. The algorithm for auto assignment in *Healthy Kids* is complex and changes quarterly. One quality measure is selected per quarter, and plans are placed into one of three auto-assignment tiers (top, middle, or bottom) based on their scores on this particular measure. The most auto-assignments are given to plans in the top tier and the fewest to plans in the lowest tier. *Healthy Kids* enrollees receive two different insurance cards—one from their HMO and the other from the Medicaid office. Both of these cards immediately identify them as enrolled in public coverage when requesting services. Once a child is enrolled in a health plan, families have 30 days to select a primary care provider.

Key informants reported that coordination between *Healthy Kids* and *MIChild* is challenging in Michigan. Because Blue Cross plays such a dominant role in *MIChild* but withdrew from *Healthy Kids* until recently (and remains quite a small player), most children transitioning across the two programs receive little continuity of care and often have to change doctors.

For behavioral health care services, *MIChild* and *Healthy Kids* have slightly different delivery systems. In *MIChild*, behavioral health services are completely carved out to community mental health service programs (CMHSPs) and are available only for children with more serious conditions. Children in need of behavioral health services must visit their local CMHSP and meet a medical need threshold. CMHSP providers use the Child and Adolescent Functional Assessment Scale (CAFAS) to assess medical need, and a child must receive a CAFAS score of 50 or higher to receive treatment. Children with a CAFAS score below 50 in effect do not have access to any behavioral health services (*MIChild* health plans are not responsible for providing any behavioral health services, nor do they meet the treatment criteria for services at CMHSPs). Informants noted that these children fall into a gap and that the system's design means there is no covered treatment available for them.

In *Healthy Kids*, health plans are responsible for covering up to 20 outpatient behavioral health visits a year. If additional services are required after those visits, or if inpatient services or substance abuse benefits are needed, children are referred to a CMHSP and, if they meet the medical need threshold, they can receive more comprehensive services. CMHSPs are administered at the county level and receive a per-enrollee-per-month payment based on the number of publicly insured children living within their given service area.

The behavioral health carve-out for *MIChild* and the limited benefits offered through *Healthy Kids* were seen as a major deficiency by some key informants, as the carve-out can be difficult for families to navigate and the separate provider system is said to severely limit care coordination. Several key informants would like to see behavioral health services become better integrated with medical health care services in the state; efforts are underway to better integrate care in Michigan, but this is a long-term vision. DCH is trying to address data-sharing issues so that providers on both sides of the spectrum can share information about patients.

MIChild includes three contracted dental plans: Delta Dental, Golden, and Blue Cross. Members are given a choice of dental plans similar to selecting their health plans. Members who do not select a dental plan are auto-assigned. In *Healthy Kids,* dental care is provided to enrollees through a combination of managed care and fee-for-service. If Delta Dental is located within a particular county, *Healthy Kids* enrollees are automatically assigned to it. Delta Dental operates in 65 of the state's 83 counties (a four-county expansion occurred in FY 2012, bringing the total from 61 to 65), although their coverage area excludes all of the major urban centers in the state, where the highest concentrations of minority children and children in poverty live. If Delta Dental does not operate within their county, *Healthy Kids* enrollees have to find a dentist who participates in regular Medicaid, which is reportedly quite difficult.

Focus Group Findings: Service Delivery

Focus group participants expressed feeling comfortable with their Blue Cross coverage through *MIChild.*

We went to Children's [Hospital] … and you pull out that Blue Cross [card], and they say, 'Oh, we take Blue Cross.' They don't really know if it's MIChild*, they just know it's a Blue Cross Card.*

I feel really safe … very comfortable, especially that it falls under Blue Cross Blue Shield, because it's a well-known insurance. Every time I've had to ask questions about the MIChild*, or call them about where to take them for mental health or the coupon issue, they were all very helpful … very easy to get on the phone.*

One focus group participant discussed issues with care coordination across *Healthy Kids* and *MIChild.*

They were never in MIChild *more than three or four months because, I don't know why, it would automatically jump to them getting Medicaid without me being informed. When I would go to the doctor's they would tell me, 'Oh, you have Medicaid and they assigned you [to a different health plan].' Or half my kids would have one health plan and half would have a different plan … I'm like, 'Oh my God, what's going on.' I didn't even know I was off from one and on the other, nobody notifies you.*

MIChild dental services were easy to access for focus group participants, although not all services were covered.

*I was already established with a dentist. I looked it up and [*MIChild*] was with Delta Dental, and they were taking it.*

[For finding a dentist], my mom called around to find out who was taking it and … I got in exactly when I wanted to.

My son chipped his tooth, and they bonded it. He rechipped it, but since they did it the first time, they wouldn't cover it again [because it was too close to the first bonding treatment].

B. Quality

Michigan's *Healthy Kids* program is widely viewed as ahead of the curve on quality monitoring and improvement. All *Healthy Kids* managed care plans are required to submit Healthcare Effectiveness Data and Information Set (HEDIS) reports, client satisfaction surveys, and performance monitoring measures (PMMs). PMMs are submitted monthly, quarterly, or annually (depending on the measure), and are thus often more frequently reported than HEDIS or Consumer Assessment of Healthcare Providers and Systems (CAHPS®).

As previously described, Michigan uses quality rankings to award *Healthy Kids* contracts within service regions. Key informants reported that the state could save money by rebidding the contracts based on price rather than quality, but the state has made a commitment to offering high quality health plans in its public insurance programs. Michigan has seen great performance improvement; most of its health plans are in the top 50 nationwide in terms of quality, and a number of them are in the top 25 in the nation.

Despite being administered by the same staff within DCH, *MIChild* and *Healthy Kids* contracts are different, which some administrators pointed out as an inefficiency in the program; given the strong focus on quality in *Healthy Kids*, it also seems a lost opportunity to better monitor *MIChild* quality of care. While the state plans to eventually merge the contracts, they anticipate resistance from Blue Cross, given its current arrangements. *MIChild* contracts are not awarded based on quality, but many of the quality improvement efforts initiated in *Healthy Kids* have a positive impact on the *MIChild* population. One of the struggles with quality monitoring in *MIChild* is that the Blue Cross PPO does not report HEDIS measures (which are designed for managed care plans, not PPOs), and the rest of the plans' data sets are very small. Instead of using HEDIS scores, the state generates measures through the encounter data that all health plans must submit. These measures

are used to compare plans against one another, but they are not aggregated into one total statewide number for the measures. Michigan uses HEDIS definitions as much as it can in these measures, but some exceptions have to be made based on the age eligibility ranges of children enrolled in *MIChild*. Michigan voluntarily reported on 12 of the 24 CHIPRA quality measures included in the Federal FY 2010 CHIP Annual Reporting Template System (CARTS) reports.[27]

In 2011, Michigan's *Healthy Kids* pediatric and adolescent care HEDIS measures were fairly strong and showed significant improvement. When compared with 2010 measures, all but one measure improved. Six of the 12 weighted averages performed above the 75th percentile, although two measures (Appropriate Treatment for Children With Upper Respiratory Infection and Appropriate Testing for Children With Pharyngitis) ranked below the 50th percentile. CAHPS scores were also high in 2011, with nearly all global and composite measures scoring between the 50th and 75th percentiles.

Healthy Kids plans can receive a quality performance bonus based on criteria set forth by DCH (this is not offered in *MIChild*). Criteria vary by year, but they include an assessment of performance in quality of care, enrollee satisfaction and access, and administrative functions. To pay the bonuses, DCH withholds 0.19 percent of the approved capitation payment, amounting to $5 to $7 million annually. At the end of the year, the plans are eligible to receive the withheld amount as a bonus. In 2010, all plans earned at least some of their money back based on their HEDIS and CAHPS measures. Michigan also is slowly implementing some pay-for-performance initiatives in *Healthy Kids*. In the first year, physicians had to adopt a system or mechanism for one of at least three elements: e-prescribing, registry, or enhanced hours. For 2012, MCOs have to do all three. The goals and bonus payments are a way of phasing in initiatives in order to get all plans moving in the same direction.

Michigan was one of eight states selected by CMS in November 2010 to participate in a multipayer demonstration grant program of patient-centered medical homes (PCMHs). The Michigan Primary Care Transformation Project (MiPCT) kicked off on January 1, 2012; it is a three-year program aimed at improving health, making care more affordable, and strengthening the patient-care team relationship. MiPCT is the largest PCMH project in the Nation, involving 500 primary care practices and 1,800 primary care physicians statewide. Payers participating in the program are Medicare fee-for-service, Medicaid managed care (i.e., *Healthy Kids),* and Blue Cross' PPO. In addition to the National grant program, a PCMH model is being rolled out and tested in Kent and Wayne counties through the Children's Healthcare Access Program (CHAP). This model (adapted from programs in North Carolina and Colorado) aims to get providers, health plans, and other stakeholders involved in children's health care issues to discuss care coordination and improvement. For example, the Wayne County CHAP initiated a program in which hospital emergency rooms fax participating practices a list of all children seen in their hospital the previous day, giving PCPs access to information that is not usually available to them.

[27] CMS began asking States to voluntarily report on 24 CHIPRA quality measures in the Federal FY 2010 CARTS reports. No State reported all 24 measures; Michigan was one of 5 States to report 12 measures; 36 States reported fewer than 12 measures, including 8 States that did not report any of the measures. See Sebelius (2011) for more information.

C. Access to Care

Access to care in Michigan was perceived to be fairly good for medical health, although key informants reported some exceptions. Access to orthopedics, allergists, and endocrinologists is limited, and access issues are much more prevalent in *Healthy Kids* than in *MIChild*. *MIChild* has higher physician reimbursement rates and, due to its strong association with Blue Cross, it does not carry a stigma among providers.

We heard that most *MIChild* enrollees do not access services through FQHCs or RHCs, more often choosing private providers (since most are enrolled in Blue Cross, which contracts with most private providers), but some do use the centers, particularly in rural areas. Before CHIPRA, states paid FQHCs and RHCs a per visit charge based on reasonable costs or states could use an alternative (Federally-approved) payment methodology to pay for FQHC and RHC services (CMS 2010). CHIPRA required states to implement a prospective payment system for FQHCs and RHCs by October 1, 2009. A prospective payment system establishes a provider's payment rate for a service before the service is delivered; the rate is not dependent on the provider's actual costs or the amount charged for the service (CMS 2010). Informants reported that Michigan received some grant funds to help implement this new payment methodology, but as of the time of our visit, the system was not yet in place. Michigan will have to reconcile payments with the centers retroactively back to the October 1, 2009 date in order to comply with the law.

Rural areas of Michigan face access issues in general, and informants reported that access problems are more acute in *Healthy Kids* and *MIChild* compared with private coverage. Rural areas have a shortage of primary care physicians, and many physicians (primary care and specialists alike) refuse to accept the Medicaid reimbursement rates. In addition, physicians and hospitals in rural areas are geographically dispersed and often understaffed. Many families must travel long distances to get care, resulting in some children failing to receive recommended care. Key informants in Detroit also spoke about limited access and travel issues in that urban area. Detroit's public transportation infrastructure is poor, and the limited hours that many clinics are open force those unable to make after-hours appointments into the emergency room.[28]

Each county in Michigan has at least one CMHSP for *Healthy Kids* and *MIChild* enrollees to access behavioral health services. Unfortunately, these programs are often little-known among families and can be inconvenient to reach and difficult to navigate. Because they are in a separate location from the child's primary care or even specialist physicians, the physical distance and lack of coordination can be a barrier for families. In addition, children accessing these services have no choice of provider offices.

[28] School-Based Health Clinics (SBHCs) are another source of health care access for children in Michigan, offering primary care service and public insurance enrollment assistance. Michigan is fourth in the country in the number of SBHCs, with just under 100 operating Statewide. Through the help of the School-Community Health Alliance of Michigan (SCHA-MI), Michigan SBHCs are able to bill health plans for services without prior authorization and without having a direct contract with the health plans. SBHCs electronically submit claims for services to the SCHA-MI, which scrubs and posts the claim and conducts any necessary follow-up on rejected claims. Michigan is also the only State able to match State general fund dollars spent on SBHCs with federal money due to a Medicaid waiver program. The rationale is that most children seen at SBHCs are Medicaid-eligible and, as such, they should be eligible to receive a federal match.

MIChild appears to offer considerably better access to dental care than *Healthy Kids*. As previously noted, access to dental care is extremely limited for *Healthy Kids* enrollees living in counties not covered by Delta Dental. Several key informants reported that, although some dental services are available at community health clinics, *Healthy Kids* enrollees living outside Delta Dental;s sphere basically do not have access to dental care. Governor Rick Snyder's 2013 budget proposal allocated $25 million to expand *Healthy Kids* dental, although neither the House nor the Senate embraced this spending. Key informants reported that $25 million is probably 25 percent of what is needed ameliorate access problems in the program.

Focus Group Findings: Access and Quality

Focus group participants said access to primary care services is good in *MIChild*. One parent compared *MIChild* access to having private coverage, except that *MIChild* was better because the financial burden was so much less:

The difference [between MIChild *and private insurance] is not the access; the difference is financial.*

One focus group participant reported finding a specialist was easy, although several others reported challenges to finding specialists.

I called and they all [specialists] accepted MIChild – *I got in within a day or two.*

When [a] doctor refers them out for a specialist and they don't tell you where to take them, you call that 1-800 MIChild *number, and you say my child has this situation, 'What specialist do I go to that takes* MIChild*?' [She said], 'I don't know. You call where you want to take them and ask if they take* MIChild.' *That is not convenient. They should give that information … I asked her, 'Do you have any information?' and the customer service person said to look at the website."*

One parent noted the particular difficulty of getting behavioral health care through *MIChild* (in fact, the *MIChild* plan is not responsible for behavioral health—the child should have been directed to a CMHSP for treatment).

I had a hard time getting a specialist. The specialist they really had to go to for ADHD and speech therapy, they wouldn't take MIChild.

Focus group participants with ESI discussed visiting providers regularly. Some focus group participants were content with the access and quality of care received through the network, whereas others struggled with coverage issues.

Overall, we are really happy with it … My daughter gets great coverage and she seems to get everything she needs.

As long as [the specialists] are within network, you don't even have to have a referral. It is more about finding a specialist you like. At first [the one we wanted] wasn't taking our plan so we had to convince her that she needed to pick that up, so she did.

When my son had to get his shots, he was sick before that. When I called, they said, 'Well, your son is coming in a week for his shots, if he is still sick them, we can see him.' … I went to the ER.

My son is autistic, so my issue with the dental is the dentist wanted to put him under because she didn't want him to bite her. That was an issue where the dental wouldn't cover the anesthesia, but the insurance didn't want to cover it either. So, they eventually did cover it. It is a separate charge [dental and health premium]. I just had to make arrangements to get [the anesthesia] covered. Because my son's autistic, there are only certain dentists that will see him.

VI. COST-SHARING

MIChild has always required families to pay a monthly premium. Initially, *MIChild* premiums were $5 a month (the family maximum), with no other cost-sharing required. In April 2007, the premium rose to $10 per family, regardless of the number of children (and still with no copays or deductibles) (Table 6).[29] The premium increase was due to budget pressures in the state; informants reported that the legislature authorized *MIChild* premiums as high as $15 per family per month, but that the state chose not to raise premiums to that level. There is no cost-sharing for children in the *Healthy Kids* M-CHIP program nor in Medicaid, as Medicaid rules prohibit cost-sharing for children.

Table 6. Cost-Sharing in Michigan's *MIChild* and *Healthy Kids* Programs

	MIChild	*Healthy Kids*
Monthly Premiums	$10/family	$0
Enrollment Fees	None	None
Copayments	None	None
Deductibles	None	None
Grace Period	30 days[a]	NA

[a] *MIChild* has a 30-day grace period for nonpayment of premiums, as CHIPRA requires. There is no lock-out period, but families are required to reapply for coverage and repay outstanding premiums if they are disenrolled for nonpayment. Families do not have to pay missed premiums more than six months old.

NA = not applicable

Currently, *MIChild* premiums can be paid only by mail, via check or money order sent to MAXIMUS. The state is investigating the possibility of electronic funds transfer via checking or savings accounts and hopes to implement that sometime in 2012.[30] When notified that the child is *MIChild*-eligible, a family also receives two sheets of coupons stating the date payment is due, the coverage month, and the premium amount. Technically, coverage does not begin until the month following the first payment, although administrators reported that enrollment does not hinge on receiving the $10 premium.[31] Payments are due on the 10th of each month for the following month's coverage, but families are not disenrolled for failure to pay until the 20th of the month; the state provides families extra time because it is easier than disenrolling and reinstating the child, and so as not to penalize the child for the parent's failure to pay. Families can telephone the call center to find out when their premiums are due (they can find this out through an automated system, rather than waiting for a customer service representative), but they cannot pay by telephone, online, or in person. Families can pay ahead of time—either just a few months or an entire year—though no incentives are offered to encourage families to do so; about 30 percent of families do. In fact, some families who pay ahead then obtain private coverage through an employer during the year. The children in these families will be removed from *MIChild* at the end of the month following a finding of other insurance.

[29] Native Americans and Alaska Natives are exempt from the $10 monthly premium.

[30] The State does not plan to pursue other payment methods, such as credit cards, primarily because the credit card companies charge additional fees, and because the State sometimes has to refund premiums (for families who paid ahead then moved to Medicaid, for example) and said it is too difficult to track and refund with credit cards.

[31] As described in Section II.B, families are also given time to provide citizenship information, but children are enrolled during this open and chase period.

Key informants think that *MIChild* is perceived as affordable by state officials and families. At the same time, 10,777 children were disenrolled from *MIChild* for failure to pay premiums in 2011 (about 900 per month). Some families never make a first payment (and thus never enroll in the program). Although the state does not track these cases (and believes it is a small number), officials said it is likely that these cases represent families transferring from *Healthy Kids* to *MIChild* who did not expect to have to make a premium payment. Most informants believe that premium collection problems in *MIChild* relate to families forgetting to pay, rather than an affordability issue, and findings from focus groups support this theory—these findings suggest that parents would welcome more payment methods (see text box). Some key informants reported that they hear far more complaints in the opposite direction—families asking if they can pay the premium so they can enroll in *MIChild* rather than enroll in *Healthy Kids*.

Focus Group Findings: Affordability

We heard only positive remarks from parents of both enrolled and disenrolled children about the cost of *MIChild* coverage and that it was affordable to them, especially compared with private coverage. Focus group participants did wish there were more ways they could pay their premiums, however.

It's just the $10 dollars for both kids and it's great. I am grateful to have it. It is hard to remember just that $10, especially since you don't write checks very much anymore. They sent me a letter and that was enough to scare me to remember. You can't take it in, you have to send it. It would be nice if they took credit card or you could pay over the phone.

I liked paying just $10 a month that was great to get the care. You can't get medical for $10 a month.

You are not making that much money and now you try to get insurance and the bill that you are hit with … so now my daughter can't continue the treatment, whereas when she had MIChild it would have been better. You are working, but you are not making enough to be able to afford health insurance. You are paying so much for health insurance and then you see the doctor, plus the deductible. I have to spend $150 every month on the insurance, so it's tough.

Focus groups with families with ESI coverage had several different coverage options through their employer, with costs rising every year. Employees could choose their plans based on cost per week, types of coverage, which providers are available, and so on.

I've always paid extra to have one of the better plans too, because you never know … what kids can come into contact with or something, and I couldn't afford a $100,000 medical bill or something like that, so we paid a little extra every month or week to have better coverage.

The costs go up every year … I worry each time the new plans come out. Then, if you get a raise, you wonder what that will do to your costs and whether your raise will offset that.

I looked at the hospital … I have like a $100 payment for that. Beyond that, everything is covered … that was important to me, knowing that being admitted to the hospital can be pretty costly.

As noted earlier, in March 2012, MAXIMUS surveyed by telephone families who had failed to renew by the deadline to understand why families do not renew. Although the sample was small—only 50 of 243 families completed the survey—affordability was not a reason families gave for not reapplying for *MIChild*.[32] The largest component (47 percent) did not renew because they had

[32] The survey question was open-ended, so families were not limited to specific reasons.

obtained other insurance; 88 percent of those now had access to ESI. The second most common reason for failure to renew was that the parent forgot to renew (21 percent).

VII. CROWD-OUT

MIChild has several crowd-out prevention procedures in place. First, on the *MIChild* application, a family must report whether the child has health insurance other than *MIChild* or Medicaid, has had health insurance from an adult's job that ended in the past six months, or has access to other insurance through a state or government agency. Children with other health insurance coverage can qualify for *MIChild* if the other coverage is not comprehensive (for example if the child has dental-only or catastrophic-only coverage); families are required to send a copy of the insurance card to MAXIMUS so that this determination can be made.[33] *MIChild* rules say families cannot have dropped private insurance coverage in the past six months, unless it was not dropped voluntarily (for example, due to job loss or the employer dropping coverage). Families who have dropped coverage in the past six months must submit a written statement as to why insurance ended, and these statements are reviewed to assess whether an exception can be granted. Although the state does not have an affordability exception policy in place, it does grant affordability exceptions on a case-by-case basis. Finally, MAXIMUS also runs a data match against commercial insurer's data to determine if applicants have other coverage; MAXIMUS then follows up with the family for clarification or more information, depending on the results of this data match. These policies have been in place since the beginning of the program and have not been altered recently.

The state has reported in its annual CARTS reports that crowd-out does not appear to be a problem in *MIChild,* mainly because most families would not risk having their child uninsured for six months merely to get CHIP coverage. The statistics collected on coverage support this theory: in Federal FYs 2007 and 2008, fewer than 1 percent of applicants had dropped other health insurance coverage to qualify for *MIChild,* and in Federal FY 2009, this figure was reported to be 0.01 percent. In its 2011 CARTS report, the state reported that all applicants who had dropped coverage in the prior six months had met the state's exemption policies and could be enrolled in *MIChild.*

VIII. FINANCING

For Federal FY 2012, the Federal matching rate for CHIP is 69.61 percent in Michigan (Table 7). In Medicaid, the Federal matching rate for Federal FY 2012 is 66.14 percent, which, according to key informants, is historically high for Michigan.

CHIPRA significantly increased the Federal allotment for Michigan, which rose 50 percent from Federal FY 2008 to 2009.[34] For several years, it appears that Michigan was overspending on its Federal allotment (Table 7), but, according to state officials, this is the result of using carry-forwards

[33] MAXIMUS investigates the coverage policy and conducts direct follow up with the family.

[34] CHIPRA substantially increased the amount of federal funding available for CHIP beginning in FFY 2009. In addition, it established a new formula for distributing federal CHIP funds among the states based on states' actual use of and projected need for CHIP funds. As a result, Michigan's CHIP allotment increased from $147,080,000 in FFY 2008 to $221,120,000 in FFY 2009.

from previous years. Based on available data, with the increased funds, it appears the state was unable to spend all of its Federal allotment beginning in Federal FY 2009.

Despite a difficult state budget environment, key informants reported no threats to the state portion of the CHIP budget in recent years. The CHIP program is relatively small in Michigan, particularly when compared with the state's Medicaid program, so there has been no pressure to freeze enrollment or cut eligibility. Most of the legislature's attention is focused on Medicaid, which has almost doubled enrollment in the past decade.

Table 7. CHIP Allotments and Expenditures

FFY	Federal Allotment (in millions of dollars)	Federal Expenditures (in millions of dollars)	Federal Matching Rate	Federal Allotment per Child	Total Expenditure per Child
2006	$117.17	$55.5	69.61	$1,764.00	$1,187.54
2007	$149.38	$43.5	69.47	$2,221.92	$919.11
2008	$147.08	$40.9	70.67	$2,204.17	$875.08
2009	$221.12	$41.3	72.19	$3,165.58	$844.73
2010	$231.49	$51.8	74.23	$3,621.43	$1,084.08
2011	$120.97	$-	76.05	$-	$-
2012	$126.20	$-	69.61	$-	$-

FFY = Federal fiscal year.

Sources: Kaiser Family Foundation, State Health Facts 2012; Center for Children and Families, Georgetown University Health Policy Institute, 2009a, 2009b, 2012, personal communication with B. Keisling, October 29, 2012.

Notes: Federal Expenditures for Federal FYs 2011 and 2012 have not been published as of this writing.

As noted in Section II, Michigan has qualified to receive CHIPRA performance bonuses every year they have been available. Total funding awarded to Michigan through the performance bonus is $19,893,138 (Federal FYs 2009 to 2011). Although some of the program's existing policies had to be adjusted to align with CHIPRA requirements, generally speaking all of the policies were in place in Michigan before reauthorization except for the FQHC and RHC prospective payment system. Michigan has used its CHIPRA performance bonuses to plug holes in the *MIChild* budget.

IX. PREPARATION FOR HEALTH REFORM

Despite participation as a plaintiff in the lawsuit against the Federal Government over the Affordable Care Act, Michigan has begun preparations for, and investments in, a new health care marketplace. In a 2011 special message on health and wellness, the governor announced that he supports a state-based exchange, called the MIHealth Marketplace, which will connect consumers to companies, products, and pricing options on health insurance. (Some informants likened the governor's vision to the Travelocity website for travel information.) The decision to pursue a marketplace over an active purchaser model was deliberate. The recommendation came out of an initiative in 2010 and 2011 in which key stakeholders—representing business, labor, advocacy groups, health plans, providers, and state agencies, among others—convened periodically to develop recommendations for what Michigan's exchange should look like. Stakeholders voted on recommendations; only those receiving a two-thirds majority could move forward. In the end, the group made more than 50 recommendations. The principles endorsed by the group were included in a Senate bill (SB 693) that passed the Michigan Senate in late 2011, but remains pending in the

House. At the time of our visit, House representatives indicated that they wanted to wait to vote on the bill until after the Supreme Court issued its decision on the Affordable Care Act. The House has since indicated that a vote will be postponed until after the November 2012 elections (the entire House is up for election), leaving the state "undecided" on both the Medicaid expansion and type of exchange it will implement as of July 2012.

Michigan received an Exchange planning grant of almost $1 million from the Center for Consumer Information and Insurance Oversight (CCIIO), a CMS agency, to begin planning for reform. As of this writing, the state has obtained a one-year, no-cost extension to finish using the grant funds (although the funds are nearly exhausted). Michigan was subsequently granted a $9.8 million "Level One" grant from CCIIO.[35] Although Michigan's Department of Licensing and Regulatory Affairs (LARA) intends to use this funding to support early implementation efforts, such as designing and building a new information technology system, the legislature has refused to appropriate the funds to LARA. Funds remain held up even after the Supreme Court decision, and it some House members have committed to delaying any action related to the Affordable Care Act until after the November election.

Because of these delays, the state is pursuing what it calls a dual-track strategy for the exchange: although the Governor wants a Michigan-only exchange and will implement that as soon as the legislature passes it, officials also have begun talks with the Federal Government about the possibility of a state/Federal partnership exchange. Several informants said that the state is doing this out of prudence, to try to comply with the Affordable Care Act deadlines.

LARA oversees licensing and regulation of the insurance industry in Michigan and is the so-called owner of the exchange project. The current design calls for the exchange to be run by a nonprofit corporation with a seven-member board appointed by the governor; the insurance commissioner will serve as an ex officio board member and an executive director would run the day-to-day operations. In this design, *Healthy Kids* and *MIChild* would be offered as options in the exchange, although the eligibility determination and plan selection processes for those programs could continue to operate separately from the exchange. Some informants would prefer this design, especially since *MIChild* is a popular program with families and providers, but not all state agencies welcome this design. For example, DHS—which currently determines *Healthy Kids* eligibility—implemented a new eligibility determination system in 2009 (the BRIDGES system), and some informants said they can envision ways that BRIDGES could be enhanced to serve as the eligibility system hub for the exchange. However, several informants noted that as it currently operates, DHS's eligibility system would not meet the needs of the exchange and that Michigan must build a new system. This plan also calls into question the future role of MAXIMUS for determining *MIChild* eligibility; it is unclear how the new system and MAXIMUS would relate to each other.

Other tensions exist about what policies are best for the state under reform. The BHP option is being debated actively. DCH representatives think a BHP option could work in Michigan, and that DCH could operate a consolidated procurement process for Medicaid, CHIP, and BHP. The governor's administration has deferred consideration on BHP until after the exchange is authorized, saying there is not enough information available about how it would work to make an informed choice for or against it. Actuarially, there are concerns among those planning the exchange that BHP

[35] Level One grants are given to States that have made some progress under their exchange planning grant.

could create new streams of churning (across Medicaid, CHIP, and BHP) and that BHP could lead to consumer confusion if it has contractors and/or benefits that differ from CHIP and Medicaid. A BHP bill was sponsored in the Senate (SB 595), but the largest health plan in the state, Blue Cross, thinks it is premature to pursue BHP until the exchange is functioning well, so it is uncertain how politically feasible this is.

Administrators have been looking at the number of people expected to be affected by reform from several angles, including what the exchange information technology system will have to handle and how access might be affected. Projections vary and the state continues to refine them, but right now the state estimates that approximately 1.5 million residents currently enrolled in Medicaid would be converted to MAGI eligibility and be processed through the new exchange-based eligibility determination system. Approximately 400,000 aged and disabled residents are expected to remain eligible for Medicaid under existing rules and continue to be processed through the current system; another 500,000 individuals are expected to become eligible for Medicaid under MAGI rules; perhaps another 500,000 individuals would qualify for subsidies; and a substantial number of people would use the system only to find out they are not eligible for any type of subsidy (including those who are solely interested in using the exchange).[36] As far as access, the state is participating in a project sponsored by the Robert Wood Johnson Foundation (RWJF) that provides technical support on reform, which has helped the state identify that there will be a shortage of primary care providers, although the current Medicaid MCOs continue to say they have plenty of capacity among their PCPs. Michigan currently employs strict physician extender laws, meaning nurse practitioners and physicians assistants are limited in their scope of practice. Several informants reported that expanding the role of these practitioners (which would require legislative approval) could improve primary care access in light of Medicaid expansion. Currently, there are no plans to transition children ages 16 to 18 with family incomes between 101 and 133 percent of the FPL to Medicaid before 2014, although informants have estimated that this would involve fewer than 10,000 children.

Although officials believe it is premature to think about designing an outreach campaign for 2014, they recognize outreach will be critical. They believe the exchange will have to be branded and that a coordinated effort will have to be devoted to raising awareness of the exchange, leveraging partners such as community navigators, insurance brokers, state agencies, and others in the outreach process. Through RWJF funding, the state brought in a firm to conduct focus groups with families who were currently uninsured but who would qualify for Medicaid in 2014. Key informants who observed some of these groups said they gained very valuable information. For example, the participants, although uninsured, put great value on health insurance and said they were not interested in exchange kiosks being set up in WalMarts or other chain stores because that would minimize the importance of the insurance. Rather, focus group participants thought that any publicly available kiosks should be placed in a government office or library setting. Some stakeholders said that Medicaid holds a negative stigma in the minds of some, and that a rebranding of Medicaid could support reform efforts. Administrators recognize that the target for outreach under reform will be adults, although they widely acknowledged that more adult Medicaid enrollees will result in more child *Healthy Kids* and *MIChild* enrollees.

[36] New income rules refer to modified adjusted gross income (MAGI), which the Affordable Care Act specifies will determine eligibility for Medicaid and subsidies in the exchange (without an asset test) (Kaiser Commission on Medicaid and the Uninsured 2010).

Several key informants expressed the hope that children and parents could be in the same plans; others felt that the more important priority was to get people covered, regardless of whether this put all family members into the same health plan.

Focus Group Findings: Access to Employer-Sponsored Insurance

Access to ESI can be difficult for lower-income or hourly workers. At the focus group with families covered by ESI, their latest union contract reduced the average hours an employee has to work to qualify for health benefits from 28 to 12; participants agreed the 12 hour average was better, and one focus group participants spoke about the problems some colleagues had when an employee had to work a minimum of 28 hours.

I've watched it go from, if you wanted to be able to work so you can get the insurance, the employer used to let you do so. There are a lot of [employees] that couldn't get an average of 28 hours or they'd finally get it built up, but come January or February [after Christmas, when hours sometimes slow down], they'd be cut back to where for that quarter they haven't had enough hours and they lose their health coverage … It was really sad because some of these people can barely make ends meet and they'd like to have that comfort of health coverage but, it's so part-time. They could go from getting a 5 hour work schedule to … working 36 hours for these weeks.

X. CONCLUSIONS AND LESSONS

Key conclusions drawn and lessons learned from this case study include the following:

- CHIPRA has had a significant financial impact in Michigan, with the Federal allocation increasing by 50 percent, combined with performance bonuses of almost $20 million and more than $2 million in CHIPRA outreach grants. However, from a policy perspective, CHIPRA's impact has been minimal, mostly because Michigan already had many of the new mandatory CHIPRA policies in place (Table 8). An exception is the prospective payment system for FQHCs and RHCs, which Michigan has only recently implemented. The state will have to reconcile payments retroactive to the mandatory implementation deadline of October 2009.[37] In fact, it seems that the Affordable Care Act has already had a bigger policy impact in the state, with the state actively preparing for reform to the extent that it can do so, despite being hindered by the legislature.

Table 8. Michigan's Compliance with Key Mandatory and Optional CHIPRA Provisions

Provision	Implemented in Michigan?
Mandatory CHIPRA provisions	
Mental health parity required for states that include mental health or substance abuse services in their CHIP plans by October 1, 2009	Yes, coverage already in place before October 1, 2009
Requires states to include dental services in CHIP plans	Yes, dental coverage was in place before CHIPRA and was expanded to come into full CHIPRA compliance effective January 1, 2010
Medicaid citizenship and identity documentation requirements applied to Title XXI, effective January 1, 2010	Yes, effective January 1, 2010

[37] According to a 2010 report, at least 13 States had not implemented PPS by mid-2010, but the current number still outstanding is unknown as of this writing (Association of State and Territorial Health Officials 2011).

Table 8 (*Continued*)

Provision	Implemented in Michigan?
30-day grace period before cancellation of coverage	Yes, 30-day grace period in place before CHIPRA
Apply Medicaid PPS to reimburse FQHCs and RHCs effective October 1, 2009	Yes, Michigan's State Plan Amendment for PPS payments to FQHCs and RHCs was approved in April 2012, and payments have begun being processed
Optional CHIPRA provisions	
Option to provide dental-only supplemental coverage for children who otherwise qualify for a state's CHIP program but who have other health insurance without dental benefits	No
Option to cover legal immigrant children and pregnant women in their first 5 years in the United States in Medicaid and CHIP	Michigan covers some legal immigrants during their first five years of residency, including refugees under Section 207, Cuban/Haitian entrants, and Iraqi and Afghan special immigrants
Performance bonus payments for those implementing five of eight simplifications	Yes; Michigan received performance bonus payments all three years they have been available
Contingency funds for states exceeding CHIP allotments due to increased enrollment of low-income children	No
$100 million in outreach funding	Two grantees in the state have received three CHIPRA outreach grants
Quality initiatives, including development of quality measures and a quality demonstration grant program	In the Federal FY 2010 CARTS report, 12 of 24 voluntary quality performance measures were reported Michigan's Medicaid plans are selected in part based on their quality scores Michigan is not participating in any CHIPRA quality grant demonstration programs

- CHIP's most significant contribution in Michigan might be that it has led to meaningful coverage increases in Medicaid—four out of every five children screened for CHIP are found to be Medicaid-eligible. Despite a period with a particularly bad economy in Michigan, analyses of American Community Survey data indicate that the absolute number of uninsured children in Michigan has dropped from about 127,000 children in 2008 to about 96,000 in 2010. The number of uninsured children in families with incomes under 200 percent of the FPL has also declined, from about 86,000 in 2008 to about 60,000 in 2010, while public coverage participation rates among children have increased from 90.8 percent in 2008 to 92.1 percent in 2009, giving Michigan the fifth highest Medicaid/CHIP participation rates nationwide in 2009 (Kenney et al. 2011; Center for Children and Families 2011; Lynch et al. 2010).

- From the inception of its CHIP program, Michigan has tried to make *MIChild* as easy as possible for families, such as permitting self-declaration of most eligibility criteria and initially permitting passive renewal, among other simplifications. The CHIPRA performance bonuses validate that Michigan has adopted many best practices in eligibility and enrollment policies. Coordination with Medicaid has hampered some of its efforts over the years, but the new Medicaid eligibility system implemented in 2010 bumped the number of referrals from Medicaid to CHIP by about 30 percent and has helped to eliminate a gap in public coverage transitions. Still, there are many opportunities for improvement—transferred applications are screened twice, for example (once by CHIP, once by Medicaid), and families who apply for the Supplemental Nutrition Assistance Program or other public benefits are not screened for Medicaid or CHIP eligibility, both missed ELE opportunities.

- Despite a difficult state budget environment, CHIP has not been threatened by budget cuts, mostly because the dollar amounts are small compared with the Medicaid budget. Michigan has committed to maintaining a low-cost program for families—just $10 a month for *MIChild,* no matter how many children a family enrolls—and in focus groups, families expressed appreciation that they could get such good coverage at low cost.

- Access in *MIChild* appears to be satisfactory except for behavioral health services. Access to behavioral health services appears problematic because the group contracted to provide those services can only treat children with a certain level of severity, leaving many children with an apparent coverage gap. Dental coverage appears satisfactory in *MIChild*, but problematic in *Healthy Kids*, due in part to the nature of the *Healthy Kids* contracting approach: a managed care contract is patch-worked throughout the states but does not cover large urban areas, especially Detroit, where dental coverage is provided through a fee-for-service system. The governor has proposed allocating $25 million toward improving dental coverage in Medicaid, but this is expected to address only about one-fourth of the dental access problem.

- Michigan views itself as a leader in quality-of-care monitoring and quality improvement in its Medicaid managed care program—selecting plans based on quality rather than price, using an auto-assignment algorithm based on quality scores, and constantly challenging plans to improve on prior scores—but these components have not yet spilled over to its CHIP contracts. Although some quality monitoring occurs in *MIChild*, it does not approach the intensity in Medicaid. The current use of separate CHIP and Medicaid contracts—administered by the same staff in DCH—seems inefficient, although the state intends to do a single procurement for both Medicaid (including *Healthy Kids*) and *MIChild* in the next contracting cycle. This should bring both programs up to the same quality standards. However, key informants noted that Blue Cross will likely resist this, and they have significant bargaining leverage as the largest health plan in Michigan, the plan that helped the state launch its CHIP program, and the plan that contributes $15 million to the *MIChild* program.

- Michigan has begun both preparing for and investing in (albeit with Federal funds) a new health care marketplace based on a state exchange model. Michigan now awaits the results of the November election before making any final decisions about the new marketplace, but it has the governor's support. It is unclear what will happen to *MIChild* under reform; it is a popular program that no one wants to see go away, and most informants think it will remain as an option in a Michigan exchange. Although some support the idea of a basic health plan, and a Senate bill has been introduced, Blue Cross thinks the BHP bill is premature and that Michigan should first invest its resources into ensuring the exchange works properly. Right now, the Michigan House of Representatives is withholding further funds for exchange planning, so the state probably will not make more progress on passing an exchange bill until after the November elections. At the time of our visit, no decision had been made as to whether the state would implement the Medicaid expansion to adults.

REFERENCES

American HealthLine. "Medicaid: Where Each State Stands On Medicaid, Updated as of August 23, 2012." August 27, 2012. Available at [http://ahlalerts.com/]. Accessed August 27, 2012.

Association of State and Territorial Health Officials. "Status of CHIP Prospective Payer System Implementation: An Assessment of State CHIP Directors." Arlington, VA, 2011. Available at [http://www.nachc.com/client/CHIP%20PPS%20ASTHO%20NACHC.pdf]. Accessed May 30, 2012).

Center for Children and Families, Georgetown University Health Policy Institute. "Health Coverage and the Uninsured – 2010." Updated December 2011. Washington, DC: Georgetown University Health Policy Institute, Center for Children and Families, 2011. Available at [http://ccf.georgetown.edu/index/data-healthcoverage#mi]. Accessed 2/15/2012.

Center for Children and Families, Georgetown University Health Policy Institute. "FY 2009 -FY 2012 CHIP Allotments, in Millions, by State." Updated April 18, 2012. Available at [http://ccf.georgetown.edu/index/cms-filesystem-action?file=statistics/chipra allotments.pdf]. Accessed May 21, 2012.

Center for Children and Families, Georgetown University Health Policy Institute. "Federal S-CHIP Expenditures by State, 1998-2008." Updated June 22, 2009a. Available at [http://ccf.georgetown.edu/index/cms-filesystem-action?file=policy/financing/historic schip expenditures.pdf]. Accessed May 21, 2012.

Center for Children and Families, Georgetown University Health Policy Institute. "Original SCHIP Allotment by State, 1998-2008." Updated June 22, 2009b. Available at [http://ccf.georgetown.edu/index/cms-filesystem-action?file=statistics/historic%20schip%20allotments.pdf]. Accessed May 21, 2012.

Centers for Medicare & Medicaid Services. "Letter to State Health Officials RE: Prospective Payment System for FQHCs and RHCs." Baltimore, MD, February 4, 2010. Available at [http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SHO10004.pdf]. Accessed May 30, 2012.

Centers for Medicare & Medicaid Services (CMS), CHIP Statistical Enrollment Data System (SEDS) as of February 18, 2011, verified and provided by CMS. 2011 data accessed on May 14, 2012.

Ellis, Eileen Marks, and Christopher Trenholm. "Case Study of Michigan: Exploring Medicaid and SCHIP Enrollment Trends and their Links to Policy and Practice." Princeton, NJ, May 2007.

Snyder, Rick. "Governor's Blog: Why We Must Act Now on Health Care." July 3, 2012. Available at [http://www.michigan.gov/snyder/0,4668,7-277-60279-281739--,00.html]. Accessed August 27, 2012.

Health Services Advisory Group. "Michigan Medicaid HEDIS 2011 Results Statewide Aggregate Report." January 2012. Available at [http://www.michigan.gov/documents/mdch/MI2011_HEDIS-Aggregate_Report_F1_374452_7.pdf]. Accessed May 25, 2012.

Health Services Advisory Group. "2011 Michigan Department of Community Health Child Medicaid Health Plan CAHPS® Report." September 2011. Available at [http://www.michigan.gov/documents/mdch/MI_CAHPS_Child_Report_367058_7.pdf]. Accessed May 25, 2012.

Hoag, Sheila, Mary Harrington, Cara Orfield, Victoria Peebles, Kimberly Smith, Adam Swinburn, Matthew Hodges, Kenneth Finegold, Sean Orzol, and Wilma Robinson. "Children's Health Insurance Program: An Evaluation (1997–2010). Interim Report to Congress." Ann Arbor, MI: Mathematica Policy Research, December 21, 2011. Available at [http://aspe.hhs.gov/health/reports/2012/CHIPRA-IRTC/index.shtml]. Accessed May 30, 2012.

Kaiser Commission on Medicaid and the Uninsured. "Health Reform Roundtables: Charting a Course Forward." Menlo Park, CA: Kaiser Family Foundation, 2010. Available at [http://www.kff.org/healthreform/upload/8102.pdf]. Accessed May 16, 2012.

Kaiser Family Foundation, State Health Facts. "Michigan: Enhanced Federal Medical Assistance Percentage (FMAP) for the Children's Health Insurance Program (CHIP)." 2012. Available at [http://www.statehealthfacts.org/profileind.jsp?rgn=24&cat=4&ind=239]. Accessed May 21, 2012.

Kenney, Genevieve M., Victoria Lynch, Jennifer Haley, Michael Huntress, Dean Resnick, and Christine Coyer. "Gains for Children: Increased Participation in Medicaid and CHIP in 2009." Washington, DC: Urban Institute and the Robert Wood Johnson Foundation, 2011. Available at [http://www.urban.org/UploadedPDF/412379-Gains-for-Children.pdf]. Accessed May 30, 2012.

Lynch, Victoria, Samantha Phong, Genevieve Kenney, and Juliana Macri. "Uninsured Children: Who Are They and Where Do They Live?" Washington, DC: Urban Institute and the Robert Wood Johnson Foundation, 2010. Available at [http://www.rwjf.org/files/research/67668.pdf]. Accessed May 30, 2012.

"Michigan CHIP Annual Report Template [CARTS]- FFY 2011." Accessed via the Medicaid and Children's Health Insurance Program Budget and Expenditure System on April 2, 2011.

Michigan Department of Community Health. "Family Guide To Michigan's Children's Special Health Care Services Program." January 30, 2009. Available at [http://www.michigan.gov/documents/mdch/family_guide_newest_1_267882_7.pdf]. Accessed June 4, 2012.

Michigan Department of Community Health. "MIChild Eligibility Manual." Lansing, MI: Michigan Department of Community Health, November 1, 2010. Available at [http://www.michigan.gov/documents/MIChildfullmanual_13163_7.PDF]. Accessed May 15, 2012.

Michigan Department of Community Health Data Warehouse, CHAMPS Model. "CSHCS Calendar Year 2010 – Enrollment Per Month." January 2011. Available at [http://www.michigan.gov/documents/mdch/CY2010_Enrollment_350014_7.pdf]. Accessed June 4, 2012.

Michigan Primary Care Association. "MPCA Staff Member Recognized for Excellence in Children's Health Outreach." Lansing, MI: MPCA, posted on November 22, 2011. Available at [http://michiganpca.wordpress.com/2011/11/22/mpca-staff-member-recognized-for-excellence-in-childrens-health-outreach/]. Accessed May 28, 2012.

National Maternal and Child Oral Health Policy Center. "CHIP Dental Coverage: An Examination of State Oral Health Benefit Changes as a Result of CHIPRA." Issue Brief, December 2011. Available at [http://www.nashp.org/sites/default/files/NMOHPC.CHIPRA.dental.12.11.pdf]. Accessed May 29, 2012.

Sebelius, Kathleen. "The Department of Health and Human Services Children's Health Insurance Program Reauthorization Act: 2011 Annual Report on the Quality of Care for Children in Medicaid and CHIP." September 2011. Available at [http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/2011_StateReporttoCongress.pdf]. Accessed May 25, 2012.

This page has been left blank for double-sided copying.

APPENDIX A

KEY INFORMANTS

This page has been left blank for double-sided copying.

SITE VISITORS

Mathematica Policy Research
Sheila Hoag
Cara Orfield
Vivian Byrd

KEY INFORMANTS: LANSING

Michigan Department of Community Health
Steve Fitton
Logan Dreasky
Dick Miles
Jackie Prockop
Olga Dazzo
Nick Lyon
Kathy Stiffler
Julie Blazic
Brian Keisling
Sheila Embry
Terry Geiger

Michigan Department of Human Services
Michelle Best
Jane Leask

Michigan Department of Licensing and Regulatory Affairs
Chris Priest

Michigan Center for Rural Health
John Barnas

Michigan League for Human Services
Jan Hudson
Jane Zehnder-Merrell

Michigan Primary Care Association
Kim Sibilsky
Phillip Bergquist
Rebecca Cienki

Michigan Senate
Holly Fountain (State Senator Roger Kahn, 32nd District)

Small Business Association of Michigan
Rob Fowler

MAXIMUS
Phyllis Easton

Governor Rick Snyder's Office
Bill Rustem

KEY INFORMANTS: DETROIT/SOUTHEAST MICHIGAN

Henry Ford Health System – Health Alliance for Neighborhood Kids
Kathleen Conway

Priority Health Government Programs
Diana Criss

Washtenaw County Community Support and Treatment Services
Elizabeth Spring
Wayne County Children's Healthcare Access Program
Jametta Lilly

Covenant Community Care
Felipe Martoral

Blue Cross Blue Shield
Karen Spring
Monica Morris
Dr. Donald Beam
Kirk Roy
Lisa Rourke
Tina Allen
Johnonda Craig
Jacob Nysson
Christine Pfeiffer
Andre Smith

This page has been left blank for double-sided copying.

APPENDIX B

APPLICATION

This page has been left blank for double-sided copying.

Apply On-line Now! https://www.healthcare4MI.com

MICHILD AND HEALTHY KIDS APPLICATION

MIChild is a low-cost health coverage program for children under age 19.
Healthy Kids is a free health coverage program for children under age 19 and pregnant women of any age.

Please fill out this entire application. Sign and date the application on page 4.

- If a question does not apply to you, write "N/A" in that space.
- **You must choose both a health and dental plan below.**

Health Plan Choice: _____	To find out which plans are in your area, call toll-free 1-888-988-6300 or call your doctor or dentist to see if they are part of a MIChild Plan.
Dental Plan Choice: _____	

- If you are pregnant and under age 18, you can apply for yourself without reporting your parents' information or you can apply as part of your family.

If you need help with reading or writing to complete this application, call toll-free **1-888-988-6300** (TTY-1-888-263-5897 for persons with hearing and speech disabilities). **Hours: Monday through Friday 8 AM to 7 PM.**

Language interpreter services are available free of charge.
Si ud. necesita ayuda con la aplicacion, llamenos a **1-888-988-6300**. La llamada es gratis.
إذا أحتجت لأى مساعدة فى تعبئة هذا الطلب، يرجى الإتصال على الرقم المجانى **1-888-988-6300** وشكراً

INFORMATION ON ADULTS IN HOUSEHOLD

Home Address	Street (include Apartment or Lot numbers)	**Mailing Address**	Street / PO Box (include Apartment or Lot numbers)
County: _____	City	(If different from Home Address)	City
	State Zip		State Zip

	Adult #1	Adult #2
Name — First Name		
Name — Middle Name		
Name — Last Name		
Name — Maiden Name - (Optional)		
Telephone number where you can be reached (include Area Code)	Day: _____/_____ Evening: _____/_____	Day: _____/_____ Evening: _____/_____
Sex (circle one)	Male Female	Male Female
Date of birth (month/ day/ year)		
Social Security # (optional)		
Are you married?	Yes No	Yes No
Have you received cash assistance (FIP) or LIF Medicaid in the last 4 months?	Yes No	Yes No
Are you a Native American or Alaskan Native?	Yes No	Yes No
Are you a migrant worker?	Yes No	Yes No
Racial / Ethnic Heritage (optional) (see codes at bottom of this page)		
What is your primary language?		

Use these letters to show racial/ethnic heritage. You do not have to fill in racial/ethnic heritage.
A-Asian or Pacific Islander **B**-Black or African American (Non-Hispanic) **E**-Other Race or Ethnicity **H**-Hispanic **I**-Native American / American Indian / Alaskan Native **J**-Native Hawaiian **O**-Caucasian/White (Non-Hispanic) **Z**-Mutually Defined or Multiracial

If you need help with this application, call toll-free 1-888-988-6300

Official use only
M

CHILDREN AND/OR PREGNANT WOMAN INFORMATION

Please attach additional pages, if needed.

	Child #1	Child #2	Child #3	Pregnant Woman or Child #4
Please include all children living in the home, even if you are not applying for that child. First Name				
Middle Name				
Last Name				
Is this person's address the same as the adult's? (The child and/or pregnant woman must apply from their home address.)	Yes No	Yes No	Yes No	Yes No
Are you applying for this person?	Yes No	Yes No	Yes No	Yes No
Sex (circle one)	Male Female	Male Female	Male Female	Male Female
Is this person pregnant? (If yes, see note at the bottom of this page)	Yes No Due date_____	Yes No Due date_____	Yes No Due date_____	Yes No Due date_____
Is this person a Native American or Alaskan Native?	Yes No	Yes No	Yes No	Yes No
Racial / Ethnic Heritage (optional) (see codes at bottom of page 1)				
What is this person's primary language?				
Date of Birth (month, day, year)				
This person's Social Security Number (Required if person is applying for health coverage. See note at the bottom of this page.)				
Citizen of the United States? (If No, send a copy of the document that provides the person's legal status. See note at the bottom of this page)	Yes No	Yes No	Yes No	Yes No
Relationship to adults from page 1 (son, daughter, adopted, step, spouse, none, self, etc.)	Adult 1_____ Adult 2_____	Adult 1_____ Adult 2_____	Adult 1_____ Adult 2_____	Adult 1_____ Adult 2_____
Child support received: List monthly amount or zero if none received.	$	$	$	$
Are the child's parents currently married to each other?	Yes No	Yes No	Yes No	Yes No
Are both parents of the child living in the home?	Yes No	Yes No	Yes No	Yes No
Does this person have any children?	Yes No	Yes No	Yes No	Yes No
Does this person have health insurance besides MIChild/Medicaid? If Yes, send a copy of the front and back of card.	Yes No	Yes No	Yes No	Yes No
Has this person had health insurance (from an adult's job) that ended in the past 6 months? (If Yes, attach written statement explaining why the insurance ended)	Yes No Date Insurance Ended_____	Yes No Date Insurance Ended_____	Yes No Date Insurance Ended_____	Yes No Date Insurance Ended_____
Does this person have access to health insurance through the state or other government agency?	Yes No	Yes No	Yes No	Yes No
Does this person have Children's Special Health Care Services?	Yes No	Yes No	Yes No	Yes No
Has this person received cash assistance (FIP) or LIF Medicaid in the last 4 months?	Yes No	Yes No	Yes No	Yes No
Does this person intend to remain in Michigan?	Yes No	Yes No	Yes No	Yes No
Has paternity been established for this child?	Yes No	Yes No	Yes No	Yes No
If a parent is not in the home, please provide the absent parent's name and address. If deceased, write deceased. (Attach additional pages if needed.)				

NOTE: Your application will be processed faster if you send copies of the following with your application:

- If pregnant with more than one child, provide Doctor's statement.
- If applicant's social security number has not been obtained, send proof that you have applied for a number. The local DHS office can help you apply for a social security number for the applicant. Social Security Numbers are optional for those not applying.
- If applicant is not a U.S. citizen, send a copy of the document (I-551 or I-94) that provides the person's legal status in the U.S. Applicants who are citizens may be asked to provide documents to prove citizenship and identity (birth certificate, driver's license, passport, etc).
- If you have insurance, send a copy of front and back of each insurance card.

Apply On-line Now! https://www.healthcare4MI.com

INCOME INFORMATION

WAGES

(Please attach additional pages, if needed.)

	Are you employed?	Monthly Gross Pay (before taxes)	Monthly Take Home Pay (after taxes)
Adult 1	Yes No (circle one)	$ _____ /month (tips included)	$ _____ /month (tips included)
Adult 2	Yes No (circle one)	$ _____ /month (tips included)	$ _____ /month (tips included)

SELF EMPLOYMENT

Name of self-employed person	Gross monthly income, minus allowable federal tax deductions (DEPRECIATION not allowed)
	$ _____ /month
	$ _____ /month

OTHER INCOME

List all other income received by household members.

1. Unemployment Benefits
2. RSDI (Soc. Sec. Benefits)
3. SSI (Supplemental Security Income)
4. Military Allotment
5. Veteran's Benefits
6. Retirement Benefits
7. Interest Income
8. Rental Income
9. Strike Benefits
10. Worker's Compensation
11. Employer Based Disability Insurance
12. Investment Income
13. Cash from Friends or Family
14. Other (please specify) _____

List below the household members who have income	Type of Income (from above list)	If RSDI/SSI Income please enter Claim #	Monthly Gross Income (before taxes)
			$ _____ /month
			$ _____ /month
			$ _____ /month
			$ _____ /month
			$ _____ /month

NOTE: **If you do not have any income, please briefly explain below how you support yourself and your family:**

_____

INCOME DEDUCTIONS

Child support you pay for children not living with you:		Do you pay any court-ordered guardian expenses?			Do you pay child day care * so you can work?			If you own rental property, provide expenses:
			Adult 1	Adult 2		Adult 1	Adult 2	$ _____ /month
Adult 1	$_____/ month	For Child 1	Y / N	Y / N	For Child 1	Y / N	Y / N	Do not complete this box unless you report rental income. These are your monthly expenses for rental property that you own and rent to others (not rent you pay). Name of rental property owner:
Adult 2	$_____/ month	For Child 2	Y / N	Y / N	For Child 2	Y / N	Y / N	
		For Child 3	Y / N	Y / N	For Child 3	Y / N	Y / N	

* Child-care expenses cannot be claimed if you pay your spouse (or other parent of child) to watch the child. Also, the child must be under the age of 15 or under 18 and need care due to a mental or physical limitation.

If you need help with this application, call toll-free **1-888-988-6300**

- If you need help with reading or writing to complete this application, under the Americans with Disabilities Act, you are invited to make your needs known by calling 1-888-988-6300 (1-888-263-5897 for persons with hearing and speech disabilities) or your local DHS office. Language interpreter services are available at no cost.
- If you would like help with paternity and/or the pursuit of financial or medical support, contact your local DHS office.
- You have the right to appeal a decision made by the DCH or DHS. You will be notified of your rights if your application is denied for any reason.

I agree to the release of information from this application and supporting proof in order to evaluate and verify eligibility. I agree that the Department of Community Health (DCH) or Department of Human Services (DHS) may use necessary medical information about me or my children, including any information about HIV, ARC, or AIDS, to determine eligibility for a specific program or for other administrative purposes. I understand that these departments will maintain confidentiality according to the Health Insurance Portability and Accountability Act, 42 CFR 431.300-431.307, and any other applicable federal and state laws and regulations. This authorization is valid for 3 years from the date this application is signed.

I understand that when DCH pays the cost of medical services, any right to recover costs from a third person or public or private contractor, except Medicare, is transferred to DCH. Payment of any recovery under such right is to be made directly to the State of Michigan, DCH or its agent.

I understand that if I get more benefits than I am entitled to through my fault, I will have to repay any extra benefits received.

I understand that this application is for one type of health benefit and is not a full Medicaid application. I understand that if found not eligible for health benefits under MIChild or Healthy Kids, I may be eligible for Medicaid benefits on some other basis. I understand I have the right to complete the DHS-1171 to apply for cash benefits, Food Assistance, Day Care assistance or other services at the local DHS office.

Neither the DCH nor DHS will discriminate against any individual or group because of race, sex, religion, age, national origins, marital status, disability or political beliefs. I understand that if I wish to file a discrimination complaint, I should contact the Department of Civil Rights Service Center by calling 313-456-3700 (TTY-1-877-878-8464).

I understand that children enrolled for MIChild or Healthy Kids will be eligible for 12 months unless they turn age 19, move out of state, fail to pay MIChild premiums or are deceased. I understand that MIChild coverage will end if my child becomes eligible for Medicaid.

I understand that computer cross-checking may be used to verify information I have provided on this application.

I understand that my children can still receive Medicaid benefits if I do not cooperate with the Office of Child Support for the establishment of child paternity and/or the pursuit of financial or medical support.

SIGN AND DATE YOUR APPLICATION

I certify under penalty of perjury that the information on this application is true, complete, and accurate to the best of my knowledge. I understand that any misrepresentation of the facts means that benefits may be taken away. I authorize DCH/DHS to verify the information on this application.

Signature _____ Date _____

MAIL COMPLETED APPLICATION TO:

MIChild
PO Box 30412
Lansing, MI 48909

Authority: Titles XIX and XXI of the Social Security Act. Completion: This form is required to enroll in a health plan.	MAXIMUS is the Administrative Services Contractor for MIChild, under contract with the DCH.

DCH-0373 (06/11)

MDCH is an Equal Opportunity Employer, Services and Programs Provider

www.mathematica-mpr.com

Improving public well-being by conducting high quality, objective research and surveys

PRINCETON, NJ ■ ANN ARBOR, MI ■ CAMBRIDGE, MA ■ CHICAGO, IL ■ OAKLAND, CA ■ WASHINGTON, DC

MATHEMATICA
Policy Research