

Children's Special Health Care Services

Children's Special Health Care Services (CSHCS) is a program within the Department of Community Health. It is for children and some adults with special health care needs and their families.

It helps persons with chronic health problems by providing:

- **Coverage and referral** for specialty services, based on the child's health problems.
- **Family centered services** to support you in your primary role as caretaker of your child.
- **Community-based services** to help you care for your child at home and maintain normal routines.
- **Culturally competent services** which demonstrate awareness of cultural differences.
- **Coordinated services** to pull together the services of many different providers who work within different agencies.

Who can join CSHCS?

Children must have a qualifying medical condition and be 20 years old or under. Persons 21 and older with cystic fibrosis or certain blood coagulation disorders may also qualify for services.

CSHCS covers more than 2,700 diagnoses. Some common medical conditions that may qualify for CSHCS are:

- cancer
- cerebral palsy
- cleft palate/cleft lip
- liver disease
- club foot
- hypospadias
- deformed limbs/amputations
- myelodysplasia/spina bifida
- certain vision disorders
- paralysis/spinal injuries
- hemophilia/blood clotting disorders
- cystic fibrosis/other chronic lung conditions
- hearing loss
- insulin-dependent diabetes
- muscular dystrophy
- certain heart conditions
- epilepsy/hydrocephalus

- neurological disorders
- kidney disease
- sickle cell anemia

If you think you or your child qualifies for CSHCS, call our toll-free **Family Phone Line** at:

1-800-359-3722

of contact the CSHCS office in your local health department for information on how to apply.

A medical doctor will review each condition to determine eligibility.

Who Is Eligible for Medicare?

Generally, you are eligible for Medicare if you or your spouse worked for at least 10 years in Medicare-covered employment and you are 65 years old and a citizen or permanent resident of the United States. You might also qualify for coverage if you are a younger person with a disability or with chronic kidney disease.

Here are some simple guidelines. You can get Part A at age 65 without having to pay premiums if:

- You are already receiving retirement benefits from Social Security or the Railroad Retirement Board.
- You are eligible to receive Social Security or Railroad benefits but have not yet filed for them.
- You or your spouse had Medicare-covered government employment.

If you are under 65, you can get Part A without having to pay premiums if:

- You have received Social Security or Railroad Retirement Board disability benefits for 24 months.
- You are a kidney dialysis or kidney transplant patient.

While you do not have to pay a premium for Part A if you meet one of those conditions, you must pay for Part B if you want it. The Part B monthly premium in 1999 is \$45.50. It is deducted from your Social Security, Railroad Retirement, or Civil Service Retirement check.

If you have questions about your eligibility for Medicare Part A or Part B, or if you want to apply for Medicare, call the Social Security Administration. The toll-free telephone number is: 1-800-772-1213. The TTY-TDD number for the hearing and speech impaired is 1-800-325-0778. You can also get information about buying Part A as well as part B if you do not qualify for premium-free part A.

Enrollment

Enrollment in Medicare is handled in two ways: either you are enrolled automatically or you have to apply. Here's how it works.

Automatic Enrollment:

If you are not yet 65 and already getting Social Security or Railroad Retirement benefits, you do not have to apply for Medicare. You are enrolled automatically in both Part A and Part B and your Medicare card is mailed to you about 3 months before your 65th birthday. If you do not want Part B, follow the instructions that come with the card.

If you are disabled, you will be automatically enrolled in both Part A and Part B of Medicare beginning in your 25th month of disability. Your card will be mailed to you about 3 months before you are entitled to Medicare.

Applying for Medicare:

You need to apply for Medicare if you are not receiving Social Security or Railroad Retirement Benefits three months before you turn 65, or if you require regular dialysis or kidney transplant. That's the beginning of your 7-month initial enrollment period. By applying early, you'll avoid a

possible delay in the start of your Part B coverage. You apply by contacting any Social Security Administration office or, if you or your spouse worked for the railroad, the Railroad Retirement Board.

If you do not enroll during this 7-month period, you'll have to wait to enroll until the next general enrollment period. General enrollment periods are held January 1 to March 31 of each year, and Part B coverage starts the following July.

Don't put off enrolling. If you wait 12 or more months to sign up, your premiums generally will be higher. Part B premiums go up 10 percent for each 12 months that you could have enrolled but did not. The increase in the Part A premium (if you have to pay a premium) is 10 percent no matter how late you enroll for coverage.

Under certain circumstances, however, you can delay your Part B enrollment without having to pay higher premiums. If you are age 65 or over and have group health insurance based on your own or your spouse's current employment, or if you are disabled and have group health insurance based on your current employment or the current employment of any family member, you have a choice:

- You may enroll in Part B at any time while you are covered by the group health plan; or
- You can enroll in Part B during the 8-month enrollment period that begins the month employment ends or the month you are no longer covered under the employer plan, whichever comes first.

If you enroll in Part B while covered by an employer plan or during the first full month when not covered by that plan, your coverage begins the first day of the month you enroll. You also have the option of delaying coverage until the first day of the following 3 months. If you enroll during any of the 7 remaining months of the special enrollment period, your coverage begins the month after you enroll.

If you do not enroll by the end of the 8-month period, you'll have to wait until the next general enrollment period, which begins January 1 of the next year.

Even if you continue to work after you turn 65, you should sign up for Part A of Medicare. Part A may help pay some of the costs not covered by the employer plan. It may not, however, be advisable to sign up for Part B if you have health insurance through your employer. You would have to pay the monthly Part B premium, and the Part B benefits may be of limited value to you as long as the employer plan was the primary payer of your medical bills. Moreover, you would trigger your 6-month Medigap open enrollment period (see Medigap Insurance).

Source: Health Care Financing Administration

Medicaid Eligibility

The following describes information about Medicaid eligibility.

States have some discretion in determining which groups their Medicaid programs will cover and the financial criteria for Medicaid eligibility. To be eligible for Federal funds, States are required to provide Medicaid coverage for most individuals who receive Federally assisted income maintenance payments, as well as for related groups not receiving cash payments. Some examples of the mandatory Medicaid eligibility groups are:

- Low income families with children, as described in Section 1931 of the Social Security Act, who meet certain of the eligibility requirements in the State's AFDC plan in effect on July 16, 1996;
- Supplemental Security Income (SSI) recipients (or in States using more restrictive criteria--aged, blind, and disabled individuals who meet criteria which are more restrictive than those of the SSI program and which were in place in the State's approved Medicaid plan as of January 1, 1972);
- infants born to Medicaid-eligible pregnant women. Medicaid eligibility must continue throughout the first year of life so long as the infant remains in the mother's household and she remains eligible, or would be eligible if she were still pregnant;
- children under age 6 and pregnant women whose family income is at or below 133 percent of the Federal poverty level. (The minimum mandatory income level for pregnant women and infants in certain States may be higher than 133 percent, if as of certain dates the State had established a higher percentage for covering those groups.) States are required to extend Medicaid eligibility until age 19 to all children born after September 30, 1983 (or such earlier date as the State may choose) in families with incomes at or below the Federal poverty level. This phases in coverage, so that by the year 2002, all poor children under age 19 will be covered. Once eligibility is established, pregnant women remain eligible for Medicaid through the end of the calendar month in which the 60th day after the end of the pregnancy falls, regardless of any change in family income. States are not required to have a resource test for these poverty level related groups. However, any resource test imposed can be no more restrictive than that of the AFDC program for infants and children and the SSI program for pregnant women;
- recipients of adoption assistance and foster care under Title IV-E of the Social Security Act;
- certain Medicare beneficiaries (described later); and
- special protected groups who may keep Medicaid for a period of time. Examples are: persons who lose SSI payments due to earnings from work or increased Social Security benefits; and families who are provided 6 to 12 months of Medicaid coverage following loss of eligibility under Section 1931 due to earnings, or 4 months of Medicaid coverage following loss of eligibility under Section 1931 due to an increase in child or spousal support.

States also have the option to provide Medicaid coverage for other "categorically needy" groups. These optional groups share characteristics of the mandatory groups, but the eligibility criteria are somewhat more liberally defined. Examples of the optional groups that States may cover as categorically needy (and for which they will receive Federal matching funds) under the Medicaid program are:

- infants up to age one and pregnant women not covered under the mandatory rules whose family income is below 185 percent of the Federal poverty level (the percentage to be set by each State);
- optional targeted low income children;
- certain aged, blind, or disabled adults who have incomes above those requiring mandatory coverage, but below the Federal poverty level;
- children under age 21 who meet income and resources requirements for AFDC, but who otherwise are not eligible for AFDC;
- institutionalized individuals with income and resources below specified limits;
- persons who would be eligible if institutionalized but are receiving care under home and community-based services waivers;
- recipients of State supplementary payments; and
- TB-infected persons who would be financially eligible for Medicaid at the SSI level (only for TB-related ambulatory services and TB drugs)
- low-income, uninsured women screened and diagnosed through a Center's for Disease Control and Prevention's Breast and Cervical Cancer Early Detection Program and determined to be in need of treatment for breast or cervical cancer.

Medically Needy Eligibility Groups

The option to have a "medically needy" program allows States to extend Medicaid eligibility to additional qualified persons who may have too much income to qualify under the mandatory or optional categorically needy groups. This option allows them to "spend down" to Medicaid eligibility by incurring medical and/or remedial care expenses to offset their excess income, thereby reducing it to a level below the maximum allowed by that State's Medicaid plan. States may also allow families to establish eligibility as medically needy by paying monthly premiums to the State in an amount equal to the difference between family income (reduced by unpaid expenses, if any, incurred for medical care in previous months) and the income eligibility standard.

Eligibility for the medically needy program does not have to be as extensive as the categorically needy program. However, States which elect to include the medically needy under their plans are required to include certain children under age 18 and pregnant women who, except for income and resources, would be eligible as categorically needy. They may choose to provide coverage to other medically needy persons: aged, blind, and/or disabled persons; certain relatives of children deprived of parental support and care; and certain other financially eligible children up to age 21. In 1995, there were 40 medically needy programs which provided at least some services to recipients.

Amplification on Medicaid Eligibility

Coverage may start retroactive to any or all of the 3 months prior to application, if the individual would have been eligible during the retroactive period. Coverage generally stops at the end of the month in which a person's circumstances change. Most States have additional "State-only" programs to provide medical assistance for specified poor persons who do not qualify for the Medicaid program. No Federal funds are provided for State-only programs.

Medicaid does not provide medical assistance for all poor persons. Even under the broadest provisions of the Federal statute (except for emergency services for certain persons), the Medicaid program does not provide health care services, even for very poor persons, unless they are in one of the groups designated above. Low income is only one test for Medicaid eligibility; assets and resources are also tested against established thresholds. As noted earlier, categorically needy persons who are eligible for Medicaid may or may not also receive cash assistance from the TANF program or from the SSI program. Medically needy persons who would be categorically eligible except for income or assets may become eligible for Medicaid solely because of excessive medical expenses.

States may use more liberal income and resources methodologies to determine Medicaid eligibility for certain AFDC-related and aged, blind, and disabled individuals under sections 1902(r)(2) and 1931 of the Social Security Act. For some groups, the more liberal income methodologies cannot result in the individual's income exceeding the limits prescribed for Federal matching.

Significant changes were made in the Medicare Catastrophic Coverage Act (MCCA) of 1988 which affected Medicaid. Although much of the MCCA was repealed, the portions affecting Medicaid remain in effect. The law also accelerated Medicaid eligibility for some nursing home patients by protecting assets for the institutionalized person's spouse at home at the time of the initial eligibility determination after institutionalization. Before an institutionalized person's monthly income is used to pay for the cost of institutional care, a minimum monthly maintenance needs allowance is deducted from the institutionalized spouse's income to bring the income of the community spouse up to a moderate level.

Medicaid - Medicare Relationship

The Medicare program (Title XVIII of the Social Security Act) provides hospital insurance (HI), also known as Part A coverage, and supplementary medical insurance (SMI), also known as Part B coverage. Coverage for HI is automatic for persons aged 65 and older (and for certain disabled persons) who have insured status under Social Security or Railroad Retirement. Coverage for HI may be purchased by individuals who do not have insured status through the payment of monthly Part A premiums. Coverage for SMI also requires payment of monthly premiums.

Medicare beneficiaries who have low income and limited resources may receive help paying for their out-of-pocket medical expenses from their State Medicaid program. There are various benefits available to "dual eligibles" who are entitled to Medicare and are eligible for some type of Medicaid benefit.

For persons who are eligible for full Medicaid coverage, the Medicaid program supplements Medicare coverage by providing services and supplies that are available under their State's Medicaid program. Services that are covered by both programs will be paid first by Medicare and the difference by Medicaid, up to the State's payment limit. Medicaid also covers additional services (e.g., nursing facility care beyond the 100 day limit covered by Medicare, prescription drugs, eyeglasses, and hearing aids).

Limited Medicaid benefits are also available to pay for out-of-pocket Medicare cost-sharing expenses for certain other Medicare beneficiaries. The Medicaid program will assume their Medicare payment liability if they qualify. Qualified Medicare Beneficiaries (QMBs), with resources at or below twice the standard allowed under the SSI program and income at or below 100% of the Federal poverty level (FPL), do not have to pay their monthly Medicare premiums, deductibles, and coinsurance. Specified Low-Income Medicare Beneficiaries (SLMBs), with resources at or below twice the standard allowed under the SSI program and income exceeding the QMB level, but less than 120% of the FPL, do not have to pay the monthly Medicare Part B premiums. Qualifying Individuals (QIs), who are not otherwise eligible for full Medicaid benefits and with resources at or below twice the standard allowed under the SSI program, will get help with all or a small part of their monthly Medicare Part B premiums, depending upon whether their income exceeds the SLMB level, but is less than 135% of the FPL, or their income is at least 135%, but less than 175% of the FPL.

Individuals who were receiving Medicare due to disability, but have lost entitlement to Medicare benefits because they returned to work, may purchase Part A of Medicare. If the individual has income below 200% of the FPL and resources at or below twice the standard allowed under the SSI program, and they are not otherwise eligible for Medicaid benefits, they may qualify to have Medicaid pay their monthly Medicare Part A premiums as Qualified Disabled and Working Individuals (QDWIs).

Medical Services Administration
Medicaid Qualified Health Plans
Phone Numbers and Addresses

Botsford Health Plan

28050 Grand River
Farmington Hills, MI 48336
(800) 479-5122
<http://botsfordsystem.org/bhp>

Cape Health Plan

26711 Northwestern Hwy., Suite 300
Southfield, MI 48034
(248) 386-3000
(888) 354-2273
<http://www.capehealth.com>

Care Choices HMO

34605 Twelve Mile Road
Farmington Hills, MI 48331
(248) 489-6000
(800) 893-1113
<http://www.carechoices.com>

Community Care Plan

2100 Raybrook SE
Grand Rapids, MI 49546
(616) 252-4590
(800) 807-5244
<http://www.communitycareplan.org>

Community Choice Michigan

2369 Woodlake Drive
Okemos, MI 48864
(800) 390-7102
<http://www.ccmhmo.org>

Great Lakes Health Plan, Inc.

17117 W. Nine Mile, Suite 1600
Southfield, MI 48075
(248) 559-5656
(800) 903-5253
<http://www.glhp.com>

Health Plan of Michigan

17515 W. Nine Mile Road, Suite 650
Southfield, MI 48075

(248) 557-3700

(888) 437-0606

<http://www.hpmich.com>

Health Plus of Michigan

2050 S. Linden Road

P.O. Box 1700

Flint, MI 48501-1700

(810) 230-2222

(800) 332-9161

<http://www.healthplus.com>

M-Care

2301 Commonwealth Blvd.

Ann Arbor, MI 48105-1573

(734) 332-2206

(800) 527-5549

<http://www.mcare.org>

McLaren Health Plan

401 S. Ballenger Highway

Flint, MI 48532

(810) 342-1072

(888) 327-0671

<http://www.mclaren.org>

Midwest Health Plan

5050 Schaefer Road

Dearborn, MI 48126

(313) 581-3700

(888) 654-2200

<http://www.midwesthealthplan.com>

Molina Healthcare of Michigan

43097 Woodward Ave., Suite 200

Bloomfield Hills, MI 48302

(248) 454-1070

(888) 898-7969

<http://www.molinahealthcare.com/>

OmniCare Health Plan

1155 Brewery Park Blvd., Suite 250

Detroit, MI 48207

(313) 259-4000

(800) 955-4578

<http://www.ochp.com>

PHP of Mid-Michigan

P.O. Box 30377-7877

Lansing, MI 48909-7877

(517) 347-9425

(800) 661-8299

<http://www.phpmi.org/>

PHP of Southwest Michigan

106 Farmers Alley, Suite 300

Kalamazoo, MI 49007

(616) 341-7200

(800) 261-0084

<http://www.phpiba.com/>

Priority Health

1231 E. Beltline NE

Grand Rapids, MI 49525-4501

(616) 942-0954

(888) 975-8102

<http://www.priority-health.com>

Total Health Care

3011 W. Grand Blvd., Suite 1600

Detroit, MI 48202

(313) 871-7800

(800) 826-2862

<http://www.totalhealthcareonline.com>

Upper Peninsula Health Plan

228 W. Washington Street

Marquette, MI 49855

(906) 225-7500

(800) 835-2556

<http://www.uphp.com>

The Wellness Plan

2875 W. Grand Blvd.

Detroit, MI 48202

(313) 875-4200

(800) 875-9355

<http://www.wellplan.com>

Adult Benefits Waiver

The Adult Benefits Waiver provides basic health insurance coverage to residents of the State of Michigan with countable incomes at or below 35% of the federal poverty level.

The coverage is funded by state general funds and an increased utilization of Michigan's SCHIP allocation to cover uninsured childless adults.

Application for the Adult Benefits Waiver is made through local Department of Human Services offices.