
AUTO-ASSIGNMENT

The process of automatically assigning a beneficiary to a Medicaid Health Plan using a Michigan Department of Community Health (DCH) approved algorithm. A beneficiary is auto assigned when s/he or the authorized representative does not voluntarily pick a health plan within the required period of time (approximately 22 to 28 calendar days).

BENEFICIARY

A person eligible for or receiving benefits under an insurance policy or plan, Medicare or Medicaid program. This term is used by health and insurance staff and refers to the foster child.

BRIDGES

Eligibility system operated by DHS.

**BRIDGES MEDICAID
PROGRAM CODES**

See chart at end of glossary.

CHAMPS

Abbreviation for Community Health Automated Medicaid Processing System (CHAMPS). Operated by the Michigan Department of Community Health, the CHAMPS data system provides Medicaid related information including payments and beneficiary verification to providers.

CMH OR CMHSP

Abbreviation for Community Mental Health (CMH) or Community Mental Health Services Program (CMHSP). Each county has a local CMH program that provides mental health services to county residents including Medicaid beneficiaries. When beneficiaries are enrolled in a Medicaid Health Plan, the health plan coordinates needed mental health services with the CMH that serves the beneficiary's county of residence.

**COMMITMENT
PERIOD (ALSO
KNOWN AS LOCK
IN)**

Commitment period describes the period during which termination of the specific Medicaid Health Plan (MHP) commitment is not possible. A foster child's MHP can be changed during the first 90 days of his/her enrollment. After the foster child has been in his/her plan for more than 90 days, he/she is committed (locked in) to that specific MHP until the annual open enrollment period during the month of May.

**CONVERSION
PROCESS**

The process of transitioning current foster children from fee-for-service Medicaid to a Medicaid Health Plan.

**COPAYMENT (ALSO
KNOWN AS CO-PAY)**

A payment that beneficiaries must pay at the time of service. Fee-for-service Medicaid and some Medicaid Health Plans have co-pays for beneficiaries age 21 and older. One example is a one dollar (\$1) co-pay for generic prescriptions.

**CHILDREN'S
SPECIAL HEALTH
CARE SERVICES
(CSHCS)**

A program, formerly known as the Crippled Children's Program, for children with chronic serious illness, disease or disability that requires extensive specialty care. Beneficiaries must apply at their local health department for CSHCS eligibility. This population is excluded from Medicaid managed care.

CUT-OFF DATE

The date when an effective date of health plan enrollment would change. For example, an enrollment processed before cut-off is effective the first of the next month. An health plan enrollment processed after cut-off is effective the first of the next available month. Also known as card cut-off.

DCH

Department of Community Health (DCH). The department is responsible for health policy and management of the state's publicly-funded health service systems. Services include:

- Medicaid health care coverage for people with limited incomes.
- Mental health services for people who have a mental illness or a developmental disability, and services for people who need care for substance abuse.
- Health needs assessment, health promotion, disease prevention, and accessibility to appropriate health care.

The department's Mental Health Services are primarily provided through contracts with 46 Community Mental Health Services Programs (CMHSP) and 18 Prepaid Inpatient Health Plans (PIHP). These programs provide community-based behavioral and mental health services and supports to persons with mental illness, developmental disabilities and addictive disorders throughout Michigan.

**DURABLE MEDICAL
EQUIPMENT (DME)**

Term used to describe medical equipment prescribed by a medical provider and used in the home to aid in a better quality of living. DME may include, but is not limited to the following: iron lungs, oxygen tents, hospital beds, wheelchairs, blood glucose monitors for diabetics, portable toilets, canes, lifts, and other similar equipment.

**EARLY AND
PERIODIC
SCREENING,
DIAGNOSIS AND
TREATMENT
PROGRAM (EPSDT)**

EPSDT is a Medicaid child health program of early and periodic screening, diagnosis and treatment services for beneficiaries under the age of 21. It supports two goals: to ensure access to necessary health resources and to assist parents and guardians in appropriate use of those resources. Detailed information is provided in FOM 801, Health Care Services for Foster Children.

**EFFECTIVE DATE OF
ENROLLMENT**

The date on which the coverage for a Medicaid Health Plan goes into effect. This is always on the first day of a month. Also called the enrollment begin or start date.

**EXCEPTION TO
MANAGED CARE
ENROLLMENT**

A process by which a Medicaid beneficiary can voluntarily request to remain in Fee-for-Service (FFS) Medicaid and not be required to join a Medicaid Health Plan. A beneficiary needs to apply for a medical exception using the DCH forms and process, which includes getting medical statements from providers. DCH approves or denies a medical exception in very limited situations. Also known as Medical Exception.

**EXCLUDED
ENROLLMENT
STATUS**

The enrollment status given to any Medicaid beneficiary who cannot enroll in a health plan. An example is beneficiaries who have both Medicaid and Medicare.

EX PARTE REVIEW

A determination made by the department without the involvement of the recipient, the recipient's parents, spouse, authorized representative, guardian, or other members of the recipient's household. A Medicaid ex parte review is based on a review of all materials available to the specialist that may be found in the recipient's current Medicaid eligibility case file.

**FEE-FOR-SERVICE
(FFS) MEDICAID**

Also known as traditional, regular, or straight Medicaid. Medicaid pays the providers. FFS Medicaid screens for the services provided to FFS beneficiaries for medically necessary services. Beneficiaries age 21 and over have co-payments on certain services due at the time the services are provided. Beneficiaries with FFS are not enrolled in a Medicaid Health Plan and can see any provider that accepts Medicaid FFS.

**HEALTH LIAISON
OFFICER**

The primary role of the Health Liaison Officer (HLO) is to promote and ensure improved health outcomes for children in foster care. Many of the larger counties have an allocated HLO position within the DHS foster care office. The individual tasks related to the position can be found in FOM 804, Health Liaison Officer.

**HEALTH
MAINTENANCE
ORGANIZATION
(HMO)**

An HMO is a network of doctors, specialists, hospitals, pharmacies and other ancillary providers that is licensed by the State of Michigan to provide health care services to enrolled members.

HIPAA

Health Insurance Portability and Accountability Act (HIPAA) was passed in 1996 to protect a patient's health information and ensure accountability. Health plans, medical billing and health care providers are subject to strict rules regarding the electronic transmission of information regarding a patient's health.

IN LOCO PARENTIS

Latin for in the place of a parent, refers to the legal responsibility of a person or organization to take on some of the functions and responsibilities of a parent.

LEVEL OF CARE (LOC)

This code is used to indicate how beneficiaries receive their Medicaid benefits. The LOC numbers do not determine any rank or importance between the different levels of care. Common LOC codes found in foster care Medicaid cases include:

Level of Care Code	Description
07	Beneficiary is enrolled in a Medicaid Health Plan
32	Beneficiary is involuntarily residing in a detention facility. Medicaid coverage is limited to off-site inpatient hospitalization only.
88	Exception to Medicaid Health Plan enrollment, beneficiary has fee-for-service Medicaid.

LOCK IN

See Commitment Period.

MANAGED CARE

A health care delivery system that provides or makes arrangements for all medically necessary health services for its beneficiaries.

MANAGED CARE ORGANIZATION (MCO)

This refers to a Medicaid Health Plan. It is also known as a Medicaid Health Plan (MHP) or Health Maintenance Organization (HMO).

MANDATORY ENROLLMENT STATUS

An enrollment status given to a Medicaid beneficiary who must enroll in a Medicaid Health Plan. Foster children are mandatory for enrollment in a Medicaid Health Plan when they have a SWSS-FAJ Service Living Arrangement code of 2 through 8 or 19.

**MEDICAID HEALTH
PLANS (MHP)**

Managed care organizations providing for the delivery of comprehensive health care services to Medicaid enrollees in exchange for a fixed, prepaid sum without regard to the frequency, extent, or kind of health care services.

**MEDICAID
PROGRAM CODES**

See chart at end of glossary.

**MEDICATION
REVIEW**

The evaluation and monitoring of medicines used to treat a person's mental health condition, their effects, and the need for continuing or changing medicines for a patient.

MEDICARE

A federal health care program for the elderly or disabled. If a Medicaid beneficiary also has Medicare, s/he has an excluded enrollment status from Medicaid Health Plans.

MI ENROLLS

Michigan Enrolls (MI Enrolls) is the state's contracted enrollment broker through DCH. Medicaid Health Plan enrollment activity is facilitated through MI Enrolls.

OPEN ENROLLMENT

The month (May) during which a beneficiary enrolled in an MHP is given the opportunity to change to a different plan.

**PARTICIPATING
PROVIDER (ALSO
KNOWN AS A PAR
PROVIDER)**

A provider who is credentialed and contracted with a Medicaid Health Plan to provide services to that plan's members.

PHARMACIES

Medicaid Health Plans have very complete pharmacy networks and most contract with all major pharmacy chains. Check the Medicaid Health Plan web sites for details or ask local pharmacies which Medicaid Health Plans are accepted.

**PRIMARY CARE
PHYSICIAN (PCP)**

This is the term for a doctor that is responsible for a beneficiary's basic medical care. Beneficiaries must work with their PCP for all of their health care needs, including specialty services. A primary care provider may be a family or general practitioner, an internist, a pediatrician, or sometimes an OB/GYN. MI Enrolls can help find a PCP during the MHP call-in enrollment process. Also known as primary care provider.

**PRIOR
AUTHORIZATION
(PA)**

For some services, Medicaid FFS or a Medicaid Health Plan requires providers to obtain prior approval before payment is made for a service. Examples of services that may require a PA include prescriptions or medical equipment. The provider is the only one who can request a prior authorization. (See definition to provider below).

**PROTECTED
HEALTH
INFORMATION (PHI)**

Federal law (HIPAA) requires that access to PHI be limited to those who have a business need to know. PHI includes name, address, ID numbers, eligibility status, enrollment information and so on. DCH requires MI Enrolls to verify callers before they can discuss PHI and limits who can enroll a foster child in a Medicaid Health Plan to authorized representatives/responsible party which is limited to the assigned DHS foster care worker or monitor and the designated Health Liaison Officer (HLO).

PROSPECTIVE

In the future.

PROVIDER

An individual or organization enrolled in the Medicaid program that provides services or supplies to beneficiaries, or an individual or organization that is credentialed and contracted with a Medicaid Health Plan. A provider may be a primary care physician (PCP), outpatient clinic, specialist, hospital, urgent care, durable medical equipment (DME) provider, or Medicaid Health Plan.

Note: Some providers who contract with Medicaid Health Plans are not Medicaid enrolled providers. Beneficiaries can only go to non-Medicaid providers if they are enrolled in a plan that participates with that provider.

**PROVIDER
NETWORK**

Medicaid Health Plans have a network of providers including, but not limited: to primary care physicians, specialists, pharmacies, hospitals, labs, durable medical equipment providers (DMEs), and outpatient clinics. Check the Medicaid Health Plan web sites for provider network information.

REFERRAL

The process of sending a patient from one practitioner to another for health care services. Medicaid Health Plans (MHPs) may require that designated primary care providers authorize a referral for coverage of specialty services. Normally, this type of referral means a written order from the enrollee's primary care doctor for the enrollee to see a specialist or get certain services. In many HMOs or MHPs, a referral must be made before the enrollee can obtain care from anyone except the primary care doctor. Without a formal referral, the plan may not pay for the care. See also Primary Care Physician.

RE-ENROLLMENT

When a Medicaid beneficiary loses eligibility, or when a case number changes, that beneficiary's enrollment in the Medicaid Health Plan is ended. If the beneficiary regains Medicaid eligibility within 60 days (includes case number changes), MI Enrolls will automatically re-enroll the beneficiary in the Medicaid Health Plan for the next available month. MI Enrolls mails a letter telling the beneficiary (or the authorized representative) about the re-enrollment, including the effective date.

REMINDER LIST

The list of foster children who have not enrolled in a Medicaid Health Plan and will be auto assigned if a choice is not made soon. A designated DHS point of contact will receive the statewide list electronically on a weekly basis. A foster child name will only appear once on a list and will not be included on subsequent reports if the auto assignment has not been processed the following week.

**ROUTINE MEDICAL
CARE**

See Routine, Non-surgical Medical Care Defined in FOM 801, Health Services for Foster Children.

SED

An acronym for Serious Emotional Disturbance (SED), and as defined by the Michigan Mental Health Code means a diagnosable mental, behavioral or emotional disorder affecting a child that exists or has existed during the past year for a period of time sufficient to meet diagnostic criteria specified in the most recent Diagnostic and Statistical Manual of Mental Disorders. The child's disorder has resulted in functional impairment that substantially interferes with or limits his/her role or functioning in family, school or community activities.

**THIRD PARTY
LIABILITY (TPL)**

TPL is also known as other insurance. Medicaid beneficiaries can have other insurance and Medicaid at the same time. The other insurance is responsible for paying before Medicaid FFS or the Medicaid Health Plan will pay for services. Some types of other insurance, such as Medicare or private HMO coverage, exclude a beneficiary from enrolling in a Medicaid Health Plan.

**VOLUNTARY
ENROLLMENT
STATUS**

An enrollment status given to a beneficiary who may either enroll in a Medicaid Health Plan, or stay in fee-for-service Medicaid. Voluntary beneficiaries may disenroll from any health plan at any time upon request. Examples of beneficiaries with a voluntary enrollment status are American Indians and migrants.

Medicaid Program Codes in Bridges

Medicaid Program Code	Program Description	Medicaid Health Plan Enrollment Status
E	Medicaid for disabled SSI recipients	Mandatory
O	Medicaid for the blind	Mandatory
B	Medicaid for the blind SSI recipients	Mandatory
L	MICH Care Medicaid and Medicaid for pregnant women	Mandatory
I	Refugee Assistance Program	Excluded
Q	Medicaid for persons under 21	Mandatory
N	Medicaid for caretaker relatives and families with dependent children	Mandatory
C	Aid to families with dependent children	Mandatory
P	Medicaid for the disabled	Mandatory