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MIChild

Health Insurance You Can Afford

BULLETIN

State of Michigan

MIChild Eligibility 05-01

Distribution: HCEP Manual Holders, FIA Central Office, MIChild Administrative Contractor, Local Health Departments, MIChild Health Plans, MIChild Dental Plans

Issued: March 1, 2005

Subject: MIChild Eligibility Policy Clarifications;
Update of Annual Federal Poverty Levels

Effective: Upon Reciept

Programs Affected: MIChild

The attached MIChild Eligibility Manual has been revised to provide policy clarifications/updates. Obsolete information has been removed from the manual.

Summary of Changes

SECTION 2 - SPECIAL POPULATIONS

- CSHCS - The child can now be enrolled in a Health Plan of Choice instead of only Blue Cross/Blue Shield. All reference to CSHCS has been removed from the manual.
- TMA-Plus - All reference to MTMA has been removed since the program has been terminated. Policy advising the parents to purchase TMA-Plus for children was incorrect and has been removed from the policy.

SECTION 3 - ELIGIBILITY CRITERIA

- Social Security Number (SSN) - The SSN verification policy has been corrected.
- Excluded Children - The last paragraph was not clear regarding loss of insurance. The policy has been clarified to reflect a penalty for voluntary removal from medical insurance in order to obtain MIChild.

SECTION 5 - MIChild/HEALTHY KIDS APPLICATION

- Past Medical Bills - The paragraph addresses Healthy Kids retroactive coverage. The paragraph has been revised to reflect the change ordered by the Schott lawsuit.

SECTION 9 - DEPARTMENT REVIEWS/COMPLAINTS/GRIEVANCES

- Requests for Department Reviews - The duties of DCH, the Administrative Contractor, and the health plans have been clarified.

SECTION 13 - DEFINITIONS

- Comprehensive Insurance - The definition has been clarified to eliminate confusion by the Administrative Contractor.
- Department Review - The definition now includes Administrative Contractor, along with the Health Plan, when addressing complaints.
- Initial Determination - This definition now includes Administrative Contractor, along with the Health Plan, for determining eligibility.

Manual Maintenance

Discard all previous versions of the MIChild Eligibility Manual and replace with the attached Manual.

Questions

Any questions regarding this bulletin should be directed to Eligibility Policy, Department of Community Health, P.O. Box 30479, Lansing, Michigan 48909-7979 or e-mail EligibilityPolicy@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, and phone number so you may be contacted if necessary. Providers may phone toll free 1-800-292-2550.

Approved

Paul Reinhart, Director
Medical Services Administration

MICHILD MANUAL

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SECTION 1 - GENERAL INFORMATION

MIChild is a health coverage program using State funds as well as funds authorized under Title XXI of the Federal Social Security Act to furnish health care coverage to a targeted population. This population consists of individuals under age 19 who are not eligible for Medicaid, whose family income is above 150% and at or below 200% of the federal poverty level, and who do not have comprehensive health coverage.

1.1 HEALTH PLANS

The Department contracts with health plans to provide services to MIChild beneficiaries. Plans are reimbursed on a per member per month capitation basis and are responsible for activities including:

- provision of most services, as determined by the Department (dental services, mental health services and substance abuse services are explained below),
- reimbursement for direct care and subcontracted providers,
- maintenance of records as determined by the Department.

Health plans may also make an initial determination of MIChild eligibility. The final determination is made by the Department.

1.2 DENTAL PLANS

The Department contracts with dental plans to provide covered dental services to MIChild beneficiaries on a per member per month capitation basis.

The dental plans have the same responsibilities as the health plans except the dental plans do not make initial determinations of MIChild eligibility. Enrollment in the dental plans occurs through the Administrative Contractor.

1.3 MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

The Department contracts with local community mental health services programs (CMHSP) and Coordinating Agencies (CA) to provide all mental health and substance abuse services to MIChild beneficiaries on a per eligible member per month capitation basis. Beneficiaries do NOT enroll with the CMHSP or CA to receive services, but are referred to them by the health plans. The CMHSPs and CAs are responsible for:

- provision of mental health services, as determined by the Department,
- reimbursement for direct care and subcontracted providers,
- maintenance of records as determined by the Department.

The CMHSP will not make initial determinations of MIChild eligibility.

1.4 ADMINISTRATIVE CONTRACTOR

The Department of Community Health contracts with an Administrative Contractor to provide administrative support for MIChild.

The Administrative Contractor is responsible for activities including:

- eligibility recommendations, with the Department granting final approval of eligibility,
- enrollment/disenrollment in the health plan and dental plan chosen by the beneficiary's family,
- maintenance of records, as determined by the Department,
- verification of enrollment and membership in health plans and dental plans,
- collection of monthly premiums from the family,
- monitoring the health plans and dental plans, as determined by the Department,
- operating a telephone bank to answer beneficiary/public questions about eligibility, applications, enrollments, and related matters.

SECTION 2 - SPECIAL POPULATIONS

There are some applicants who may be eligible for, or enrolled in, other federal/state programs. These applicants may also be eligible for MIChild.

2.1 TMA-PLUS

TMA-Plus (Transitional Medical Assistance-Plus) is a program operated by the State for persons losing coverage under the Medicaid program Transitional Medical Assistance (TMA). TMA-Plus allows parents who have worked their way off cash assistance to continue health care coverage if no employer coverage is offered, or the cost of employer coverage is more than the TMA-Plus premium. TMA-Plus is only available to parents whose income is at or below 185% of the FPL and who have at least one child under 18 years of age residing in the home with the parent(s).

A family may be eligible for TMA-Plus and MIChild. The children will be either Healthy Kids/Medicaid or MIChild eligible. The family may choose to obtain the adult's coverage using TMA-Plus.

The family may purchase MIChild coverage for the children at the MIChild premium. There is no six-month waiting period for MIChild benefits.

2.2 COURT-ORDERED MEDICAL INSURANCE

There are situations when the non-custodial parent/guardian has not provided court-ordered medical insurance. In these situations, the child may be enrolled in MIChild. The custodial parent/guardian must be advised that he must pursue the court-ordered insurance.

- Any beneficiary with comprehensive health insurance must be disenrolled from MIChild.
- If the non-custodial parent/guardian is still in the process of obtaining comprehensive health insurance, the child may enroll in, or remain on, MIChild.
- If the custodial parent/guardian has not pursued the court-ordered medical insurance, the child must not be enrolled in, or remain on, MIChild.

2.3 SPEND-DOWN APPLICANTS

A family may be required to meet a spend-down amount to become Medicaid eligible. In these situations:

- The child may be MIChild eligible.
- The incurred medical expenses of anyone in the child's fiscal group may be used to meet the spend-down amount.
- When the spend-down is met, children on MIChild are **not** to be disenrolled from MIChild.
- Once the child is Medicaid eligible due to spend-down, MIChild will be considered a third-party resource to be billed prior to billing Medicaid. The Department will reconcile the payments in an internal process.

2.4 Newborn Eligibility

The newborn in a family whose mother is already receiving Medicaid for the month of birth is eligible for Medicaid for one year. In these cases, the newborn must not be enrolled in MIChild.

A family may not receive MIChild benefits for any member who is Medicaid eligible, other than spend-down applicants. If determined eligible for Medicaid, the children must be disenrolled from MIChild effective the last day of the month prior to the month that Medicaid begins, so there is no break in health coverage for the children.

2.5 Newborns of Dependent Children

If a beneficiary enrolled in MIChild gives birth, the newborn's fiscal group will have to be redetermined using only the mother and the newborn in the fiscal group. Both the mother and the newborn will usually be Healthy Kids/Medicaid eligible. A new MIChild/Healthy Kids application must be submitted.

If the unborn child was included in the original determination of the fiscal group, and the income for the fiscal group is equal to or less than 185% of the FPL, the newborn would be Healthy Kids/Medicaid eligible until age 1. The other children currently on MIChild would remain on MIChild. The entire group retains the redetermination date of the original group.

If the unborn child was included in the original determination of the fiscal group, and the income for the fiscal group is more than 185% of FPL, the newborn would be MIChild eligible. The other children currently on MIChild would remain on MIChild. The entire group retains the redetermination date of the original group.

If the unborn child was NOT included in the original determination of the fiscal group, the addition of one new fiscal group member will always make the newborn Healthy Kids/Medicaid eligible. The other children may remain MIChild until re-evaluated at redetermination. A new application must be submitted for the newborn.

2.6 Retroactive Medicaid

There may be cases where the MIChild beneficiary obtains Medicaid coverage for the same time period as MIChild eligibility. In these situations, the beneficiary should be disenrolled from MIChild as soon as he is identified as being Medicaid eligible, effective the first of the month following identification of Medicaid. A beneficiary enrolled in MIChild cannot be retroactively disenrolled from MIChild.

SECTION 3 - ELIGIBILITY CRITERIA

Eligibility for MIChild must be based on the following criteria. Verifications for each criterion are included.

3.1 CITIZENSHIP

The applicant must be a citizen of the United States or a documented alien. Some legal immigrants are not eligible for MIChild for the first five years of residency. Legal immigrants who are eligible in the first five years of residency include refugees and children of veterans.

Statement of citizenship by the applicant or responsible relative is considered verification that the child is a United States citizen.

Alien status can be verified by:

- Alien Registration Receipt Card (I-551). (The Citizenship and Alien Status Section of this manual contains alien status codes that appear on the I-551 and their impact on MIChild eligibility.)
- I-94 form stamped "Processed for I-551," or "Cuban/Haitian Entrant (Status Pending)," "parole," "212 (d) (5)," or "Form I-589 Filed."
- I-94 form indicating admission into the United States from Cuba or Haiti and letter or notice from the Bureau of Citizenship and Immigration Services indicating ongoing (not final) deportation, exclusion, or removal proceedings.
- Passport stamped "Processed for I-551 Temporary Evidence of Lawful Admission for Permanent Residence."

Any other notations on the I-94 or other forms (e.g., visa) are not acceptable and the child is not eligible for MIChild.

3.2 RESIDENCY

The applicant must be a resident of the state of Michigan.

A person is considered a resident if he lives in Michigan and intends to remain in Michigan permanently or indefinitely.

Children in a family that comes to Michigan with the intent to work (e.g., migrants) are eligible for MIChild benefits, provided all other eligibility requirements are met.

The applicant's or responsible relative's statement of intent to remain or work in Michigan is verification of Michigan residency.

If the applicant is leaving Michigan for more than 30 days but intends to return to Michigan, then intent to remain a resident must still be verified. Such verification could include proof that utility bills, rent, or property taxes are currently being paid.

3.3 Social Security Number

All applicants, except newborns, must have a Social Security Number (SSN), or an application for an SSN must have been filed. SSN is not required for the parents unless they are also applying for medical benefits for themselves.

The applicant's statement of the SSN or their statement that application has been made for a SSN is acceptable verification.

Each child must have obtained a SSN by annual redetermination.

3.4 Age

The applicant must be between 0 and 18 years of age. MIChild coverage ends the last day of the month in which the child turns 19.

The applicant’s or responsible relative’s statement of the child’s age is verification of the age criteria. In addition, the applicant’s date of birth must be entered on the MIChild application.

3.5 Insurance Coverage

The applicant must not:

- be currently covered under a comprehensive health insurance policy (group or private), or
- have had comprehensive employer-based health insurance in the past six months, including Medicare, with exception allowed for non-voluntary loss of insurance. Applicants will not be eligible for coverage until the seventh month after the employer-based coverage ends. Applications received within 90 days of the eligible month will be processed for coverage, if otherwise eligible, beginning the seventh month. (The Definitions Section of this manual contains a definition of nonvoluntary loss of insurance.)

Specialty insurance coverage, such as dental-only or catastrophic-only coverage, is not considered comprehensive health insurance.

Coverage through the CSHCS program or the Native American Health Services is not to be considered comprehensive health insurance for eligibility purposes.

The applicant’s or responsible relative’s written statement attesting to all the above is verification.

3.6 Assets

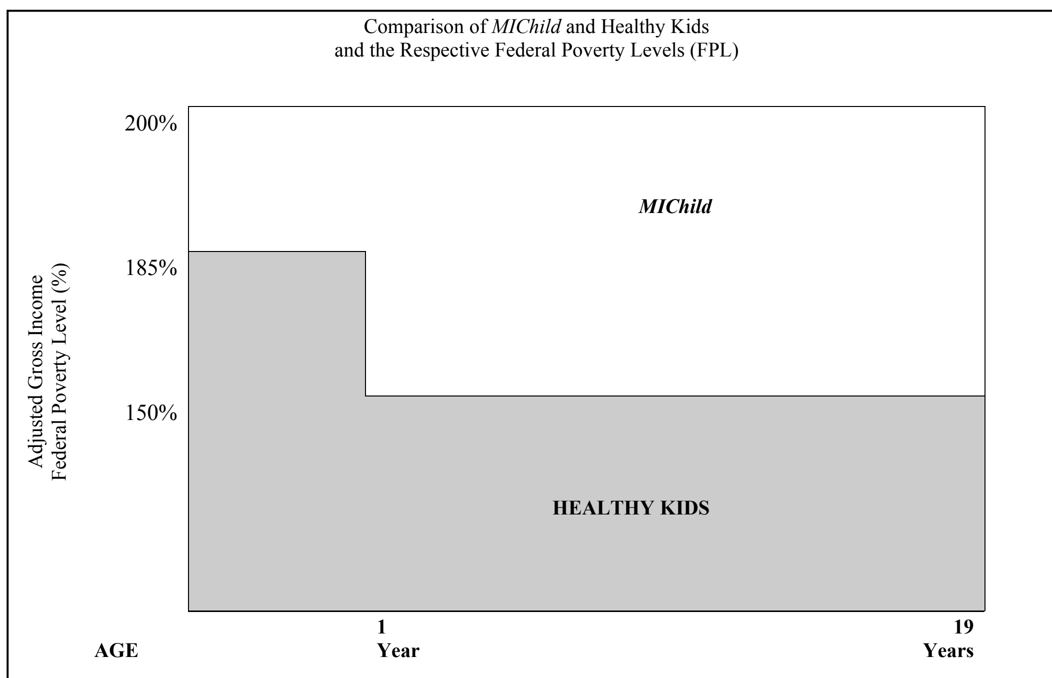
No asset test is used.

3.7 Income

The adjusted gross income must be above 150% and at or below 200% of the FPL, depending on the child’s age.

- For children age 1 year to 19 years of age, the adjusted gross income must be above 150% and at or below 200% of the FPL.
- For children under 1 year of age, the adjusted gross income must be above 185% and at or below 200% of the FPL.

The Eligibility Determination Section of this manual provides further detail on calculating the adjusted gross income. A copy of the current monthly federal poverty level amounts is available on the MDCH website at www.michigan.gov/mdch >>Health Care Coverage>>Children & Teens>>MIChild.



All income (earned and unearned) of the fiscal group must be reported on the application. Self-declaration of income by the applicant must include the payee's name and the gross amount of monthly income.

NOTE: If the responsible parent/guardian receives child support on behalf of the child, then this amount must be considered as income for the child.

3.8 Excluded Income

The following income must not be used to determine MIChild eligibility:

- Earnings of a child under age 19, if the child is living with a relative who provides care and supervision.

- Supplemental Security Income (SSI) benefits. (Anyone receiving SSI is automatically eligible for Medicaid. That person, but not his income, should be included in the fiscal group for budgeting purposes.)
- Certain payments to Native Americans. (The Native American Payment Exclusion Section of this manual provides a list of public laws involving payments to Native Americans.)

3.9 Premiums

The premium is $5.00 per family per month, regardless of the number of children in the family. (The Premiums Section of this manual contains additional information regarding premium payment.)

3.10 Nonfactors

The following must not be a factor in determining MIChild eligibility:

- Disability status
- Pre-existing condition
- Diagnosis

3.11 Excluded Children

Individuals who are not eligible for MIChild include children who:

- are eligible for Medicaid (even if not yet enrolled in Medicaid). (The Special Populations Section of this manual contains additional information on newborns, spend-down beneficiaries, and Medicaid.)
- have been criminally adjudicated and are in a correctional facility, including a detention home or training school.
- are admitted to an institution for the mentally disabled (e.g., ICF/MR).
- are eligible for health insurance coverage on the basis of a family member's active permanent employment by a state, county, or city government agency in Michigan. School employees are not considered government employees.
- are covered by court-ordered medical insurance. (The Special Populations Section contains additional information regarding court-ordered medical insurance.)
- have been disenrolled from MIChild for failure to pay MIChild premiums. Applicants will not be eligible for coverage until the seventh month after the disenrollment for nonpayment of premiums. Applications received within 90 days of the eligible month will be processed for coverage, if otherwise eligible, beginning the seventh month. NOTE: Any remaining months in the disqualification period will be waived if any family member received Medicaid for at least one month since the closure of the MIChild case.
- have had comprehensive employer-based health insurance in the past six months who have been voluntarily removed from the comprehensive insurance, regardless of the cost. (Refer to the Non-Voluntary Loss of Insurance portion of the Definitions Section for additional information.) Applicants will not be eligible for coverage until the seventh month after the employer-based

coverage ends. Applications received within 90 days of the eligible month will be processed for coverage, if otherwise eligible, beginning the seventh month.

3.12 Exception Process

If there are special circumstances or questions regarding an applicant's MIChild eligibility, the Department will provide guidance with eligibility determination.

The health plans should contact the Administrative Contractor for assistance.

The Administrative Contractor should contact the Department for assistance.

SECTION 4 - APPLICATION PROCESS

An application to enroll may be submitted to either the participating health plan or directly to the Administrative Contractor. (The MIChild/Healthy Kids Application Section of this manual provides instructions for completion.) If applications are received elsewhere (DHS, doctor's office, etc.), they must be forwarded to the Administrative Contractor.

4.1 LOCAL AGENCIES

The Department may contract with local agencies to provide outreach for MIChild. These agencies will provide information regarding MIChild, including eligibility criteria, the application process, and coverage.

These agencies will have applications available at their offices and provide assistance with completion of the applications. They may also provide assistance with the verifications required for MIChild. Applications must be forwarded to the Administrative Contractor.

4.2 INITIAL DETERMINATION OF ELIGIBILITY

A health plan that contracts with the Department to provide MIChild coverage may determine initial eligibility upon approval by the Department. Final authorization of MIChild eligibility is the responsibility of the Department. (The health plan must determine if the child may be eligible for Healthy Kids/Medicaid prior to the initial determination of MIChild eligibility. Health plans approved to make initial eligibility recommendations must maintain an error rate of no more than 3%, and must determine initial eligibility for all MIChild applications.)

The health plan or Administrative Contractor will review the application. If the application is unsigned or not fully completed, or required verifications are not present, the application is considered incomplete. The health plan may assist the applicant with this completion process.

Initial determination of eligibility must be made within two (2) work days of receipt of the completed application. Initial determination of eligibility will consist of:

- Reviewing and approving, if eligible, the completed application. The application must indicate the family's choice of health plan AND dental plan to be considered a complete application.
- Contacting the Administrative Contractor to determine if the applicant was previously enrolled in MIChild and was disenrolled for failure to pay premiums. Applicants will not be eligible for coverage until the seventh month after the disenrollment for nonpayment of premiums. Applications received within 90 days of the eligible month will be processed for coverage, if otherwise eligible, beginning the seventh month.
- Verifying that the applicant is not currently enrolled in, or appears to be eligible for, Medicaid or other federal/state programs.
- Determining the adjusted gross income (refer to the Eligibility Determination Section of this manual).
- Comparing the adjusted gross income with the federal poverty level amounts.
- Enrolling the child in a health plan, if eligible, effective the date eligibility was determined.

- Providing the family with a notification that the health plan has determined initial eligibility for MIChild and the effective date of enrollment.

The health plan must forward completed applications showing the effective date of the initial eligibility and eligibility verifications within two (2) work days of initial eligibility determination to the Administrative Contractor.

Dental plans, community mental health services programs, and coordinating agencies may not recommend eligibility for MIChild.

4.3 Administrative Contactor

4.3.A. Applications Sent By The Applicant Directly To The Administrative Contractor

Applications may be sent directly to the Administrative Contractor for approval. In this situation, any required verification must be attached to the application. If the applicant has not selected a health plan or dental plan, Blue Cross/Blue Shield will be selected for the applicant as the health plan, and Delta Dental will be selected for the applicant as the dental plan. Completed applications must be reviewed within ten (10) work days of receipt. The day the application is received is the first day of this ten work day time frame. A decision on eligibility must be mailed to the family's address via first class mail before the close of business on the tenth work day. The Administrative Contractor must follow-up with applicants filing incomplete applications.

The Administrative Contractor must determine if the applicant was previously enrolled in MIChild and was disenrolled for failure to pay premiums. Applicants will not be eligible for coverage until the seventh month after the disenrollment for nonpayment of premiums.

The Administrative Contractor verifies any required documents and makes an eligibility recommendation to the Department of Community Health for MIChild. A Department employee will make the final determination of MIChild eligibility. Notice of approvals/disapprovals will be mailed by the Administrative Contractor to the family.

4.3.B. Applications Received from the Health Plans

Applications received from a health plan must be reviewed by the Administrative Contractor within the same ten (10) work day time frame as noted above unless the child was initially determined eligible by the health plan. If initial eligibility was granted, the application must be reviewed and a final eligibility decision made before the 15th of the month following the month in which initial eligibility was granted. This time frame includes the Department's approval of the application.

- If the application is approved, the family, CMHSP, Coordinating Agency (CA), health plan and dental plan must be notified, in writing, by the Administrative Contractor that MIChild eligibility has been approved effective the day the health plan approved the application.

- If the application is denied, the letter to the family must clearly state the reason for the denial and the family's right to request a Department Review of the denial. If initial eligibility was granted by the health plan, the family must be notified of the date that initial eligibility ends. A copy of the letter is sent to the CMHSPs, CAs, and the health plan and dental plan.

4.3.C. Approval Letters

Approval notices must include:

- the applicant's name and address,
- the begin date of MIChild eligibility,
- annual redetermination date,
- information regarding payment of the premiums,
- the health plan and dental plan the family has chosen, including the phone numbers,
- CMHSP, CA and substance abuse information
- Notice of changes which must be reported in writing to MIChild within 10 days of the change, including change of address, receipt of Medicaid, or the only beneficiary leaves the home or dies,
- the Department of Community Health nondiscrimination statement, and
- the statement "If you do not understand this form, please contact 1-888-988-6300" in English, Arabic and Spanish.

4.3.D. Denial Notices

Denial notices must state:

- the applicant's name and address,
- the reason for denial of eligibility,
- legal basis for denial (i.e., Title XXI of the Social Security Act, as amended),
- if initial eligibility was granted by the health plan, the notice that initial eligibility is no longer in effect, the date the initial eligibility ends, and MIChild coverage is terminated,
- Department Review rights, (include a Department Review Request form)
- the Department of Community Health's nondiscrimination statement, and
- the statement "If you do not understand this form, please contact 1-888-988-6300" in English, Arabic and Spanish.

4.4 Department of Community Health

All applications will be reviewed by the Department of Community Health for final determination of MIChild eligibility. If the Department determines that the child does not meet MIChild eligibility criteria, the Department will notify the Administrative Contractor, and the Administrative Contractor will notify the family and providers with the information noted above.

4.5 Begin Date of Eligibility

The begin date of eligibility for MIChild will depend on the following:

- If the health plan makes an initial determination of eligibility, MIChild eligibility begins the actual day the health plan approved the application.
- If the health plan does NOT make an initial determination of eligibility, MIChild eligibility begins the first day of the month following the month of approval. **NOTE:** If the application is approved within five (5) work days of the beginning of the next month, the eligibility is effective the first of the following month. For example, if the application is approved May 28, the effective date is July 1.
- If the applicant has had comprehensive, employer-based insurance coverage within the past six months, coverage may begin the month after the six-month penalty ends. (Refer to the Eligibility Criteria Section of this manual for information on eligibility criteria.)
- If the applicant was recently disenrolled for failure to pay the MIChild premium, a six-month penalty is imposed. Coverage may begin the month after the six-month penalty ends. (Refer to the Eligibility Criteria and Premiums sections of this manual for disenrollment information due to nonpayment of premiums.)

The dental, CA and mental health coverage will begin the same date.

4.6 Inpatient Hospitalization

There may be instances involving an inpatient hospital admission.

- If MIChild eligibility begins while a beneficiary is in the hospital, the health plan is reimbursed for a full month of service. The health plan is not responsible for services rendered while the beneficiary was in the hospital, as the health plan did not authorize the hospitalization. The health plan is responsible for all medically necessary services once the beneficiary is discharged.
- If MIChild health plan coverage ends while a beneficiary is in the hospital, the health plan is reimbursed for a full month of service. The health plan is responsible for services rendered while the beneficiary was in the hospital, as the health plan authorized the hospital stay.

4.7 Enrollment in Health Plans and Dental Plans

Enrollment in participating health plans and dental plans will be the responsibility of either the health plan and dental plan or the Administrative Contractor, depending on who makes the initial eligibility determination.

- The MIChild application may be received from the health plan and dental plan's initial determination of eligibility. If that health plan and dental plan is chosen, the health plan and dental plan will be responsible for enrolling the beneficiary in their health plan and dental plan. If a different health plan or dental plan is chosen, the application is to be referred to the Administrative Contractor for enrollment into the chosen health plan and dental plan. The Administrative Contractor is responsible for enrolling the beneficiary in the health plan and the dental plan. The health plan and dental plans will refer beneficiaries to CMHSPs and CAs.
- If the MIChild application is received directly from the applicant or from an outside agency (e.g., schools, Tribal Health Centers), then the Administrative Contractor will be responsible for enrolling the beneficiary in the health plan and dental plan chosen by the family. Each health plan and dental plan, CMHSP, and CA will be notified by the Administrative Contractor of new MIChild enrollees.

4.8 Referral to Medicaid

The application must be reviewed for Medicaid eligibility prior to MIChild eligibility approval.

4.9 Changes in Family Status

If the family has applied for MIChild but has been determined ineligible, the children may be enrolled in MIChild any time a change occurs that makes a child eligible for MIChild. This could include a change in family size, loss of a job, or change in family income. (A change in the child's health status does not make a child eligible for MIChild.) If a family has a change in status that makes the children newly eligible for MIChild, the family should reapply as soon as possible.

4.10 Enrollment Lock-In

The MIChild beneficiary is "locked-into" a health plan and dental plan for 12 months from the date of enrollment, as long as the child remains MIChild eligible. Beneficiaries have the first 30 calendar days of that period to change health plans and dental plans.

A beneficiary may change health plans and dental plans for cause, at any time, as determined on an individual basis and approved by the Department.

4.11 Annual Redetermination of Eligibility

Eligibility determinations will be done annually. The Administrative Contractor must provide the family with redetermination forms for MIChild 30 work days prior to the end of the beneficiary's eligibility year. The redetermination form lists the eligibility information the Administrative Contractor has on file. If no changes have occurred, the beneficiary signs and returns the redetermination form, indicating no changes have occurred. MIChild eligibility will continue as long as the premiums continue to be paid for the next year. If changes have occurred, the beneficiary must return the redetermination form with changes noted and required documentation, if any, within 10 calendar days from the date of the redetermination notice. Each individual's eligibility will be redetermined.

If the redetermination form is returned indicating a change of information but is incomplete, the family will be notified of the required documentation needed following the time frames specified for original applications. The Administrative Contractor will follow-up with the family, either by telephone or in writing. Failure of the family to complete the redetermination process will result in disenrollment from MIChild effective the last day of the enrollment year.

4.12 Post-Eligibility Audits

Post-eligibility audits will be done from a random sample of application and redetermination approvals. If the audit results in loss of MIChild eligibility, or if the family fails to cooperate with the audit process, MIChild benefits will terminate. (Refer to the Post-Eligibility Audit Process Section of this manual for additional information.)

The Administrative Contractor uses the same forms for approval/denial notices as for initial determinations.

SECTION 5 - MICHILD/HEALTHY KIDS APPLICATION

5.1 GENERAL INFORMATION

The DCH-0373-D, MIChild/Healthy Kids Application, is used to apply for MIChild benefits.

If applying at the Department of Human Services (DHS), the FIA-1171 may be used to apply for MIChild/Healthy Kids.

The DCH-0373-D form may be completed by anyone, but must be signed by the applicant. It should be completed in ink and in English. The current version of the form should be used. Dates should be entered in the MM/DD/YYYY format. Telephone numbers must include the area code.

If an item does not apply, the applicant should enter "N/A."

5.2 PAGE 1

The top portion of the application provides basic information about MIChild and Healthy Kids/Medicaid programs. This page also requires information about the adults in the household.

5.2.A. CHOICE OF HEALTH PLANS

Choosing health plans and dental plans is required for MIChild. If the children are eligible for Healthy Kids/Medicaid, the family will be contacted by the Administrative Contractor to verify their choice of health plan prior to enrollment. Dental coverage is provided through dental plans in some counties for Healthy Kids/Medicaid. If the applicant has not selected a health plan or dental plan, Blue Cross/Blue Shield will be selected for the applicant as the health plan, and Delta Dental will be selected for the applicant as the dental plan.

Pregnant women do not need to choose a health plan.

Identification of the primary care physician will assure continuity of care for the children, assuming the primary care physician is participating in a MIChild health plan.

5.2.B. ADULT'S INFORMATION

If there are more than two adults in the home, additional pages must be included with the application. Each additional adult must include his first, middle, and last name; and his relationship to each child. Each adult is asked to list his primary language. Additional pages must include the applicant's original signature. Pregnant women complete the appropriate column on Page 2.

5.3 PAGE 2

This page requests information on all children or pregnant women, including each child's or pregnant woman's primary language and relationship to each adult listed on Page 1, as well as citizenship status.

If there are more than three children living in the home, additional pages must be included with the application. The additional information must include each first, middle, and last name, primary language and the relationship of the child to each adult. Additional pages must include the applicant's original signature.

5.3.A. Social Security Number (SSN)

A SSN, or an application for a SSN, is required for each person who wishes to receive medical coverage. If a SSN is not available, the applicant should be given a Social Security Number Application (SS-5) to request an SSN, or be directed to the local Social Security Administration for assistance.

5.3.B. Children's Information

All children in the home must be listed for budgeting purposes.

Completion of the racial/ethnic information is voluntary.

If a child does not have a social security number, the applicant should be given an SS-5 to apply for the SSN.

If a child is not a citizen of the United States, a copy of the front and back of the I-551 or I-94 must be obtained.

Many of the questions on this page are self-explanatory. Only those questions that may need clarification are listed below.

5.3.C. Health Insurance Questions

These questions should be answered "yes" only if any of the children are currently receiving benefits under any health insurance. While coverage through a parent's employer usually makes a child ineligible for MIChild, the information is required for Healthy Kids/Medicaid.

Catastrophic coverage, or specialty coverage such as dental only, is not considered comprehensive health insurance coverage.

5.3.D. Past Medical Bills Questions

This information is required to determine possible retroactive coverage for Healthy Kids/Medicaid. Pregnant women are automatically enrolled for three months of retroactive coverage. The retroactive health services must be for medical expenses incurred within three months prior to applying for Healthy Kids/Medicaid. There is no retroactive coverage for MIChild.

5.4. Page 3

This page requests income information for all persons in the home. Gross and net income information must be reported. Self-employed persons should list allowable deductions. Persons with rental income

should include an explanation of their expenses for the rental property. (Further explanation of income reporting may be found in the Eligibility Determination Section of this manual.)

5.5. PAGE 4

This page includes important information regarding the rights and responsibilities of applicants, nondiscrimination information, notice requirements, and the applicant's signature.

Prior to signing the application, and additional sheets if necessary, the applicant should read the information regarding release of information, use of this application for Medicaid purposes, subrogation, discrimination, and pursuit of financial or medical support for children.

If a health plan and dental plan are not chosen by the applicant, plans will be selected for them. (Refer to the Choice of Health Plans portion of the of this section for additional information.) The application is not considered until the application is signed.

SECTION 6 - ELIGIBILITY DETERMINATION

6.1 GENERAL INFORMATION

MIChild eligibility is determined using the MIChild/Healthy Kids Application (DCH-0373-D). The FIA-1171 application may be used by DHS. The information contained on the application and supporting verifications, as specified, include all the information needed to determine eligibility.

If the application is incomplete, or verifications need to be obtained, the health plan and/or Administrative Contractor must request such information in writing from the applicant. The applicant has 30 calendar days from the date of notification to provide the needed information, or the application will be denied.

6.2 HEALTHY KIDS

Eligibility for Healthy Kids/Medicaid must be determined prior to consideration of MIChild eligibility.

Once the child has been determined NOT eligible for Healthy Kids/Medicaid, MIChild eligibility may be determined

6.3 NONFINANCIAL FACTORS

There are several nonfinancial factors that must be documented, either by separate document or by the applicant's statement. These factors include:

- citizenship/alien status,
- residency,
- social Security Number,
- age,
- health insurance coverage.

(The Eligibility Criteria Section of this manual provides further information regarding these factors.)

6.4 GROUP COMPOSITION (INCOME GROUP)

The group composition for MIChild is the same as for Healthy Kids/Medicaid.

6.5 FINANCIAL FACTORS

As indicated in the Eligibility Criteria Section of this manual, the adjusted gross income for MIChild must be above 150% and at or below 200% of the FPL, depending on the child's age.

The adjusted gross income is determined for the month that eligibility will begin. For example, if the application is received directly by the Administrative Contractor in June, then eligibility cannot begin until July. Therefore, the monthly budget should be determined for July.

Budgets will always be determined using a four-week month, even if there are five weeks in the month being determined.

The adjusted gross income is calculated by adding the countable income, applying the appropriate deductions, and computing the distribution of the income. The resulting figure must be compared to the FPLs on the MDCH website to determine if the income level meets MIChild eligibility criteria.

6.6 Countable Income

Self-declaration of income is allowed for applicants using the DCH-0373-D application. The following items must be used to determine the family's income for MIChild eligibility purposes:

Countable Income	▪ All income (earned and unearned) of the fiscal group. Self- declaration of monthly income by the applicant must include the payee's name. ▪ RSDI (Retirement, Survivors and Disability Insurance) benefits. (If a family member receives RSDI, then so do all of his dependents.) Self-declaration of the gross monthly amount is used. ▪ Self-employment income. The family's self-declaration of monthly income and deductions, on a monthly basis, will suffice. ▪ Unearned income received by the children applying for, or receiving, MIChild and the children's parents who live with the children (e.g., child support, Social Security benefits) is included in the self-declaration of income section of the application. ▪ Income from rental property. Self-declaration of the gross monthly rental income amount is used. ▪ Seasonal income is budgeted using the income received during the time the applicant is employed. If the seasonal income has ended at the time of application, do not include it in the budget. ▪ Contractual income. When budgeting contractual income: ➢ Determine the length of the contract ➢ Determine the amount of income to be paid during the length of the contract ➢ Divide the income by the number of months of the contract **Example**: A teacher has a 12-month contract payable over 9 months. Since the actual contract is for 12 months, the income is averaged over 12 months (contracted for 12 months @ $36,000 per year equals $3,000 per month). If the contract itself only covers 9 months of the year and is paid out over the 9 months, the income is averaged for that same 9 months (contracted for 9 months @ $36,000 per year equals $4,000 per month). **Note:** If the contractual employee also has other income, the amount of income that can be reasonably anticipated for the budget month must be counted even if both income sources are the same employer. The additional income should be treated the same as a second income.

	Example: School bus driver with a 12 month contract payable over 9 months for driving a daily route to school. The income is averaged over the 12-month length of contract. The same driver also has an agreement with the school system to drive students to three events per month for three months @ $50 per trip. The income is countable since it can reasonably be anticipated. Therefore, $150 per month is added to the contractual income already budgeted for this person for those 3 months. ▪ Garnishment of wages: The gross amount of wages (before garnishment is deducted) are counted as income.

6.7 Income Deductions

The following should be deducted:

- Standard work expense of $90 from the countable earnings of each person who is working.
- $30 plus 1/3 of a fiscal group member's remaining earned income if the member received FIP cash assistance or Low Income Family medical coverage from the DHS in at least one of the four calendar months preceding the month of the eligibility budget.
- Child care payments. A standard $200 is deducted monthly, per child, for which the applicant claims a child care expense, regardless of the actual amount of the expense. (The Child Care section below provides details on determining who is eligible for this deduction.)
- $50 from the total child support received for each child.
- 65% of rental income for administrative purposes, or the actual rental expenses if the landlord claims a larger expense.
- For self-employment, deduct the actual operating expenses claimed or 25% of the gross earnings, whichever is the higher deduction benefiting the family. Operating expenses are based on the family's statement for self-employed persons. (Depreciation; net loss; federal, state, and local income taxes; personal business expenses, including entertainment and retirement funds, are NOT considered deductions.)
- Court-ordered child support paid by a fiscal group member for a child who does not live with the fiscal group. Arrearage payments are **not** deductible.
- $60 from guardianship/conservator fees paid.

6.8 Child Care

Child care (dependent care) may be deducted only if the following are met:

- child must be living with the family member who is paying for the care,
- child must be that family member's child,
- child must be under age 15, or under age 18 and need care because of a mental or physical limitation,

- other parent is not available to provide the child care due to conflicting work, school or training schedules.

If the family has any monetary obligation for child care for an eligible child, the full $200 child care deduction is budgeted as an expense. If the full amount of the child care is paid by another entity (e.g., DHS), the child care deduction cannot be allowed. Example: The child has a child care expense of $300 monthly. DHS pays $150 of this care. Because the family has an obligation to pay the balance of the child care, the full $200 deduction is allowed. If the entire $300 is paid by DHS, no deduction would be allowed.

Add the total allowable child care deduction to get each family's total deduction for child care. This total amount is used as the child care deduction for each child's budget.

6.9 Eligibility Certification

The Eligibility Certification (MSA-0853) is a worksheet available for determining the financial eligibility of a MIChild applicant. (The form is available electronically from the Michigan Department of Community Health website at www.michigan.gov/mdch.)

- **Healthy Kids/Medicaid**: The MSA-0853 may be used for eligibility determinations for Healthy Kids/Medicaid and MIChild. Healthy Kids/Medicaid eligibility MUST be determined prior to any determination of MIChild eligibility. For Healthy Kids/Medicaid, the group composition is the same as for MIChild; therefore, a budget needs to be determined for each child in the family. The DHS Program Eligibility Manual contains the guidelines to be used to determine Medicaid eligibility. Once Healthy Kids/Medicaid eligibility is ruled out, then MIChild eligibility may be determined using the same form.
- **MIChild**: The group composition for each child in the family is the same as for Healthy Kids/Medicaid (e.g., child, mother, and father).

  The MSA-0853 includes space to add the income limits for reference. This form is to be used in conjunction with this manual.

  - Income is to be entered in monthly amounts.
  - Eligibility recommendations for Healthy Kids/Medicaid or MIChild should be entered.
  - Status of the application should be noted.
  - The signature must be left blank. DCH staff approves eligibility.

Eligibility Certification (MSA-0853)

MIChild / Healthy Kids
ELIGIBILITY CERTIFICATION

Michigan Department of Community Health
Medical Services Administration

Case Name
Case Number

	Healthy Kids	MIChild
Income Limit ▶	$	$
Number in Income Group ▶		
1. Earned Income	$	$
2. Minus $90 deduction	$ 90.00	$ 90.00
3. **Subtotal:** (line 1 minus line 2)	$	$
4. 30 1/3 Disregard (if eligible)	$	
5. **Subtotal:** (line 3 minus line 4)	$	$
6. Dependent Care Deduction *(see worksheet below)*	$	$
7. **Subtotal:** (line 5 minus line 6)	$	$
8. Child Support Income	$	$
9. Minus $50 deduction	$	$
10. Line 8 minus line 9	$	$
11. **Subtotal:** (line 7 plus line 10)	$	$
12. Other Unearned Income	$	$
13. **Subtotal:** (line 11 plus line 12)	$	$
14. Court Ordered Support / Guardian Fees Paid	$	$
15. **Gross Eligibility Income:** (line 13 minus line 14)	$	$

DEPENDENT CARE DEDUCTION:

CHILD'S NAME	$200 per Child
TOTAL ▶	$

Eligibility for: ☐ **Healthy Kids** ☐ **MIChild**

Comments:

Eligibility Determination:

☐ **Pended** ▶ Date: ____________ Reason: ____________

☐ **Approved** ☐ **Denied** ▶ Reason: ____________

DCH Approval Signature: Date:

MSA-0853 (Rev. 3/01) (W) Previous Edition Obsolete

6.10 DETERMINATION

If the child has met all nonfinancial and financial factors for eligibility, then the child is eligible for MIChild.

6.11 HEALTH PLANS

All applications, both denied and approved, and appropriate verifications must be sent to the Administrative Contractor. Health plans should keep a copy of the application and all documentation in the child's record.

SECTION 7 - PREMIUMS

7.1 ASSESSMENT OF PREMIUMS

MIChild families will be assessed a premium of $5.00 per family per month, regardless of the number of children in the family. The family is responsible for payment of the premium each month.

Native Americans and Alaska Natives are exempt from the $5.00 per month premium. The family is exempt from payment if any family member listed on the application and living in the household is a Native American or Alaska Native, even if that member is an adult or a Medicaid recipient.

7.2 ADMINISTRATIVE CONTRACTOR RESPONSIBILITY

The Administrative Contractor is responsible for collecting the appropriate premium amount each calendar month. It is the Administrative Contractor's option, with the family's concurrence, to obtain the premium on a monthly, quarterly, or yearly basis, or by some other payment arrangement.

The Administrative Contractor will send the family a yearly coupon booklet for premium payment purposes. There will be one coupon for each month the premium is due.

If the health plan provides an initial determination of MIChild eligibility, then the full premium for that child should be collected beginning with the first full month of eligibility. For example, if the applicant is initially determined eligible for MIChild on January 21st, the first premium due is for February coverage. The premium and the coupon are to be sent to the Administrative Contractor.

7.3 FAILURE TO PAY PREMIUMS

If the family fails to pay the appropriate premium, the family has until the 10th of the month for which the premium was due to make the payment. If the 10th of the month is not a workday, the due date will be the next business day following the 10th. MIChild eligibility and coverage will continue for that month. For example, if during the month of January the family did not pay the premium for February, the premium must be U.S. postmarked by February 10th for MIChild benefits to continue past the last day of February.

The Administrative Contractor will notify the family, in writing, of the:

- the amount due,
- the date the past due premium must be paid,
- the beneficiary's disenrollment from the health plan if the past due premium is not paid,
- the date coverage will end,
- the need to report any change in circumstances (for example: loss of income, additional family members, or requirement to pay child support for a child not living with the family) which may result in a new determination of eligibility,
- the right to request a Department Review and the procedures to follow in requesting a Department Review.

Failure to pay the monthly premium will result in disenrollment from MIChild effective the first day of the following month for which the premium was due.

If the applicant is disenrolled for failure to pay the MIChild premium, a six-month penalty is imposed. Coverage may not begin until the month following the end of the six-month penalty period. (Refer to the Excluded Children portion of the Eligibility Criteria Section of this manual for disenrollment information due to nonpayment of premiums.)

SECTION 8 - DISENROLLMENT

8.1 GENERAL INFORMATION

It is the Administrative Contractor's responsibility to disenroll the beneficiary from the health plan.

The health plan is responsible for the beneficiary's medical care until the Administrative Contractor notifies the health plan that its responsibility for the beneficiary has ended. This notification will be in a form agreeable to both the health plan and the Administrative Contractor.

8.2 RETROACTIVE DISENROLLMENT

The Administrative Contractor must not retroactively disenroll any beneficiary unless the beneficiary died before the beginning of the month in which the capitation payment was made.

8.3 DISENROLLMENT FROM MICHILD

Enrollment in MIChild is for one year, except in the following situations which result in immediate loss of MIChild eligibility.

- Nonpayment of premiums. The effective date of disenrollment is the last day of the month for which the premium was due. The disenrollment period is six months.
- Loss of MIChild eligibility due to admission to a correctional facility or an institution for the mentally disabled (ICF/MR). The effective date of the disenrollment is the last day of the month of admission to the institution.
- Family/child moves from the state. The MIChild beneficiary must be disenrolled from the health plan effective the last day of the month that the child resided in Michigan.
- Death of a MIChild beneficiary. The effective date of disenrollment will be the date the beneficiary died.
- A MIChild beneficiary becomes active Medicaid before annual redetermination. A MIChild beneficiary may not receive MIChild and Medicaid for the same coverage period. The effective date of disenrollment is the last day of the month that enrollment in Medicaid was discovered.
- If a change is reported in writing that results in disenrollment from MIChild, the child will be disenrolled effective the month following receipt of the written notification if the notification is received by the enrollment cut-off date. Refund will only be made for months MIChild coverage does not exist.
- Beneficiary meets a Medicaid spend-down during a month MIChild is active. The beneficiary is not disenrolled; DCH will reconcile the payments in an internal process.
- Beneficiary turns age 19. The effective date of disenrollment is the last day of the month in which the person turns age 19.

The following is a reason for disenrollment at annual redetermination:

- Loss of MIChild eligibility due to eligibility for other programs (e.g., Medicaid), other insurance coverage, income in excess of MIChild limits, failure to complete redetermination forms, or failure

to provide required verifications. The effective date will be the last day of the enrollment year for the beneficiary.

The Administrative Contractor must provide the family with a creditable certificate of coverage upon disenrollment from MIChild.

8.4 Disenrollment From the Health Plan

Reasons for disenrollment from the health plan include:

- Family/child moves from the health plan's service area. The MIChild beneficiary must be disenrolled from the health plan effective the first day of the month following the Administrative Contractor's implementation of the change of address. The health plan remains responsible for services until the effective date of disenrollment.
- Improper actions on the part of the beneficiary/family that are inconsistent with the health plan membership, including fraud, abuse of the health plan, or other intentional misconduct; or if, in the opinion of the health plan, the beneficiary's/family's behavior makes it medically infeasible for the health plan to safely or prudently render covered services to the beneficiary. Such termination is subject to the written grievance procedures of the health plan, except that the notice of termination must be immediately communicated to the beneficiary/family, along with the procedures for expeditious review. The health plan must contact the Administrative Contractor and supply supporting documentation of the possible disenrollment. The Administrative Contractor will review the documentation and make a recommendation to the Department. The Department must approve the disenrollment. The effective date will be the last day of the month the Department approves the disenrollment.
- The health plan's contract with the Department is terminated for any reason. The effective date of disenrollment is the date the contract is terminated.

SECTION 9 - DEPARTMENT REVIEWS/COMPLAINTS/GRIEVANCES

9.1 GENERAL INFORMATION

Requests for Department Review, complaints, and grievances regarding eligibility for MIChild should be resolved as follows:

- If the family appeals a denial of initial eligibility made by the health plan or Administrative Contractor, the appeal should be resolved through the health plan or Administrative Contractor if possible.
- The Administrative Contractor is available if resolution through the health plan is not possible.
- The applicant/family also has the right to appeal directly to a Department Review without first appealing to the health plan or Administrative Contractor.

Complaints, grievances and requests for Department Review regarding services or other actions taken by the health plan must be resolved by the health plan and if necessary, the DCH Department Review process or the Department of Labor and Economic Growth.

9.2 REQUESTS FOR DEPARTMENT REVIEW

The family must be notified of the eligibility decision as indicated in the Application Process Section of this manual. Included with the notification is the family's right to request a Department Review and the Department Review Request form. The family has the right to appeal the eligibility decision made by the Department.

9.3 HEALTH PLAN

If the family wishes to appeal the initial determination of eligibility, the family should first try to resolve the issue with the health plan. Many times, additional documentation or verbal clarification of an issue may resolve the matter.

The family has the right to request that the application be immediately reviewed by the Administrative Contractor if the issue cannot be resolved by the health plan. Unresolved issues at the Administrative Contractor level must be referred to the Department for resolution through the Department Review process.

The DCH Administrative Tribunal will notify the family of the Department's decision regarding MIChild eligibility.

SECTION 10 - DENTAL SERVICES

10.1 GENERAL INFORMATION

The Department contracts with licensed dental managed care entities to provide dental services to MIChild enrollees. These entities are responsible for providing MIChild covered services for a per member per month capitation rate.

10.2 ELIGIBILITY

The dental contractor cannot determine initial eligibility for MIChild. Eligibility will be determined as described in the Application Process Section of this manual.

Once the application is forwarded to the Administrative Contractor and eligibility is verified, the Administrative Contractor will notify the dental plan that the child is enrolled and the effective date of enrollment. This notification must be within the 10 work day period that the Administrative Contractor has to review the application.

The effective date of enrollment will be the same as for the health plan. (Refer to the Begin Date of Eligibility portion of the Application Process Section for additional information.)

10.3 ENROLLMENT

The child must be enrolled in a dental plan in order for services to be covered. The Administrative Contractor enrolls the child in a dental plan.

10.4 LOSS OF ELIGIBILITY DURING TREATMENT

Certain procedures that were started before the loss of eligibility may be covered provided that the services were completed within a 60 calendar day period from the date of loss of eligibility.

The dental capitation that was paid to the dental contractor covers the completion of these services. The child's family must not be billed for these services.

No capitation payments will be made once MIChild eligibility ends.

10.5 DISENROLLMENT

The Administrative Contractor must notify the dental plan of any disenrollments in MIChild. The effective date of disenrollment will be the same as for the health plan.

SECTION 11 - MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

11.1 GENERAL INFORMATION

The Department contracts with CMHSPs and CAs to provide mental health and substance abuse services to MIChild enrollees. These entities are responsible for providing MIChild covered services for a per eligible member per month capitation rate.

11.2 ELIGIBILITY

CMHSPs and CAs cannot determine initial eligibility for MIChild. Eligibility will be determined as described in the Application Process Section of this manual.

Once the application is forwarded to the Administrative Contractor and eligibility is verified, the Administrative Contractor will notify the CMHSP and CA that the beneficiary is enrolled in MIChild and the effective date of enrollment. The child is not enrolled in a CMHSP or CA.

The effective date of enrollment will be the same as for the health plan. (Refer to the Begin Date of Eligibility portion of the Application Process Section for additional information.)

11.3 ENROLLMENT

The child is automatically eligible for MIChild covered mental health and substance abuse services authorized by the CMHSP or CA once MIChild eligibility is determined.

11.4 DISENROLLMENT

The Administrative Contractor must notify the CMHSP and CA of any MIChild disenrollment. The effective date of disenrollment will be the same as for the health plan.

SECTION 12 - POST-ELIGIBILITY AUDIT PROCESS

12.1 GENERAL INFORMATION

The Department will conduct random post-eligibility audits to ensure that MIChild eligibility has been granted appropriately.

12.2 ADMINISTRATIVE CONTRACTOR RESPONSIBILITY

The Administrative Contractor will forward to the Department, on a weekly basis, lists of all applications approved initially and at redetermination and of all denied applications.

12.3 DCH RESPONSIBILITY

The Department will randomly select, from the lists described above, the names of case files selected for audit and will request copies of these eligibility materials from the Administrative Contractor.

Upon receipt of these eligibility materials from the Administrative Contractor, the Department will review the materials and request documentation from the beneficiary to substantiate the statements made on the application. This documentation may include copies of pay stubs, written verification from employers, income tax records of self-employed persons, documentation from Friend of the Court or court documents establishing guardianship fees.

The request for documentation will be made on the Notice of MIChild Audit (DCH-0956). The requested verifications must be returned to the Department, postmarked no later than 15 calendar days from the date of the DCH-0956. Detailed instructions, including a telephone number to call for additional assistance, and a warning that failure to cooperate with the audit will result in immediate termination of MIChild benefits are included on this form.

12.4 RESULT OF AUDIT

If the audit determination process results in confirmation of the original eligibility decision, the beneficiary will receive notice of the successful audit.

Other determinations that may result from the audit are:

- The child originally qualified for Healthy Kids/Medicaid, not MIChild, **or**
- The child did not qualify for MIChild due to other insurance, excess income, or other eligibility factors.

NOTE: Children found eligible for Healthy Kids/Medicaid will be terminated from the MIChild program, and will be enrolled in Healthy Kids/Medicaid by DHS staff.

NOTE: Children found not eligible for either MIChild or Healthy Kids/Medicaid will receive notice that they will be terminated from the MIChild program. Included with the notification is the family's right to request a Department Review, and the Department Review Request form. The family has the right to appeal the eligibility decision made by the Department.

12.5 Disenrollment Notices

Notice of disenrollment from MIChild will include information that the child may reapply at a later date if the family situation changes and medical coverage is needed.

12.6 Audit Reports

Audit results will be provided on a regular basis and shared with MIChild staff for training purposes.

SECTION 13 - DEFINITIONS

The following definitions apply to this manual:

Abuse	Provider practices that are inconsistent with sound fiscal, business, or medical practices, resulting either in unnecessary cost to the Program or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards of care.
Adjusted Gross Income	The amount of income for the group, minus allowable deductions.
Administrative Contractor	The entity that contracts with the Department of Community Health to provide administrative support for MIChild.
AFDS	Alternative Finance Delivery System. A category of licensure for prepaid limited health service organizations, such as dental and vision plans.
Applicant	An individual who has had an application for MIChild submitted on his behalf. (The person remains an applicant until MIChild is approved, denied, or the application is withdrawn.)
Beneficiary	A child enrolled in MIChild.
CA	The Coordinating Agency that provides substance abuse services to MIChild enrollees.
CMHSP	Community Mental Health Services Program is the agency that provides mental health services to MIChild enrollees.
Certificate of Coverage	Written notification from the health plan of the coverage available under MIChild.
Certificate of Creditable Coverage	Written certification of: 1) the period of creditable coverage for the person and the coverage, if any, under such COBRA continuation provision; and 2) the waiting period, if any, imposed with respect to the person for any coverage.
CSHCS	Children's Special Health Care Services is a program established under Title V of the Federal Social Security Act, being 42 U.S.C. 701 to 716, and pursuant to Sections 5801 to 5879 of Act No. 368 of the Public Acts of 1978, as amended. The program provides specialty medical care and related services to persons under age 21 for certain severe and chronic medical diagnoses, and persons age 21 and over with Cystic Fibrosis or certain blood coagulation disorders.

Comprehensive Insurance	Insurance that covers inpatient and outpatient hospital services, laboratory, x-ray, pharmacy and physician services. Catastrophic coverage, dental-only coverage, or emergency coverage only is NOT considered to be comprehensive insurance coverage.
Court Ordered Medical Support	Comprehensive medical support ordered by the court as the result of a divorce, separation, paternity, etc.
Dental Plan	The nonprofit dental or health corporation or dental AFDS that contracts with the Department of Community Health to provide dental services to MIChild beneficiaries.
Department	Department of Community Health and its designated agents.
Department Review	The process by which the Department reviews complaints about denial of MIChild eligibility, and complaints and grievances about services or other actions taken by the health plan or Administrative Contractor.
DHS	Department of Human Services (formerly the Family Independence Agency)
FPL	The Federal Poverty Level guidelines are a simplified version of the federal government's statistical poverty thresholds. The poverty guidelines, developed and released annually by the U.S. Department of Health and Human Services, are used as a criterion by many federal and state programs to determine whether applicants are financially eligible.
Final Determination of Eligibility	The Department's determination, after review of the application verifications, of the applicant's eligibility for MIChild.
Fraud	Intentional deception or misrepresentation made by a person with the knowledge that the deception or misrepresentation could result in some unauthorized benefit to that person or another.
Group Composition	The fiscal group used to determine financial eligibility for a MIChild applicant.
Health Plan	Licensed health maintenance organizations, licensed insurers, and licensed nonprofit health care corporations that have contracted with the Department to provide services to MIChild beneficiaries.
Initial Determination of Eligibility	Process whereby the health plan or Administrative Contractor determines probable eligibility for MIChild without actually approving the applicant's eligibility.
Locked In	Beneficiary's inability to change health plans and dental plans until an open enrollment period.

Nonvoluntary Loss	A loss of comprehensive health insurance coverage due to reasons beyond the family's control. This includes: the employer going out of business; the employee losing his job; the employer dropping comprehensive health insurance coverage for all dependents of the employee; the carrier no longer offering the comprehensive health insurance coverage. COBRA coverage may be dropped and MIChild benefits may begin immediately. There is no six-month wait in this case.
Premium	Monthly cost-sharing amount payable by the parent or other entity. It is considered to be one requirement for MIChild eligibility.
Recommendation of Eligibility	The Administrative Contractor's recommendation, after review of verifications, of the applicant's eligibility for MIChild.
Spend Down	A process which allows persons with excess income to become eligible for Medicaid if sufficient allowable medical expenses are incurred. Such persons must incur medical expenses each month equal to, or in excess of, an amount determined by the local DHS specialist to qualify for Medicaid. Once the spend-down amount has been met, there is Medicaid eligibility from the day the spend-down amount is met until the end of the month. (The MIChild premium may be used as an incurred expense.)
TMA-Plus	The Transitional Medical Assistance-Plus program operated by the State that allows persons losing Transitional Medical Assistance to buy-in to Medicaid, provided certain criteria are met.
Work Day	The same days of the week (Monday through Friday) that State of Michigan employees must be at work. This excludes State-approved holidays.

SECTION 14 - CITIZENSHIP AND ALIEN STATUS

The following chart indicates if the child meets the citizenship criterion for MIChild. Eligibility as an alien is based on the codes on the I-551 (Alien Registration Receipt Card).

CITIZENSHIP/ALIEN STATUS	MIChild Eligibility
U.S. Citizen (including person born in Puerto Rico)	YES
Person born in Canada , at least 50% Native American	YES
Qualified Military Alien	YES
Spouse or Dependent Child of Qualified Military Alien	YES
Refugee under Section 207	YES
Asylee under Section 208	YES
Cuban/Haitian Entrant (Class Code CR6, CU6, or CU7)	YES
Amerasian (Class Code AM)	YES
Permanent Resident Alien (Class Code RE or AS)	YES
Permanent Resident Alien	
(Class Code Other Than AM, AS, CR, CU, RE)	YES
U.S. Entry before 8/22/96	YES
U.S. Entry on or after 8/22/96	YES
First 5 years in U.S.	NO *
More than 5 years in U.S.	YES
Permanent Resident Alien, has I-551	YES
Deportation (Removal) Withheld under Section 241(b)(3) or 243(h)	YES
Granted Conditional Entry under Section 203(a)(7)	YES
Paroled under Section 212(d)(5) for at least 1 year	YES
U.S. Entry before 8/22/96	YES
U.S. Entry on or after 8/22/96	YES
First 5 years in U.S.	NO *
More than 5 years in U.S.	YES
Paroled under Section 212(d)(d) for less than 1 year	NO
Nonimmigrant (e.g., student, tourist)	NO
Aliens not described above (e.g., illegal aliens)	NO

* Unless a qualified military alien, or the spouse or dependent child of a qualified military alien

The following is an example of the I-551, Alien Registration Receipt Card.

NAME

DATE OF BIRTH

RESIDENT ALIEN

BUSH GARCIA, RONALD
NAME

11 19 60
DOB

FINGER PRINT ID

PICTURE ID

AO92000000
ALIEN NUMBER

ALIEN NUMBER

04 04 07
CARD EXPIRES
SAMPLE CARD

CARD EXPIRATION DATE

DATE OF ADJUSTMENTS/ADMISSION AS LAWFUL PERMANENT RESIDENT

CLASS CODE

ALIEN REGISTRATION RECEIPT CARD
PERSON IDENTIFIED BY THIS CARD IS ENTITLED TO RESIDE PERMANENTLY AND WORK IN THE U.S.

TEMP RES ADJ DATE - 111687

CU6 LOS 900508 576
107471002

A1USAO92000000<01<9104<<<<<<<<<
5011195MO1O4O45<<<<<<9DA6C3FO2
BUSH GARCIA<<RONALD <<<<<<<

DATE OF ADJUSTMENT TO LAWFUL TEMPORARY RESIDENT STATUS

SECTION 15 - NATIVE AMERICAN PAYMENT EXCLUSIONS

The following laws include reference to income by Native Americans that must be excluded from the determination of income.

Public Law 92-203	Tax exempt portions of payments under the Alaska Native Claims Settlement Act
Public Law 92-254	Judgment funds to members of the Blackfeet Tribe of the Blackfeet Reservation, Montana, and Gros Ventre Tribe of the Fort Belknap Reservation, Montana
Public Law 93-134	Funds distributed to members of the Indian tribes and the purchases made with such funds. Also, exclude up to $2,000 per year of income received by an individual that is derived from leases or other uses of individually-owned trust or restricted lands.
Public Law 93-531	Relocation assistance payments to members of the Hopi and Navajo Tribes.
Public Law 94-114	Receipts distributed to members of certain Indian tribe.
Public Law 94-189	Payments received under the Sac and Fox Indian agreements.
Public Law 94-540	Judgment funds to the Grand River Band of Ottawa Indians.
Public Law 95-433	Payments by the Indian Claims Commission to the Confederated Tribes and Bands of the Yakima Indian Nation or the Apache Tribe of the Mescalero Reservation.
Public Law 96-420	Section 5 Payments to the Passamaquoddy Tribe and the Penobscot Nation or any of their members received pursuant to the Maine Indian Claims Settlement Act of 1980.
Public Law 98-64	Funds distributed to members of Indian tribes and purchases made with such funds.
Public Law 98-123	Funds distributed to members of the Red Lake Band of Chippewa Indians.
Public Law 98-124	Funds distributed to the Assiniboine Tribe of the Fort Belknap Indian Community and the Assiniboine Tribe of the Fort Peck Indian Reservation.
Public Law 99-346	Payments and distributions of judgment funds to the Saginaw Chippewa Indian Tribe of Michigan. May be called payments from the Investment Fund or Elderly Assistance Investment Fund.
Public Law 105-143	Funds distributed to the Ottawa and Chippewa Indians of Michigan.