MODIFIED ADJUSTED GROSS INCOME (MAGI) RELATED ELIGIBILITY MANUAL

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CHAPTER 1-GENERAL INFORMATION

The Medicaid Program was established by the Social Security Act. Amendments to the Social Security Act by the U.S. Congress affect the administration and scope of the Medicaid program. The U.S. Department of Health and Human Services (HHS) administers the Social Security Act. Within HHS, the Center for Medicare and Medicaid Services (CMS) is responsible for the administration of the Medicaid program.

The Affordable Care Act of 2010 is the collective term for the Patient Protection and Affordable Care Act (Publication L. 111-148) and the Health Care and Education Reconciliation Act (Publication L. 111-152).

HHS develops and issues federal regulations that set the requirements and guidelines for states to follow in the determination of Medicaid eligibility. Each state must submit a state plan for Medicaid. When federal statute or regulations provide for options, the state plan must indicate which optional provisions the state selects. In selecting optional provisions and developing policy, the Department of Community Health (DCH) is governed primarily by state statutes. The state plan must be approved by HHS and the governor's clearinghouse for conformity to the Code of Federal regulations (CFR), Michigan Compiled Laws (MCL), and federal court orders.

The goal of the Medicaid program is to ensure that essential health care services are made available to those who otherwise could not afford them. The Medicaid program is comprised of several categories or sub-groups.

One of the sub-groups is MAGI related. MAGI is defined as modified adjusted gross income. MAGI for purposes of Medicaid eligibility is a methodology which State agencies and the exchange must use to determine financial eligibility. MAGI groups include the groups formerly known as FIP-related. Children, caretaker relatives/parents and pregnant women are examples of groups who receive Medicaid coverage under the MAGI related category.

Individuals may qualify under more than one category. Federal law gives them the right to the most beneficial category. The most beneficial category is the one that results in eligibility or the least amount of excess income. Individuals are not expected to know the distinct categories. Income will be verified via electronic Federal data sources in compliance with MAGI methodology.

1.1 RIGHTS AND RESPONSIBILITIES

Individuals have rights and responsibilities as specified in this section.

The local office must do all of the following, determine eligibility, calculate the level of benefits, and protect individual rights.

On the same day an individual comes to the local office, an individual has the right to file an application and get local office help to provide the minimum information for filing.

An application whether faxed, mailed or received from the internet must be registered with the receipt date, if it contains at least the following information:

- Name of the applicant.
- Birth date of the applicant

- Address of the applicant (unless homeless).
- Signature of the applicant/authorized representative.

Information concerning individuals is confidential and protected. Individuals have the right to be treated with dignity and respect.

Discrimination based on race, sex, religion, natural origin, marital status, disability or political beliefs is prohibited.

Individuals must cooperate with the local office in determining initial and ongoing eligibility. This includes completion of necessary forms.

Individuals must completely and truthfully answer all questions on forms and in interviews.

The individual might be unable to answer a question about himself or another individual whose circumstances must be known. Allow the individual at least 10 days (or other timeframe specified in policy) to obtain the needed information.

Failure to cooperate with social security number, child support or third-party liability requirements might disqualify an individual but is not a refusal of necessary eligibility information.

Record the need for special language accommodations and the applicant's primary spoken and written language.

An individual who needs a bilingual interpreter must be informed to choose one of the following, arrangements for an interpreter by DHS, including payment of any costs, use of his or her own adult interpreter.

If the individual does not identify his own interpreter, select one of the following, if available, and inform the individual. DHS staff individual with bilingual ability the individual cannot decline the use of such an interpreter if available. An individual from a community agency or other volunteer may assist. The volunteer must have adequate bilingual ability and must be informed of DHS policy on confidentiality.

If a DHS staff individual is not available to interpret and the individual declines the use of a volunteer, select one of the following, contractual provider of interpreter services or interpreter hired on an as-needed basis.

Document translation/interpretation assistance provided to an individual on the DHS-848, Certification of Translation/Interpretation for non-English Speaking Applicants or Recipients.

1.2 MAGI RELATED GROUPS

The MAGI related groups are:

- Children (U19). The income limit for children birth to age 1 is 195% FPL. The income limit for a child age 1-19 is 160% FPL.
- Pregnant Women (PW). The income limit for pregnant women of any age is 195% FPL.
- Parents and caretakers (PCR). The income limit for parents and caretakers is 54% FPL.
- Healthy Michigan Plan (HMP). The income limit for adults age 19-64 is 133% FPL.

- Former foster children (FCTM). There is no income test for individuals' ages 18-26 who were in foster care at age 18.
- MOMS. The income limit for pregnant women of any age is 195% FPL.
- MIChild. The income limit for children birth to age 19 is 212% FPL.

More information regarding income limits is available at www.medicaid.gov.

1.3 APPLICATION

A streamlined application is used to apply for the health insurance affordability programs. The health insurance marketplace application is available electronically or by paper. The application is a single point of entry to purchase private insurance through the health insurance marketplace and assess eligibility for assistance including, Medicaid, CHIP, and the Advanced Payment of Tax Credits (APTC) or Cost Sharing Reduction (CSR). The Application for Health Coverage & Help Paying Costs is available in a short form for individuals as well as a longer form for families.

An application for assistance may be made online, by telephone, email or in person at a DHS local office.

HealthCare.gov is the federal online portal to complete an application or request assistance with the federal application.

The DCH-1426, Application for Health Coverage and Help Paying Costs is the State of Michigan (SOM) version of the federal health care application. This application may be used to apply for private health insurance plans, a tax credit that can help pay premiums for health coverage, all categories of Medicaid, and MIChild. Individuals may apply online at www.michigan.gov/mibridges.

If an individual indicates a disability during the application process, additional information may be needed. A DHS-1004, Supplemental Health Care Questionnaire will be provided to collect this information. The supplemental form must be returned to the local DHS office so that a determination of Medicaid eligibility based on age or disability may be completed.

1.4 AUTHORIZED REPRESENTATIVE

An authorized representative (AR) is a person who applies for assistance on behalf of the individual and/or otherwise acts on the individual's behalf. An AR is not the same as an authorized hearing representative.

When no one in the group is able to make application for program benefits, any group member capable of understanding AR responsibilities may designate the AR. The AR assumes all the responsibilities of an applicant or beneficiary.

AR's must give their name, address, and title or relationship to the individual. To establish the individual's eligibility, they must be familiar enough with the circumstances to complete the application, answer interview questions, and collect needed verifications.

An application may be made on behalf of an individual by his spouse, parent, legal guardian, adult child, stepchild, specified relative or any other person provided the person is at least age 18 or married. If this person is not a spouse, parent, legal guardian, adult child, stepchild, or specified relative, the person must have a signed authorization to act on behalf of the individual, by the individual, individual's spouse, parent(s) or legal guardian.

The application form must be signed by the individual or the individual acting as his authorized representative.

When an AP is received in the local office without the applicant's signature or without a signed document authorizing someone to act on the applicant's behalf you must do the following:

- Register the application as a request if it contains a signature.
- Send a DHS-330, Notice of Missing Information, to the individual explaining the need for a valid signature. The signature page of the application may be copied and sent to the agency or individual who filled out the application with the notice.
- Allow 10 days for a response. You cannot deny an application due to incompleteness until 10 calendar days from the date of your initial request in writing to the applicant to complete the application form or supply missing information.

An application received from an agency is acceptable if it is signed by an individual and is accompanied by written documentation from the individual authorizing the agency to act as their authorized representative. If unrelated adults living in the same home apply for assistance, neither has the authority to act on the other's behalf without written permission from the applicant.

An authorized representative must be one of the following:

- An adult child or stepchild.
- A core relative.
- Designated in writing by the individual.
- Court appointed.
- A representative of an institution (such as jail or prison) where the individual is in custody.

Individuals, who provide medical care or their agents, should not act for the individual when there is a relative, guardian or friend who is willing and able to act. If a court has appointed a guardian for an individual's estate (such as income and assets), the guardian is usually expected to act for the individual.

An application may be made for newborns surrendered under the Safe Delivery Law, (MCL 712.1-712.20) by the provider hospital, child-placing agency, court-appointed lawyer-guardian ad litem or prospective adoptive parent.

A department employee may apply on behalf of a member of the employee's family or a child committed to, or placed with, the department by court order.

An authorization to represent is a form of a power of attorney. When a person who gave the authorization dies, the power of attorney ends. After death, the person does not exist as a legal entity, so no one can represent the person. However, if a person dies while the application is pending, the application should be processed.

An estate may be created to handle the remaining business and financial issues that were outstanding at the time of death. Only a probate court can create a decedent's estate. The court will also appoint someone to act as a representative of the estate.

A court, agency or guardian legally responsible for a beneficiary must be identified as an authorized representative.

A Medicaid application can be processed by the local office serving the beneficiary or the authorized representative.

Medicaid applications for incarcerated individuals must be handled by the county of residence prior to incarceration.

An individual may apply for Medicaid at any of the following: any local DHS office in Michigan, any local health department, any other DCH authorized contract agencies.

CHAPTER 2 - RESIDENCY

2.1 MICHIGAN RESIDENT

An individual is considered to be a Michigan resident if the individual attests to living in Michigan. When an individual attests to being temporarily absent from the state and the address provided indicates where the individual intends to return, the individual is considered a Michigan resident.

2.2 HOMELESS INDIVIDUAL

An individual who does not have a fixed address may provide a mailing address. Residency in the state will be established based on the individual attestation of Michigan residency.

CHAPTER 3 CITIZENSHIP/ALIEN STATUS

3.1 FEDERAL AGENCIES

USCIS refers to the U.S. Citizenship and Immigration Services. SSA refers to the Social Security Administration. In this section DHS refers to Department of Homeland Security.

3.2 CITIZENSHIP/ALIEN STATUS

An individual must be a United States citizen or have a qualified alien status. Citizenship/alien status is not an eligibility factor for emergency services only (ESO) Medicaid. However, an individual must meet all other eligibility factors, including residency.

An individual claiming U.S. citizenship is not eligible for ESO coverage.

Primary evidence of citizenship is documentary evidence of the highest reliability that conclusively establishes that the person is a U.S. citizen.

The data match with the SSA is sufficient to verify citizenship and should be completed prior to requesting verification from an individual. If a match is not available proceed to the following forms of verification.

Primary evidence of citizenship is:

- A U.S. passport.
- A U.S. passport card.
- A Certificate of Naturalization (N-550 or N-570).
- A Certificate of Citizenship (N-560 or N-561).

Secondary Evidence

Secondary evidence of citizenship is documentary evidence of satisfactory reliability that is used when primary evidence is not available. Secondary evidence is:

- A U.S. public birth record showing birth in one of the 50 United States, District of Columbia, American Samoa, Swain's Island Puerto Rico (if born on or after January 13, 1941), Virgin Island of the U.S. (if born on or after January 17, 1917), Northern Mariana Islands (if born on or after November 4, 1986) or Guam (if born on or after April 10, 1899).
- A Michigan enhanced driver's license or enhanced state ID.
- Certification of Report of Birth (DS-1350). The Department of State issues a DS-1350 to U.S. citizens in the U.S. who were born outside the U.S. and acquired U.S. citizenship at birth based on the information shown on the FS-240.
- Consular Report of Birth Abroad of a Citizen of the United States of America (FS-240). Children born outside the U.S. to U.S. military personnel usually have one of these.
- Certification of Birth Abroad (FS-545). Before November 1, 1990 Department of State consulates also issued Form FS-545 along with prior version of the FS-240. In 1990, U.S. consulates ceased to issue Form FS-545. Treat an FS-545 the same as the DS-1350.
- United States Citizen Identification Card (I-197 or I-179). INS issued Form I-179 and I-197 to naturalized U.S. citizens living near the Canadian or Mexican borders who needed it for frequent border crossings. Although neither form is currently issued, either form that was previously issued is still valid.
- American Indian Card (I-872). The Department of Homeland Security (DHS) issues this card to identify a member of the Texas Band of Kickapoo's living near the U.S./Mexican border. A classification code KIC and a statement of the back denote U.S. citizenship.
- Northern Mariana Card (I-873). INS issued this form to a collectively naturalized citizen of the U.S. who was born in the Northern Mariana Islands before November 4, 1986. The card is no longer issued, but those previously issued are still valid.
- Final adoption decree. The decree must show the child's name and U.S. place of birth. In situations where an adoption is not finalized and the state in which the child was born will not release a birth certificate prior to final adoption, a statement from a state approved adoption agency that shows the child's name and U.S. place of birth is acceptable. The adoption agency must state in the certification that the source of the place of birth information is an original birth certificate.
- Evidence of civil service employment by the U.S. government. The document must show employment by the U.S. government prior to June 1, 1976.
- Official military record of service. The document must show a U.S. place of birth, (a DD-214 or similar official document showing a U.S. place of birth.)
- Verification with the Department of Homeland Security's Systematic Alien Verification for Entitlements (SAVE) database.
- Evidence of meeting the automatic criteria for U.S. citizenship outlined in the Child Citizenship Act of 2000.
- The Child Citizenship Act of 2000 allows certain foreign-born, biological and adopted children of American citizens to acquire American citizenship at birth, but they are granted citizenship when they enter the United States as lawful permanent residents (LPRs).

The child must meet all of the following requirements:

- Have at least one American citizen parent by birth or naturalization.
- Be under 18 years of age.
- Live in the legal and physical custody of the American citizen parent.
- Be admitted as an immigrant for lawful permanent residence.
- If the child is adopted, the adoption must be full and final.

Third Level Evidence

Third level evidence of U.S. citizenship is documentary evidence that is used when neither primary nor secondary evidence is available. Third level evidence may be used only when primary evidence cannot be obtained within a reasonable length of time, secondary evidence does not exist or cannot be obtained, and the individual alleges being born in the U.S.

Third level evidence is usually a non-government document established for a reason other than to establish U.S. citizenship and showing a U.S. place of birth. The place of birth on the non-government document and the application must agree.

Third level evidence is:

- An extract of a hospital record on hospital letterhead, established at the time of birth and was created at least five years before the initial application date (or near the time of birth for children) and indicates a U.S. place of birth. Do not accept a souvenir birth certificate.
- Life, health, or other insurance record showing a U.S. place of birth and was created at least five years before the initial application date.
- Religious record recorded in the U.S. within three months of birth showing the birth occurred in the U.S and showing either the date of the birth or the individual's age at the time the record was made. The record must be an official record recorded with the religious organization. Entries in a family bible are not considered religious records.
- Early school record showing a U.S. place of birth. The school record must show the name of the child, the date of admission to the school, the date of birth, a U.S. place of birth, and the name(s) and place(s) of birth of the applicant's parents.

Fourth Level Evidence

Fourth level evidence should only be used in the rarest of circumstances and includes:

- Federal or state census record showing U.S. citizenship or a U.S. place of birth, generally for persons born 1900 through 1950. The census record must show the person's age. To secure this information the individual or state should complete a Form BC-600, Application for Search of Census Records for Proof of Age. Add in the remarks section U.S. citizenship data requested. Also indicate that the purpose is for Medicaid eligibility. This form requires a fee.
- Seneca Indian tribal census record.
- Bureau of Indian Affairs tribal census records of the Navaho Indians.
- Bureau of Indian Affairs Roll of Alaskan Natives.

- U.S. State Vital Statistics official notification of birth that is amended more than five years after the person's birth.
- Statement signed by the physician or midwife who was in attendance at the time of birth.
- Institutional admission papers from a nursing facility or other institution or medical records from a hospital, doctor, or clinic and was created at least five years before the initial application date and indicates a U.S. place of birth. Admission papers generally show biographical information including a place of birth. An immunization record is not considered a medical record for purposes of establishing U.S. citizenship.
- A written affidavit, an affidavit should only be used in rare circumstances. The affidavit must be completed by the individual and one additional individual who has personal knowledge of the event(s) establishing the claim of citizenship.

3.3 EMERGENCY SERVICES ONLY

Emergency services is defined as services required after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including pain) such that the absence of immediate medical attention could reasonably be expected to result in:

- Placing the individual's health in serious jeopardy
- Serious impairment to bodily functions or
- Serious dysfunction of any bodily organ or part.

Services for pregnant women include routine prenatal care, labor and delivery, and routine post-partum care.

3.4 SYSTEMATIC ALIEN VERIFICATION FOR ENTITLEMENTS

The Systematic Alien Verification for Entitlements (SAVE) Program enables federal, state, local government agencies and licensing bureaus to obtain immigration status information needed to determine a noncitizen applicant's eligibility for many public benefits.

The SAVE Program is an intergovernmental information-sharing initiative designed to aid eligibility specialists in determining a noncitizen applicant's immigration status. This will ensure that only entitled noncitizen applicants receive federal, state, or local public benefits.

The SAVE Program is an information service which benefits issuing agencies, institutions, licensing bureaus, and other entities.

3.5 QUALIFIED ALIEN

Qualified alien means an alien who is:

- Lawfully admitted for permanent residence under the INA.
- Granted asylum under section 208 of the INA.
- A refugee who is admitted to the U.S. under section 207 of the INA; this includes Iraqi and Afghan special immigrants.
- Paroled into the U.S. under section 212(d) (5) of the INA for a period of at least one year.

- An alien whose deportation is being withheld under section 241(b) (3) or 243(h) of the INA.
- Granted conditional entry pursuant to section 203(a) (7) of the INA.
- A Cuban/Haitian entrant.
- An alien who has been battered or subjected to extreme cruelty in the U.S. by a U.S. citizen or legal permanent resident spouse or parent, or by a member of the spouse or parent's family living in the same household, or is the parent or child of a battered person.

3.6 ACCEPTABLE STATUS

Individuals with the following status are considered to be in acceptable status for entry into the U.S.

- Individuals born in Canada who are at least 50 percent American Indian.
- Member of a federally acknowledged American Indian tribe.
- Qualified military alien--a qualified alien on active duty in, or veteran honorably discharged from, the U.S. Armed Forces.

  Note: Active duty must not be for training, such as two weeks active duty training for National Guard. The discharge must not have been due to alien status.

- Veteran means a person who either:
  - Served in the active military, naval, or air service for the shorter of 24 months of continuous active duty or the full period for which he was called to active duty.
  - Died while in the active military, naval, or air service.
  - Served in the military forces of the Commonwealth of the Philippines while such forces were in the service of the Armed Forces of the U.S. during the period from July 26, 1941, through June 30, 1946.
  - Served in the Philippine Scouts under Section 14 of the Armed Forces Voluntary Recruitment Act of 1945.
  - A qualified alien spouse and unmarried qualified alien dependent child of a qualified military alien.
  - Dependent child is a child claimed as a dependent on the qualified military alien's federal tax return and under 18, or under age 22 and a student regularly attending school.
  - Spouse includes the unmarried surviving spouse of a deceased qualified military alien. The marriage must fulfill one of the following:
    - The spouse was married to the veteran for one year or more.
    - A child was born to the spouse and veteran during or before the marriage.
    - The spouse was married to the veteran within the 15-year period following the end of the period of service in which an injury or disease causing the death of the veteran was incurred or aggravated.
- Holder of one of the following immigration statuses:
  - Permanent resident alien with class code RE, AS, SI or SQ on the I-551 (former refugee or asylee).
  - Refugee admitted under INA section 207.
  - Granted asylum under INA section 208.
  - Cuban/Haitian entrant.
  - Amerasian under P.L. 100-202 (class code AM on the I-551).

- Victim of trafficking under P.L. 106-386 of 2000; see VICTIMS OF TRAFFICKING in this item.
- Alien whose deportation (removal) is being withheld under INA section 241(b) (3) or 243(h).

- Alien admitted into the U.S. with one of the following immigration statuses:
  - Permanent resident alien with a class code on the I-551 other than RE, AM or AS.
  - Alien paroled into the U.S. for at least one year under INA section 212(d) (5).

  Note Exception (both statuses above): The eligibility of an alien admitted into the U.S. on or after August 22, 1996 with one of these statuses is restricted as follows unless the alien is a qualified military alien or the spouse or dependent child of a qualified military alien:

- An individual is limited to emergency services for the first five years in the U.S.
- Alien granted conditional entry under INA section 203(a) (7).
- Permanent resident alien with an I-151, Alien Registration Receipt Card.
- An alien who has been battered or subjected to extreme cruelty in the United States or whose child or parent has been battered or subjected to extreme cruelty in the United States.
- The eligibility of a battered alien admitted into the U.S. on or after August 22, 1996, is restricted as follows:
- An individual is limited to emergency services for the first five years in the U.S.
- An alien is considered a battered alien if all of the following conditions are met:
  - The USCIS or the Executive Office of Immigration Review (EOIR) has granted a petition or found that a pending petition sets forth a prima facie case that the alien is eligible for legal permanent residence status (LPR) by way of being one of the following:
    - A spouse or child of a U.S. citizen or LPR.
    - The widow or widower or a U.S. citizen to whom the alien had been married for at least two years before the citizen's death.
    - A battered alien or the alien parent of a battered child, or the alien child of a battered parent.

  The abuse was committed by the alien's spouse or parent, or by a member of the spouse or parent's family residing in the same household as the alien, and the spouse or parent consented to or acquiesced in such battery or cruelty (and if the victim was the alien's child, the alien did not participate in or condone the abuse).

  - There is a substantial connection between the battery or extreme cruelty and the need for assistance.
  - The battered alien, child, or parent no longer lives in the same household as the abuser.
  - Alien paroled into the U.S. for less than one year under INA section 212(d) (5). Coverage is limited to emergency services only.
  - Non-immigrant, an alien temporarily in the U.S. for a specific purpose, i.e., student or tourist. The individual must not have exceeded the time period authorized by USCIS. Coverage is limited to emergency services only.
  - Individual who does not meet any of the citizenship or alien statuses listed. Coverage is limited to emergency services only. This includes undocumented individuals and non - immigrants who have stayed beyond the period authorized by USCIS

- A qualified alien who is under 18 years of age.

3.7 LAWFULLY PRESENT IN THE U.S.

An individual is (or was) lawfully residing in the U.S. if the individual meets (or met) one of the following criteria:

- Is a qualified alien.
- Has been inspected and admitted to the U.S. and has not violated the terms of the status under which he was admitted or to which he has changed after admission.
- Has been paroled into the U.S. pursuant to section 212(d) (5) of the INA for less than one year or was either:
  - Paroled for deferred inspection or pending exclusion proceedings under 236(a) of the INA.
  - Paroled into the U.S. for prosecution under 8 CFR 212.5(a) (3).
- Is in temporary resident status under section 210 or 245A of the INA.
- Is under temporary protected status under section 244A of the INA.
- Is a family unity beneficiary under section 301 of P.L. 101-649, as amended.
- Is under deferred enforced departure pursuant to a decision made by the President of the United States.
- Is in deferred action status pursuant to service operations instructions at OI 242.1(a)(22).
- Is the spouse or child of a U.S. citizen whose visa petition has been approved and who has a pending application for adjustment of status.
- Is an applicant for asylum under section 208)(a) of the INA.
- Is an applicant for withholding of deportation under section 243(h) of the INA who has been granted employment authorization.
- Is an applicant for asylum or withholding of deportation who is under the age of 14 and has had an application pending for at least 180 days.

3.8 VICTIMS OF TRAFFICKING

The Office of Refugee Resettlement (ORR) within the U.S. Department of Health and Human Services issues letters of certification to persons they determine are victims of trafficking. Children under age 18 are issued eligibility letters instead of certification letters.

Individuals with the original certification and/or eligibility letters are not required to provide any other immigration documents to receive benefits.

When a victim of trafficking applies for assistance, accept the original certification and/or eligibility letter. Retain a copy the letter and return the original to the individual.

Telephone the ORR trafficking verification line at 1-866-401-5510 to confirm the validity of the certification and/or eligibility letter and inform ORR of the benefits for which the person has applied. Document the telephone call.

Victims of trafficking are issued T visas and eligible relatives of the trafficking victims are entitled to visas designated as T-2, T-3, T-4 or T-5 (collectively referred to as Derivative T Visas). The eligible relative(s) with a Derivative T Visa is eligible for the same program(s) as the victim of trafficking, providing they meet other eligibility criteria.

CHAPTER 4 SOCIAL SECURITY NUMBER

4.1 REQUIRED TO PROVIDE

Individuals must provide their Social Security Number (SSN), cooperate in obtaining an SSN or be excused from supplying and obtaining an SSN.

This condition of eligibility does not apply to individuals who are only applying for benefits on behalf of someone else.

4.2 EXEMPT FROM PROVIDING

The following individuals whose medical coverage is limited to emergency services are excused from providing and obtaining an SSN, an individual illegally present in the U.S, and an individual in nonimmigrant status (e.g., alien with a student visa). This does not include parolees, permanent residents and other legal aliens whose medical coverage is limited to emergency services.

CHAPTER 5-HOUSEHOLD COMPOSITION

5.1 FAMILY SIZE

The size of the household will be determined by the principles of tax dependency in the majority of cases. Parents, children and siblings are included in the same household. Parents and stepparents are treated the same. Individual family members may be eligible under different categories.

5.2 TAX FILERS AND NON- TAX FILERS

a. The household for a tax filer, who is not claimed as a tax dependent, consists of:

- Individual
- Individual's spouse
- Tax dependents

b. The household for a non- tax filer who is not claimed as a tax dependent, consists of:

- Individual
- Individual's spouse
- The individual's natural, adopted and step children under the age of 19 or under the age of 21 if a full time student.
- If the individual is under the age of 19 (or under 21 if a full time student), the group consists of individual's natural, adopted and step parents and natural, adoptive and step siblings under the age of 19 (or under 21 if a full time student).

c. The household for an individual who is a tax dependent of someone else, consists of:

- The household of the tax filer claiming the individual as a tax dependent, except that the individual's group must be considered as non-filer/non-dependent if:
- The individual is not the spouse or a biological, adopted, or step child of the taxpayer claiming them; or
- The individual is under the age of 19 (or under 21 if a full time student) and expects to be claimed by one parent as a tax dependent and are living with both parents but the parents do not expect to file a joint tax return; or
- The individual is under the age of 19 (or under 21 if a full time student) and expects to be claimed as a tax dependent by a non-custodial parent,
- The individual's group consists of the parent who has a court order or binding separation, divorce, or custody agreement establishing physical custody controls, or
- If there is no such order or agreement or in the event of a shared custody agreement, the custodial parent is the parent with whom the child spends most nights.

5.3 CORE RELATIVES

Core relatives include any of the following:

- Parent.
- Aunt or uncle.
- Niece or nephew.
- Any of the above relationships prefixed by grand, great or great-great.
- Stepparent.
- Sister or brother.
- Stepsister or stepbrother.
- First cousin.
- First cousin once removed (i.e., a first cousin's child).

A core relative may also include the spouse of any individual above, even after the marriage is ended by death or divorce. Core relatives include relationships established by adoption. The individual's statement regarding relationship, presence in the home and tax dependency is acceptable.

5.4 HOUSEHOLD COMPOSITION EXAMPLES

Kayla is a grandmother who claims her 20 year old daughter, Samantha and 2 year old granddaughter, Joy as tax dependents. Samantha is a full-time student. Kayla is the tax filer.

- Tax rules apply to all.
- Kayla's group is 3. Kayla, Samantha and Joy.
- Samantha's group is 3. Samantha, Kayla and Joy.
- Joy's group is 2, Samantha and Joy.

Bob and Mary are married. Mary is the mother of Jane, age 22. Jane attends college in Ohio. Bob is the tax filer and claims Mary and Jane as tax dependents.

- Tax rules apply to all.
- Group is 3 for all individuals.

CHAPTER 6-ASSETS

6.1 NO ASSET TEST REQUIRED

Assets are not considered in determining eligibility for MAGI related groups. Assets include cash, any other personal property and real property. Real property is land and objects affixed to the land such as buildings, trees and fences. Condominiums are real property. Personal property is any item subject to ownership that is not real property. Savings accounts and vehicles are examples of personal property. The asset limit for SSI-Related Medicaid categories did not change. See the Department of Human Services (DHS) Bridges Eligibility Manual (BEM) 400.

CHAPTER 7 INCOME

Modified adjusted gross income (MAGI) is a methodology for how income is counted and how household composition and family size are determined. It is based on federal tax rules for determining adjusted gross income. It eliminates asset tests and special deductions or disregards.

Every individual is evaluated for eligibility based on MAGI rules. The MAGI rules are aligned with the income rules that will be applied for determination of eligibility for premium tax credits and cost-sharing reductions through exchanges.

7.1 COUNTABLE INCOME SOURCES

The following are common sources of income which are countable in a MAGI related determination:

- Wages/Salary
- Self-Employment
- RSDI
- Pensions
- Unemployment Benefits
- Spousal Support

7.2 NON-COUNTABLE INCOME SOURCES

The following are common sources of income which are not countable in a MAGI related determination:

- Child Support
- Workers Compensation
- American Indian/Native American payments

- Veteran's Benefits such as:
  - Aid and attendance
  - Augmented compensation
  - Educational benefits
  - Housebound allowance
  - Unusual medical expenses
- Supplemental Security Income
- Adoption Subsidy
- Disaster Relief Payments

5% Disregard

- The 5% disregard is the amount equal to 5% of the Federal Poverty Level for the applicable family size.
- It is not a flat 5% disregard from the income.
- The 5% disregard shall be applied to the highest income threshold.
- The 5% disregard shall be applied only if required to make someone eligible for Medicaid.

Reasonable Compatibility

- Attested income will be found not reasonably compatible with income from trusted sources if the difference exceeds 10%.
- If the group's attested income is below the income threshold for the program being tested and trusted data source also validates income below the income threshold, the no reasonable compatibility test is performed. Applicant is eligible.
- If the group's attested income is above the income threshold for the program being tested but trusted data source finds income below the income threshold, then no reasonable compatibility test is performed, Applicant is not eligible based on attested income.
- If the group's attested income is above the income threshold for the program being tested and the trusted data source validates income above the income threshold, then no reasonable compatibility test is performed. Applicant is not eligible based on attested income.
- If the group's attested income is below the income threshold for the program being tested but the trusted data source indicates income above the income threshold, then reasonable compatibility test is performed:
- If income is reasonable compatible, then the applicant is eligible
- If the income is not reasonable compatible, then the program pends and the individual is required to provide proof of attested income.

CHAPTER 8 CHILD SUPPORT

8.1 CHILD SUPPORT

Parents have a responsibility to meet their children's needs by providing support and/or cooperating with the Office of Child Support (OCS) , the Friend of the Court (FOC) and the prosecuting attorney to establish paternity and/or obtain support from an absent parent.

Absent parents are required to support their children. Support includes child support, medical support and payment for medical care from any third party. A parent who does not live with the child due solely to the parent's active duty in a uniformed service of the U.S. is considered to be living in the child's home.

The custodial parent or caretaker of children must comply with all requests for action or information needed to establish paternity and/or obtain child support on behalf of children for whom they receive assistance, unless a claim of good cause for not cooperating has been granted or is pending.

8.2 COOPERATION

Cooperation is a condition of eligibility. The following individuals who receive assistance on behalf of a child are required to cooperate in establishing paternity and obtaining support, unless good cause has been granted or is pending:

- Head of household and spouse.
- Core relative/individual acting as a parent and spouse.
- Parent of the child for whom paternity and/or support action is required.

Cooperation is required in all phases of the process to establish paternity and obtain support. It includes all of the following:

- Contacting the support specialist when requested.
- Providing all known information about the absent parent.
- Appearing at the office of the prosecuting attorney when requested.
- Taking any actions needed to establish paternity and obtain child support (including but not limited to testifying at hearings or obtaining genetic tests).

8.3 GOOD CAUSE

Failure to cooperate without good cause results in disqualification. Disqualification includes member removal, as well as denial or closure of program benefits. Exceptions to the cooperation requirement are allowed for all child support actions except when the beneficiary fails to return assigned child support payments received after the support certification effective date.

Inform the individual of the right to claim good cause by giving them a DHS-2168, Claim of Good Cause - Child Support, at application, before adding a member and when an individual claims good cause. The DHS-2168 explains all of the following:

- The department's mandate to seek child support.
- Cooperation requirements.

- The positive benefits of establishing paternity and obtaining support.
- Procedures for claiming and documenting good cause.
- Good cause reasons.
- Penalties for noncooperation.
- The right to a hearing.

Grant good cause when both of the following are true: requiring cooperation/support action is against the child's best interests and there is a specific good cause reason.

There are two types of good cause:

1. Situations in which establishing paternity/securing support would harm the child.

Do not require cooperation/support action in any of the following circumstances:

- The child was conceived due to incest or forcible rape.
- Legal proceedings for the adoption of the child are pending before a court.
- The individual is currently receiving counseling from a licensed social agency to decide if the child should be released for adoption, and the counseling has not gone on for more than three months.

2. Situations in which there is danger of physical or emotional harm to the child or individual.

Physical or emotional harm may result if the individual or child has been subject to or is in danger of:

- Physical acts that resulted in, or threatened to result in, physical injury.
- Sexual abuse.
- Sexual activity involving a dependent child.
- Being forced as the caretaker relative of a child to engage in non-consensual sexual acts or activities.
- Threats of, or attempts at, physical or sexual abuse.
- Mental abuse.
- Neglect or deprivation of medical care.

When an individual claims good cause, the specialist and the individual must sign the DHS-2168. The individual must complete Section 2, specifying the type of good cause and the individual(s) affected. Provide a copy of the completed DHS-2168 to the individual.

To prevent any support action while the good cause claim is pending, enter good cause status and claim date in the absent parent logical unit of work and file the DHS-2168 in the case within two working days of completion. A claim may be made at any time. The specialist is responsible for determining if good cause exists. Do not deny an application or delay program benefits just because a good cause claim is pending.

A good cause claim must do all of the following:

- Specify the reason for good cause.
- Specify the individuals covered by it.
- Be supported by written evidence or documented as credible.
- Request the individual provide evidence of good cause within 20 calendar days of the claim. Allow an extension of up to 25 calendar days if the individual has difficulty in obtaining the evidence.

Assist individuals in obtaining written evidence if needed. If written evidence does not exist, document why none is available and determine if the claim is credible.

A credibility determination is based on the available information. Include individual statement and/or collateral contacts with individuals who have direct knowledge of the situation.

Verification of good cause due to domestic violence is required only when questionable.

Make a good cause determination within 45 calendar days of receiving a signed DHS-2168 claiming good cause. The Office of Child Support (OCS) can review and offer comment on the good cause claim before a determination is made. The 45-day limit may only be exceeded if all of the following apply:

- The individual was already granted an additional 25-day extension to the original 20-day limit.
- More information is needed that cannot be obtained within the 45-day limit.
- Supervisory approval is needed.
- Extensions must be documented in the case record.

One of three findings is possible when making a determination:

- Approved - Continue with Child Support Action.
- Court order is already established and individual participation is no longer necessary to pursue support.
- Approved - Discontinue or do not initiate Child Support Action. This applies when there is a risk to the child or custodial parent/caretaker or there is an existing child support order.
- Denied - Good cause does not exist. This applies if the family does not present criteria that meet the definition of good cause or there was no convincing evidence of risk.

All good cause determinations must be:

- Approved by a supervisor.
- Reviewed at every redetermination if subject to change.
- Documented on the DHS-2169, Notice of Good Cause Finding - Child Support/Third Party Liability, a copy must be placed in the case record.
- Entered in the absent parent logical unit of work to include status, claim date, and begin date when approved. An end date is entered when applicable.

Support Specialists work for the OCS to support families by:

- Accepting referrals/applications for child support services on behalf of public assistance recipients, as well as from the general public.
- Obtaining absent parent information from individuals.
- Reviewing and offering comment on good cause claims.
- Attending pre-hearing conferences and administrative hearings in support of OCS actions.
- Determining cooperation and non-cooperation.
- Referring appropriate cases to the local prosecutor or the Friend of the Court (FOC).

The good cause claim should be entered within two working days of the individual's claim. No support action or contact with the individual will be initiated while the good cause claim is pending. Consider the support specialist recommendation even though it is not binding. Consider the recommendation especially when determining if support action can proceed without the individual's cooperation without resulting in physical or emotional harm to the child or caretaker.

Refer unmarried children who have no legal father or who have a legal parent absent from the home to the OCS for child support action.

The following children are not referred to OCS:

- Children whose absent parent is deceased.
- Children adopted by a single parent only.
- Teen and minor parents with an adult participation status.
- Children not living with a core relative.

The support specialist will not take action on deductible cases until after certification of the first period of Medicaid coverage. Cooperation is required for an individual who is a deductible beneficiary once the first period of Medicaid coverage is authorized. This requirement continues as long as the individual is active and includes periods for which Medicaid coverage is not authorized.

The support specialist determines cooperation for required support actions. The date the beneficiary fails to cooperate will be populated in the absent parent logical unit of work and negative action is applied automatically. Cooperation is assumed until negative action is applied as a result of non-cooperation being entered. The non-cooperation continues until a comply date is entered by the primary support specialist or cooperation is no longer an eligibility factor. The comply date will be populated in the absent parent logical unit of work and the mandatory member will be added to active Medicaid automatically.

8.4 NON-COOPERATION

The support disqualification begins when a date of non-cooperation is entered and there is no pending or approved good cause. The disqualification is not imposed if any of the following occur on or before the timely hearing request date:

- OCS records the date the individual complied.
- The coverage ends for another reason.
- The non-cooperative beneficiary leaves the group.

- Support/paternity action is no longer a factor in the child's eligibility (for example, the child leaves the group).
- Beneficiary requests an administrative hearing.

At application, an individual has ten (10) days to cooperate with the OCS. Inform the individual to contact OCS. The disqualification is imposed if the individual fails to cooperate on or before the due date when all of the following are true:

- There is a begin date of non-cooperation and no subsequent comply date.
- Support/paternity action is still a factor in the child's eligibility.
- Good cause has not been granted nor is a claim pending.

Inform the individual that the disqualification will be imposed unless a comply date is received from the support specialist. Encourage the individual to cooperate with the support specialist and discuss any consequences of the non-cooperation. Promptly refer individuals who indicate a willingness to cooperate to the support specialist.

A support specialist may be reached at 1-866-540-0008 or 1-866-661-0005 to evaluate the individual's cooperation status.

8.5 DISQUALIFICATION

Failure to cooperate without good cause results in member disqualification. The adult member who fails to cooperate is not eligible for Medicaid when both of the following are true; 1) the child for whom support/paternity action is required receives Medicaid. 2) The individual and child live together.

Do not begin or continue a disqualification for failure to cooperate during pregnancy when a woman meets all other eligibility factors or up to two months post-partum.

The child's Medicaid eligibility is not affected by the adult member's disqualification. The adult member's Medicaid must have an ex-parte review before closure because of a failure to cooperate.

8.6 REMOVING A DISQUALIFICATION

Ask a disqualified individual at application, renewal or reinstatement if they are willing to cooperate. A disqualified member may indicate willingness to cooperate at any time. Immediately inform individuals willing to cooperate to contact the primary worker or the support specialist.

Do not restore or reopen benefits for a disqualified member until the individual cooperates (as recorded on the child support non-cooperation record) or support/paternity action is no longer needed. End the non-cooperation record if either of the following exists:

- OCS records the date the individual complied, or
- Support/paternity action is no longer a factor in the child's eligibility.

The coverage of the disqualified individual is restored beginning with the month of cooperation.

Child support is certified (sent to the state) when it is paid for a period of time an individual was a dependent receiving Medicaid. This is reimbursement for the Medicaid expenditures.

Support certification will occur automatically based on completion of a referral to the OCS when Medicaid eligibility is certified.

The support certification effective date is based on the initial eligibility date and if direct child support was included in the initial eligibility determination. When direct child support is not included in the initial eligibility determination, the certification is effective when eligibility begins. When direct child support is included in the initial eligibility determination, certification is effective the first of the original ongoing month.

8.7 VOLUNTARILY ESTABLISH PATERNITY

Parents who wish to voluntarily establish paternity must complete form DCH-0682, Affidavit of Parentage. Give these individuals the DCH-0682 and the instructions for completion. Individuals may complete the affidavit in the local office, may take it with them for completion, and/or may seek assistance from the support specialist.

It is critical that parents are provided with sufficient information on the paternity acknowledgement process. If assisting individuals in completing the affidavit, be sure to review the consequences, rights and responsibilities of acknowledging paternity that are listed on the DCH-0682.

Individuals with technical questions about paternity or child support may be referred to the support specialist. Signatures of both parents on the affidavit must be notarized.

CHAPTER 9 SPOUSAL SUPPORT

9.1 SPOUSAL SUPPORT

If a married individual does not live with the individual's spouse, a referral to the local county prosecutor may be necessary to establish the absent spouse's responsibility for financial support. If the absent spouse is also the parent of a group member under age 18, a child support referral is necessary.

9.2 REFERRAL TO COUNTY PROSECUTOR

Refer appropriate cases to the county prosecutor under locally established procedures when he has indicated he will take action under the Poor Law or Status of Minors Act.

Make the referral within 14 days of opening a case or whenever a referral is required.

Make a referral:

- When an eligible group member and spouse do not live together and the absent spouse is not the parent of a group member under age 18.

Do not make a referral when the absent spouse/parent:

- Is complying with a current probate court order for support.
- Is the parent of a group member under age 18 who has been referred for support action.
- Currently receives public assistance.
- Is required to support the recipient spouse via a circuit court order.

A Medicaid applicant's absent spouse's assets, excluding his home, household goods, personal goods and one vehicle, is $104,400 or less and his gross annual income is $31,320 or less.

When a community spouse has more than $2,610 per month income ($31,320 per year) and/or $104,400 in assets due to a court order or a hearing decision under the spousal impoverishment provisions of section 1924 of the Social Security Act.

A Medicaid beneficiary's absent spouse's gross annual income is $31,320 or less.

Take the following actions when a referral has been made:

- Assume court action is inadvisable and stop the process if there is no reply from the prosecutor's office after 30 days.
- Obtain any additional information about the absent spouse if requested.
- Initiate a Poor Person's petition in the county probate court if court action is recommended by the prosecutor's office.
- Budget any resulting court ordered spousal support received by the group as unearned income.

The spouse/minor in the group is ineligible if the individual refuses to provide information about an absent spouse/parent or cooperate with the prosecutor.

CHAPTER 10 PRESUMPTIVE ELIGIBILITY

10.1 HOW TO APPLY

A streamlined electronic application is used to determine presumptive eligibility. Information on the presumptive application will be self-attested, without the need for verification.

10.2 ELIGIBILITY FOR PRESUMPTIVE

Presumptive eligibility is determined based on gross income reported at the time of application. Presumptive eligibility will be determined for a pregnant woman and children whose application is filed online, by a trained qualified entity.

Qualified entities include local health departments, hospitals, and tribal health facilities operated by the Indian Health Services trained and authorized by Department of Community Health (DCH) to process applications.

10.3 EFFECTIVE DATE

Presumptive eligibility is effective the date the eligibility is determined by the qualified entity. Presumptive eligibility ends when ongoing eligibility becomes effective or if a full application is not received.

A complete eligibility determination must be made within 60 days of the date of the presumptive eligibility determination.

Presumptive eligibility is limited to one period of eligibility during any consecutive 12 month period.

CHAPTER 11 RENEWALS

11.1 REQUIRED ANNUALLY

A thorough evaluation of eligibility is required at least every 12 months. An in person interview is not required.

11.2 RENEWAL PACKET

A renewal packet is sent to the individual three days prior to the negative action cut-off date in the month before the renewal is due. This allows time to process the renewal before the end of the renewal month. Verifications are due the same date as the renewal packet.

An individual is provided a full ten (10) calendar days from the date the verification is requested (date of request is not counted) to provide all documents and information. If the 10th day falls on a weekend or holiday, the verification would not be due until the next business day.

Timely notice of the negative action is required if the time limit is not met.

11.3 VERIFICATIONS

Renewals must use all pertinent existing information available for an individual to attempt to automatically renew eligibility. Verification must not be requested from the individual if that information is available in the State of Michigan systems.

Only information that has changed or is missing may be requested from the individual. Correspondence must indicate what information was utilized in making the eligibility renewal decision.

11.4 EX-PARTE

An ex parte review is required before Medicaid closures when there is an actual or anticipated change, unless the change would result in closure due to ineligibility for all Medicaid. When possible, an ex parte review should begin at least 90 days before the anticipated change is expected to result in case closure. The review includes consideration of all categories.

When the ex parte review shows that an individual does have eligibility for Medicaid under another category, change the coverage.

When the ex parte review shows that an individual may have continuing eligibility under another category, but there is not enough information in the case record to determine continued eligibility, send a verification checklist (including disability determination forms as needed) to proceed with the ex parte review. If the individual fails to provide requested verification or if a review of the information provided establishes that the individual is not eligible under any Medicaid category, send timely notice of Medicaid case closure.

When the ex parte review suggests there is no potential eligibility under another MA category, send timely notice of Medicaid case closure.

When it is determined that an individual will no longer meet the eligibility criteria for MAGI related Medicaid, because of an actual or anticipated change, determine whether the individual has indicated or demonstrated a disability as part of the ex parte review.

If the ex parte review reveals the individual has already been determined disabled for purposes of qualifying for a disability based Medicaid eligibility category, by the SSA or the department, and the determination is still valid, continue the individual's Medicaid eligibility under the disability based Medicaid category for which the individual is otherwise eligible.

- If, during the ex parte review it is determined an individual has indicated or demonstrated a disability, request from the individual additional information needed to proceed with a disability determination. Pending the determination, continue the individual's Medicaid coverage.
- If the individual fails to provide the information requested after being given a reasonable opportunity to do so, and eligibility under all other categories has been ruled out, send timely notice of Medicaid case closure indicating the individual is not eligible for disability based Medicaid as well as MAGI related categories.
- If, following the disability determination process, the individual is determined to not be disabled for purposes of qualifying for disability based Medicaid categories and eligibility under all other categories has been ruled out, send timely notice of Medicaid case closure indicating the individual is not eligible for disability based Medicaid as well as MAGI related categories.
- If, following the disability determination process, the individual is determined disabled for purposes of qualifying for disability based Medicaid categories, continue the individual's Medicaid coverage under the disability based Medicaid category for which the individual is otherwise eligible.

Medicaid coverage will continue until the individual no longer meets the eligibility requirements for any other Medicaid category.

11.5 REINSTATEMENT

If a renewal results in a closure, the individual must be provided a notice that indicates what information was used to reach the decision of ineligibility. An individual has 90 days to submit documentation that the information used was not accurate. Coverage must be reinstated in this instance.

CHAPTER 12 VERIFICATIONS

12.1 SELF-ATTESTATION

Self-attestation is acceptable for most eligibility factors. Citizenship, social security numbers and lawful presence require documentation.

Sources available to the state, i.e., SSA, SAVE, DCH vital records must be utilized first before requesting documentation from the individual.

12.2 DOCUMENTATION

When electronic verification is not successful, documentation may not be requested of an individual for whom documentation does not exist or is not reasonably available at the time of an application or renewal. Such circumstances include, but are not limited to, individuals who are homeless and victims of domestic violence or natural disasters.

12.3 PREGNANCY

Self-attestation of pregnancy is acceptable unless the information is not reasonably compatible with other information in SOM files.

CHAPTER 13 HEARINGS

13.1 NOTICE OF CASE ACTION

Individuals have the right to contest a department decision affecting Medicaid eligibility whenever they believe the decision is incorrect, or when their application is not acted upon with reasonable promptness. The department, through the Michigan Administrative Hearings System (MAHS), provides an administrative hearing to review the decision and determine appropriateness of the department's decision. This item includes procedures to meet the requirements for a fair hearing as defined by the Code of Federal Regulations (CFR). All protections of and individual's health, public welfare, and federal tax information afforded under the law must be followed throughout the hearings process; from notice of case action through conduct of the hearing and issuance of decision.

For all case actions affecting an individual's Medicaid eligibility, the department must provide a written notice of case action to the individual. When a case action is completed the notice must specify:

- The action being taken by the department.
- The reason(s) for the action.
- The specific manual item(s) that cites the legal base for an action, and the regulation and law itself.

The application forms and each written notice of case action must inform individuals of their right to a hearing. These include an explanation of how and where to file a hearing request, and the right to be represented.

Do not provide a notice of case action when implementing a hearing decision or policy hearing authority decision. The hearing decision serves as notice of the action by anyone the individual chooses.

13.2 REQUESTING A HEARING

The individual whose Medicaid eligibility was affected holds the right to request a hearing. The following people have authority to exercise this right on the behalf of the individual by signing the hearing request:

The individual's;

- legal guardian
- attorney at law
- parent
- spouse

A request for a hearing must be made in writing and signed by one of the persons listed above. The request must bear a signature. Faxes or photocopies of signatures are acceptable.

The DHS-18, Request for Hearing, or the hearing request section of the individual notice may be used. Note the date of receipt of the original written request on the form or notice.

The Michigan Administrative Hearings System (MAHS) will deny requests signed by unauthorized persons and requests without signatures. MAHS will deny a hearing request when the required verification is not submitted.

The following documents are acceptable sources to verify that a person has the legal authority to sign a hearing request on behalf of another individual:

- Probate court order or court-issued letters of authority naming the person as guardian.
- Appearance from attorney verifying the person is a client.
- Authorization signed by the individual authorizing this person to represent the individual in the hearing process.
- Birth or marriage certificate naming the individual as parent or spouse.

Note any known information about the identity of the person who signed the request (for example, a spouse) on the DHS-3050, Hearing Summary. Attach a copy of any required verification document to the DHS-3050 and forward to MAHS.

MAHS will deny a hearing request when the required verification is not submitted. Note on the hearing summary if verification is not submitted or is questionable. Process requests signed by someone whose authorized hearing representative status is questionable or unverified according to standard hearings procedures, including restoration of benefits, if appropriate. If MAHS denies the request, implement the disputed case action and recoup the restored benefits.

At the time of submitting the hearing request or after, an individual may designate an authorized hearing representative (AHR) to stand in for or represent them for the rest of the hearing process. The appointment of an authorized hearing representative must be made in writing by the individual.

MAHS may grant a hearing about any of the following:

- Denial of an application.
- Reduction in the amount of program benefits or service.
- Suspension or termination of program benefits or service.
- Restrictions under which benefits or services are provided.
- Delay of any action beyond standards of promptness.

13.3 RESPONSIBILITY FOR PROCESSING A HEARING REQUEST

The processing of the hearing request is the responsibility of the local DHS office.

Instruct individuals or authorized hearing representatives to deliver, mail, or fax the hearing request to their local DHS office. The request should be labeled: “Attention Hearings Coordinator”. The hearings coordinator at the local DHS office receives the request on behalf of the department. Route all hearings-related material through the coordinator without regard to whom the material is addressed.

All hearings requests received at the local DHS office must be date-stamped and forwarded immediately to the hearings coordinator. If the hearing request is received by a local office that is not responsible for the disputed action, date-stamp the request and forward it immediately to the correct local office.

The individual or authorized hearing representative has 90 calendar days from the date on the written notice of case action to request a hearing. Days, as used in this item, mean calendar days unless otherwise specified.

See Timely Hearing Request in this item if a request is received within the pended negative action period or within 11 days of the effective date of an immediate negative action.

For requests that do not meet the definition of a timely hearing request; see Untimely Hearing Request in this item.

Only MAHS may deny a request for a hearing. Accept, process, and forward all hearing requests to MAHS.

For all inappropriate requests and/or requests filed more than 90 days from the date of the notice of case action, do the following: Complete a DHS-3050, Hearing Summary, stating why the request should not be heard; for example: the request was received after 90 days from the date of the notice of case action (attach a copy of the notice). Forward the hearing request and the summary to MAHS.

MAHS will inform the individual (referred to by administrative hearings as the claimant), the AHR and the hearings coordinator if the request is denied.

MAHS will not grant a hearing regarding the issue of a mass update required by state or federal law unless the reason for the request is an issue of incorrect computation of program benefits or patient-pay amount. Central office may issue separate instructions regarding deletion of pending negative actions and forwarding of hearing requests to MAHS for disposition.

Final action on hearing requests, including implementation of the decision and order (D & O), must be completed within 90 days. The standard of promptness begins on the date the hearing request was first received by any local DHS office.

The local DHS office has 15 days from receipt of hearing request to do all of the following:

- Log the request.
- Contact the individual or authorized hearing representative.
- Arrange a prehearing conference with all appropriate staff.
- Obtain and submit to MAHS verification of the authorized hearing representative's prior authorization, if needed.
- Forward the request with a DHS-18A, Hearing Request Withdrawal, or a DHS-3050.

A DHS-1940, Hearing Request Record, or its equivalent must be maintained by the hearings coordinator. The coordinator is responsible for tracking the progress of the hearing request from receipt through disposition.

A copy of the hearing request record must be made available to the region or central office upon request.

13.4 RESOLVING ISSUES PRIOR TO HEARING

Resolve disagreements and misunderstandings quickly at the lowest possible level to avoid unnecessary hearings. The department's efforts to clarify and resolve the individual's concerns must start when the hearing request is received and continue through the day of the hearing.

Upon receipt of a hearing request, determine the nature of the complaint schedule a prehearing conference with the individual or authorized hearing representative and conduct a supervisory review.

The individual or authorized hearing representative is not required to phone or meet with any Department staff in order to have a hearing. Any notice of prehearing conference must explain this.

PREHEARING CONFERENCE

The department must assure that individuals receive the services and assistance to which they are entitled. Concerns expressed in the hearing request should be resolved whenever possible through a conference with the individual or authorized hearing representative rather than through a hearing. The pre-hearing conference must be held and if possible within the 15-day prior to forwarding the request and pre-hearing summary to MAHS.

Prehearing conference for Medicaid ineligibility determinations made through the local DHS office or individual requests hearing through his or her local DHS office:

The spokesperson for the local office at the prehearing conference may be anyone from the county director to a first-line supervisor. Whoever is assigned this function, however, acts on behalf of the county director.

A DHS-1560, Prehearing Conference notice must be generated and mailed to the individual or authorized hearing representative upon receipt of a hearing request.

A formal prehearing conference must take place as soon as possible after the local office receives the request unless, the individual or authorized hearing representative chooses not to attend the prehearing conference; or a conference was held prior to receipt of the hearing request, and the issue in dispute is clear, and DHS staff fully understand the positions of both the department and the individual.

All appropriate staff must be consulted before the prehearing conference and should attend, as necessary. When the disputed case action involves a Medicaid ineligibility determination solely based on MAGI financial information, DHS local office staff must participate in the prehearing conference.

Prehearing conference for Medicaid ineligibility determinations made through the online portal:

A DHS-1560, telephone Prehearing Conference notice must be generated and mailed to the individual or authorized hearing representative upon receipt of a hearing request. A formal telephone prehearing conference must take place as soon as possible after the request is received. If the individual requests an in-person prehearing conference, schedule a prehearing conference at the local DHS office closest to the individual's residence.

Do all of the following at the prehearing conference:

- Determine why the individual or authorized hearing representative is disputing the DHS action.
- Review any documentation the individual or authorized hearing representative has to support his allegation.
- Explain the department's position and identify and discuss the differences.
- Determine whether the dispute can be resolved locally or requires MAHS to resolve.
- Mention to individuals the availability of reimbursement for child care or transportation costs incurred in order to attend the hearing.

HEARING SUMMARY

Complete a DHS-3050, Hearing Summary, if the dispute is not resolved at a prehearing conference. In the event additional space is required to complete the DHS-3050, Hearing Summary, attach a word document to the DHS-3050 and number the word document accordingly.

The narrative must include all of the following:

Clear statement of the case action, including all programs involved in the case action.

- Facts which led to the action.
- Policy which supported the action.
- Correct address of the AHR or, if none, the individual.
- Description of the documents the local office intends to offer as exhibits at the hearing.

Attach a copy of any documents used in reaching the Medicaid eligibility determination. Number the documents in the bottom right hand corner of each page, as proposed exhibits to offer into evidence at hearing. The hearing summary and attached documents must be provided to the individual prior to or at the time it is forwarded to MAHS.

ADMINISTRATIVE REVIEW

The local office manager or designee must review all hearing requests which are not resolved by the first-line supervisor. The purpose of the review is to assure that local office staff has done the following:

- Applied DHS policies and procedures correctly.
- Explained DHS policies and procedures to the AHR or, if none, the individual.
- Explored alternatives.
- Offered appropriate referrals to the individual.
- Considered requesting a central office policy clarification or policy exception, if appropriate.

The local office manager or designee must evaluate the advisability of a hearing in relation to such factors as intent of policy, type of issue(s) raised, strength of the department's case, and administrative alternative.

The local office manager is accountable for the decision that a hearing request cannot be resolved except through formal hearing.

The administrative review does not replace the hearing process. The hearing must be held as scheduled unless the department deletes the negative action or the individual or authorized hearing representative withdraws the hearing request.

The individual is not entitled to benefits pending the hearing when the reason for the hearing request is a denial at application.

TIMELY HEARING REQUESTS

A timely hearing request is a request received anywhere in the department within 11 days of the effective date of a negative action. When the 11th calendar day is a Saturday, Sunday, holiday, or other non-workday, the request is timely if received by the following workday.

While waiting for the hearing decision, recipients must continue to receive the assistance authorized prior to the notice of negative action when the request was filed timely. Upon receipt of a timely hearing request, reinstate program benefits to the former level for a hearing request filed because of a negative action.

Do not restore benefits reduced or terminated due to a mass update required by state or federal law unless the issue contested is that the benefits were improperly computed.

Do not restore program benefits when the AHR or, if none, the recipient specifically states in writing that continued assistance pending the hearing decision is not requested.

UNTIMELY HEARING REQUESTS

If an AHR or, if none, an individual files an untimely hearing request, program benefits continue at the current level.

CHANGES PRIOR TO HEARING

Pending the hearing decision, restored benefits must not be reduced or terminated unless a change not related to the hearing issue occurs that affects the recipient's eligibility or benefits; and the AHR or, if none, the recipient fails to request a hearing about the change after the subsequent notice of negative action.

RECOUPMENT

If a hearing request is filed timely and program benefits are restored, recoup over issuances if:

- The request is later withdrawn.
- MAHS denies the request.
- The individual or authorized hearing representative fails to appear for the hearing and MAHS gives you written instructions to proceed. If instructions have not arrived within two weeks, call the MAHS office in Lansing.
- The hearing decision upholds the department's action.

Calculate the over issuance from the date the negative action would have taken effect until the date the negative action is subsequently implemented.

If an administrative recoupment is processed to recover an over issuance due to a hearing, send a timely notice of case action. In this situation, the individual is entitled to a hearing solely on the issue of the recoupment amount.

WITHDRAWALS

When any issue is still in dispute, mail a withdrawal form to the individual or authorized hearing representative if it is requested.

When correcting a case action, follow procedures in the corrected case action section. Do not ask for a withdrawal based on an action that will be taken in the future.

When the individual's AHR requested a hearing on behalf of the individual, the individual may not withdraw the hearing request without first providing the department with a written, signed notice stating he/she wishes to revoke the AHR's authorization to represent the individual

The authorization to represent must be revoked by the individual before signing the DHS-18A, Hearing Request Withdrawal.

MAHS will not accept a withdrawal if it fails to adequately address and dispose of all concerns in the hearing request. MAHS will not accept a withdrawal based on an action that will be taken in the future. MAHS will notify the hearings coordinator, individual and AHR if a withdrawal is not accepted.

When all issues are resolved and the individual or authorized hearing representative wishes to withdraw the request, ask for a signed, written withdrawal. The DHS-18A, Hearing Request Withdrawal, may be used for this purpose. After resolved, do not forward the request for hearing without asking for a withdrawal.

The withdrawal must clearly state why the individual or authorized hearing representative has decided to withdraw the request. Enter all identifying case information on the withdrawal, attach the original copy to the request and forward them to MAHS. Retain a copy of the withdrawal.

When an individual comes to the local office for a hearing and while at the local office decides to withdraw the request, contact MAHS and allow the assigned ALJ the opportunity to discuss the withdrawal with the AHR, or if none, the individual.

EVIDENCE

Individuals and AHRs have the right to review the case record and obtain copies of needed documents and materials relevant to the hearing. Send a copy of the DHS-3050 and all documents and records to be used by the department at the hearing to the individual and AHR. DHS-4772, Hearing Summary Letter, may be used for this purpose.

Do not disclose the identity of any person who has reported information relating to an alleged program violation. DHS cannot provide access to case records restricted by law or specific orders of a court. Access to certain mental health records is restricted.

SUBPOENAS

Request a subpoena if the specialist, the individual or authorized hearing representative requires a person outside DHS to come to a hearing to testify; or a document from outside DHS to be offered as evidence at a hearing.

Send a memo requesting the subpoena to MAHS. Attach a copy of the notice of hearing (or other indication of date, time and place of hearing) if available. Allow adequate time to mail or hand-deliver the subpoena. The memo must include all of the following:

- Name and address of the person whose testimony is required.
- The specific document that is to be subpoenaed.
- Why the person's presence and/or the document are needed at the hearing, and cannot be provided by another means.
- How the person's testimony or the document relates to the hearing issue.

The requester is responsible for serving the subpoena and must pay the attending witness $12 per day or $6 per half-day plus the state travel rate per mile from and to the person's residence in Michigan.

DHS employees are expected to participate in hearings without a subpoena when their testimony is required. If the specialist, the individual or authorized hearing representative requests that a DHS employee (for example, from another county or central office) participate in the hearing and that participation cannot be arranged, send a memo to MAHS giving all of the following:

- The name and location of the employee.
- Why the employee's participation is needed.
- How the employee's testimony relates to the hearing issue.

MAHS will decide whether to require the employee's participation.

A hearing will take place if the local office and the individual or authorized hearing representative, have been unable to resolve the issue(s) which prompted the hearing request.

13.5 CONDUCT OF HEARING

The Michigan Administrative Hearing System (MAHS) conducts administrative hearings regarding MAGI determinations.

The MAHS authority includes:

- Granting/denying a hearing request.
- Scheduling/rescheduling the hearing.
- Notifying all parties of the time/place of the hearing.
- Granting/denying requests for in-person hearings.
- Granting/denying requests for adjournments.
- Issuing administrative subpoenas.

- Reimbursing individuals for hearings-related expenses.
- Holding the hearing.
- Issuing a decision and order.
- Granting/denying a rehearing/reconsideration request.

EXPEDITED HEARINGS

Request an expedited hearing when unusual circumstances exist, for example, the health and safety of the individual is at risk. A local office supervisor or hearings coordinator may request an expedited hearing by calling the MAHS director or designee.

Do all of the following within two workdays of receiving the hearing request: complete the DHS-3050. Include an explanation about why an expedited hearing is needed. Write "Expedited Hearing" at the top of the hearing request. Forward the hearing request and the summary to MAHS. The hearing itself is conducted in the same manner as any other hearing.

POSTPONEMENTS

The individual, authorized hearing representative, or local office may request a postponement (also called adjournment) of a scheduled hearing. Instruct the individual or authorized hearing representative to call MAHS to request a postponement. Only MAHS can grant or deny a postponement. MAHS will notify the hearings coordinator if the postponement is granted. When the hearing is rescheduled, a new DHS-26A, Notice of Hearing, is mailed to everyone who received the original notice.

If the postponement is granted at the request of the individual or authorized hearing representative the standard of promptness is extended for as many days as the hearing is postponed. However, postponement of a telephone hearing to schedule an in-person hearing does not extend the standard of promptness.

Postponements requested by the local office and MAHS postponements do not extend the standard of promptness.

For Medicaid ineligibility determinations made through the local DHS office or if the online determination individual requests a hearing at his or her local DHS office:

DHS local office staff will do all of the following:

- Complete the hearing summary.
- Notify the individual/representative, MAHS, other department staff and local DHS if all issues in the hearing request are resolved prior to the hearing.
- Arrange the prehearing conference.
- Make available to the client prior to hearing, any documents used to make the determination.
- Provide a room for the hearing.
- Escort the individual to the hearing room.
- Telephone MAHS at (877)833-0870 to begin a telephone hearing.
- Represent the department at the hearing.

- Implement MAHS D&O and notify the individual/ representative, other department staff and local DHS within prescribed time frames.

For Medicaid ineligibility determinations made through the online portal:

MAHS will issue a notice of 3-way hearing. The notice will inform that the individual and the local DHS office that the administrative law judge will call them at the telephone numbers provided on the request for hearing and the DHS 3050 hearing summary. The notice will inform both parties that documents they intend to offer at the telephone hearing should be mailed to MAHS at least a week prior to the hearing.

The DHS office staff is responsible for:

- Arranging the telephone prehearing conference, and
- Completing the hearing summary. The DHS 3050 must include a current phone number for the individual, as well as the number for the state hearing representative when the hearing file is submitted to MAHS. A copy of the hearing summary must be provided to the individual at the same time it is forwarded to MAHS.
- In the event a DHS individual does not have a phone this must be noted on the DHS 3050 Hearing Summary with a DHS local office identified where the hearing will take place.
- Notifying the individual/representative, MAHS, other department staff and local DHS if all issues in the hearing request are resolved prior to the hearing.
- Representing the state at the hearing.
- Implementing MAHS D&O and notify the individual/ representative, other department staff and local DHS within prescribed time frames.

MAHS must give ten days advance written notice of the time, date, and place of the hearing. However, the individual or authorized hearing representative may request less advance notice to expedite the hearing.

Individuals have the right to all of the following:

- Representation by legal counsel, or other person of choice, at the individual's expense.
- Barrier-free access to the hearing site.
- Interpreters arranged by and covered by the local DHS office.
- Child care and transportation costs as necessary to ensure that full participation in the hearing process is possible.

REIMBURSEMENT FOR TRANSPORTATION AND CHILD CARE

Individuals may request reimbursement of transportation and child care costs at the hearing. Individuals must make the request on the hearing record and provide the ALJ the following information: their name and address, for transportation expense reimbursement, the number of miles traveled round-trip for the hearing. For child care expense reimbursement, the provider type (for example, child care center) and a signed and dated receipt from the provider showing the full names and ages of all children for who care was provided.

MAHS will issue the reimbursements when the total combined cost exceeds $3.

TELEPHONE HEARINGS

MAHS schedules a hearing for which the ALJ appears by telephone for most cases. However, at the request of the AHR or, if none, the individual, MAHS must schedule an in-person hearing. In exceptional circumstances the local office may request an in-person hearing by calling MAHS and explaining the reason for the request.

REQUESTS FOR IN-PERSON HEARINGS

The individual or authorized hearing representative may indicate in the hearing request the desire for an in-person hearing. The DHS-26A, Notice of Hearing, also instructs the individual or authorized hearing representative to call MAHS to request an in-person hearing.

In-person hearings are conducted in the local office that serves the individual, or the county office in which the individual resides.

LATE ARRIVAL FOR THE HEARING

Hearings will be held on the scheduled date if the individual or authorized hearing representative arrives within 30 minutes of the scheduled time.

If the individual or authorized hearing representative arrives more than 30 minutes late, do not send the person away. Immediately call MAHS for direction on how to proceed. Whenever possible, the hearing will be held on the scheduled date.

FAILURE TO APPEAR FOR THE HEARING

Contact MAHS if the individual or authorized hearing representative does not appear for the hearing within 30 minutes of the scheduled time. Do not take negative action until written authorization from MAHS has been received. If the individual or authorized hearing representative later contacts DHS to have the hearing rescheduled, tell the person to: write MAHS at P.O. Box 30639, Lansing, MI, 48909-8139; or call MAHS at the toll-free number included on the DHS-26A.

PERSONS AT THE HEARING

An AHR may appear at the hearing with or without the individual. A support person may be present if the individual states on the record that the person's presence is requested.

PRESENTATION OF THE CASE

The local office and individual or authorized hearing representative will each present their position to the ALJ, who will determine whether the actions taken by the local office are correct according to fact, law, policy, and procedure. For local office Medicaid eligibility determinations, the individual or authorized hearing representative and local office staff will be together in the hearing room and will speak into a speaker telephone. The ALJ will be on the other end of the phone line.

Following the opening statement(s), if any, the ALJ directs the local office representative/case presenter to explain the position of the local office. The hearing summary, or highlights of it, may be read into the record at this time. The hearing summary may be used as a guide in presenting the evidence, witnesses and exhibits that support the department's position.

Always include the following in planning the case presentation:

- An explanation of the action(s) taken.
- A summary of the policy or laws used to determine that the action taken was correct.
- Any clarifications by central office staff of the policy or laws used.
- The facts which led to the conclusion that the policy is relevant to the disputed case action.
- The DHS procedures ensuring that the individual received adequate or timely notice of the proposed action and affording all other rights.
- The documents which support the facts and compliance with the DHS procedures.

Both the state and the individual or authorized hearing representative must have adequate opportunity to present the case, bring witnesses, establish all pertinent facts, argue the case, refute any evidence, cross-examine adverse witnesses, and cross-examine the author of a document offered in evidence.

ADMISSION OF EVIDENCE

The ALJ will follow the same rules used in circuit court to the extent these rules are practical in the case being heard. The ALJ must ensure that the record is complete, and may do the following:

- Take an active role in questioning witnesses and parties.
- Be more lenient than a circuit court judge in deciding what evidence may be presented.
- Refuse to accept evidence that the ALJ believes is:
  - Unduly repetitious.
  - Immaterial.
  - Irrelevant.
  - Incompetent.

Either party may state on the record its disagreement with the ALJ's decision to exclude evidence and the reason for the disagreement; and object to evidence the party believes should not be part of the hearing record.

The ALJ may allow written documents to be admitted in place of oral testimony if the ALJ decides this is fair to both sides in the case being heard.

Federal tax information (FTI) is safeguarded from disclosure by federal Internal Revenue Service rules. An affidavit by the eligibility specialist, attesting to the MAGI database determination of ineligibility, is sufficient to establish that ineligibility was based on the individual's MAGI. The individual's specific federal tax information (FTI) need not be presented as evidence during the hearing. FTI is not required at hearings for Medicaid ineligibility based on reasons other than MAGI.

When refusing to admit evidence, the ALJ must state on the record the nature of the evidence and why it was not admitted.

HEARING DECISIONS

The ALJ determines the facts based only on evidence introduced at the hearing, draws a conclusion of law, and determines whether DHS policy was appropriately applied. The ALJ issues a final decision unless the ALJ believes that the applicable law does not support DHS policy or DHS policy is silent on the issue being considered. In that case, the ALJ recommends a decision and the policy hearing authority makes the final decision.

MAHS mails the final hearing decision to the individual, the AHR and the local office. In most cases, the individual has the right to appeal a final decision to circuit court within 30 days after that decision is received.

MAHS has 65 days to schedule and conduct a hearing, render a decision and mail it to the local office, the individual and the authorized hearing representative.

IMPLEMENTING THE DECISION AND ORDER

Some hearing decisions require implementation by the local office. Implement a decision and order within 10 calendar days of the mailing date on the hearing decision. Do not provide a notice of case action. The D&O serves as notice of the action.

If unable to determine what action is required, contact the policy clarification mailbox. The policy staff will clarify the situation with the appropriate supervisory ALJ.

CERTIFYING IMPLEMENTATION OF THE DECISION AND ORDER

When a decision requires a case action different from the one originally proposed, a DHS-1843, Administrative Hearing Order Certification, is sent with the D&O.

Complete the necessary case actions within 10 calendar days of the mailing date noted on the hearing decision. Complete and send the DHS-1843 to MAHS to certify implementation and place a copy of the form in the case file.

If it is impossible to implement the D&O as written within 10 calendar days, a local office manager or hearings coordinator, should call MAHS at (517) 373-0722 and speak with the supervisor of the ALJ who issued the D&O. The supervisor will offer advice on how to proceed. A Local office manager or hearings coordinator is responsible to follow-up to ensure implementation of the D&O is completed.

REHEARING

A rehearing is a full hearing which is granted when:

- The original hearing record is inadequate for purposes of judicial review;
- There is newly discovered evidence that existed at the time of the original hearing that could affect the outcome of the original hearing decision.

A Reconsideration is a paper review of the facts, law and any new evidence or legal arguments. It is granted when the original hearing record is adequate for purposes of judicial review and a rehearing is not necessary, but one of the parties believes the ALJ failed to accurately address all the relevant issues raised in the hearing request.

REHEARING/RECONSIDERATION REQUESTS

The department, individual or authorized hearing representative may file a written request for rehearing/reconsideration. Request a rehearing/reconsideration when one of the following exists:

- Newly discovered evidence that existed at the time of the original hearing, and that could affect the outcome of the original hearing decision.
- Misapplication of manual policy or law in the hearing decision, which led to a wrong conclusion.
- Typographical, mathematical, or other obvious error in the hearing decision that affects the rights of the individual.
- Failure of the ALJ to address in the hearing decision relevant issues raised in the hearing request.
- The Department, AHR or the individual must specify all reasons for the request.

LOCAL OFFICE REHEARING/RECONSIDERATION REQUESTS

A written request from the local DHS office for a rehearing/reconsideration must be sent to the Division of Family Program Policy (DFPP) in central office for a recommendation. The written request must include all of the following:

- A copy of the decision and order.
- A copy of the hearing summary and all evidence presented at the hearing.
- Explanation of why a rehearing/reconsideration is appropriate.

Send requests to:

Division of Family Program Policy
Grand Tower Building, Suite 1307
PO Box 30037
Lansing MI 48909

Fax to: (517) 335-7771

If the Division of Family Program Policy supports the local office request, the request shall be made a part of the record. DFPP will forward the request to all parties including: MAHS, the individual, AHR, and the requesting local office.

A written request made by the AHR or, if none, by the individual, must be faxed to: (517) 335-6088 Attention: MAHS – Request for Rehearing or Reconsideration.

MAHS will not review a party's response filed to any rehearing/reconsideration requests.

A request must be received within 30 days of the date the hearing decision is mailed.

GRANTING A REHEARING/RECONSIDERATION

MAHS will either grant or deny a rehearing/reconsideration request and will send written notice of the decision to all parties to the original hearing.

MAHS grants a rehearing/reconsideration request if the information in the request justifies it, and there is time to rehear/reconsider the case and implement the resulting decision within the 90-day standard of promptness.

If the individual or authorized hearing representative made the request and it is impossible to meet the standard of promptness, the individual or authorized hearing representative may waive the timeliness requirement in writing to allow the rehearing/reconsideration.

If MAHS grants a reconsideration, the hearing decision may be modified without another hearing unless there is need for further testimony.

If a rehearing is granted MAHS will schedule and conduct the hearing in the same manner as the original.

IMPLEMENTATION PENDING A REHEARING

Pending a rehearing or reconsideration request, implement the original Decision and Order unless a circuit court or other court with jurisdiction issues an order which requires a delay or stay.

Legal Citations:

42 CFR 431.00, *et seq*
MCL 400.1, *et seq*

MAC 400.901 *et seq*

CHAPTER 14 - MEDICAID BENEFITS

The beneficiary is usually free to select a provider or Medicaid Health Plan (MHP). However, there are some situations when the beneficiary may be restricted to a primary provider. Reimbursement for services rendered is limited to enrolled providers except for emergencies.

Health Plans provide Medicaid-covered health care services for an enrolled group of beneficiaries in a defined service area.

Beneficiaries are given an opportunity to select a Medicaid Health Plan. If no selection is made, the beneficiary is automatically enrolled by the state's contracted enrollment broker, Michigan ENROLLS, with a Health Plan in the beneficiary's county of residence.

Health Plan enrollees are identified by Level of Care (LC) code 07 (HMO ENROLLEE). Health Plan enrollees will also receive an identification card from their Health Plan.

There are beneficiaries who must enroll in a Health Plan, who may voluntarily enroll in a Health Plan or are excluded from enrollment in a Health Plan.

The following must enroll in a Health Plan, unless they are persons who may voluntarily enroll in a health plan or persons excluded from enrollment in a health plan.

- Children under 21.
- Pregnant women.
- Caretaker Relatives/Parents

- Children's Special Health Care Services (CSHCS) and full Medicaid.
- Healthy Michigan Plan

The following may voluntarily enroll in a Health Plan:

- Migrants.
- Native Americans.
- Persons in the traumatic brain injury program.

The following are excluded from enrollment in a health plan:

- Plus Care recipients.
- Persons limited to emergency MA coverage (ESO).
- Persons enrolled in the CSHCS program only.
- Persons residing in an ICF/MR (intermediate care facility for the mentally retarded) or a state psychiatric hospital.
- Persons with commercial HMO coverage, including Medicare HMO coverage.
- PACE (Program for All-inclusive Care for the Elderly) beneficiaries.
- Deductible beneficiaries.
- Children in child caring institutions.
- Refugee Assistance Program Medical Aid-only beneficiaries.
- Repatriate Assistance Program Medical-only beneficiaries.

When a person(s) is excluded from health plan enrollment, other members of that person's family may enroll in a health plan.

If an individual enrolled in a health plan enters a long-term care facility for custodial purposes, the health plan may initiate a request for disenrollment from the health plan. The health plan may request disenrollment by calling: the Department of Community Health Quality Assessment and Improvement Section, (517)-335-5205.

For additional information regarding health plans, contact:

Department of Community Health
Comprehensive Health Plan Division
PO Box 30479
Lansing, MI 48909-7979 or Michigan Enrolls: 1-888-367-6557.

A list of the health plans available in each county is on the DCH Web pages. The DCH Web page address is: www.michigan.gov/mdch. This list is updated monthly.

Health plan enrollees with other insurance should advise their health plan of their insurance coverage.

The health plan is responsible for providing and arranging for all medically necessary services covered by Medicaid with the exception of:

- Dental care (Services rendered by an oral surgeon are included in the health plan capitation rate).
- Mental health services including inpatient psychiatric services (the health plan is responsible for up to 20 outpatient visits).
- Substance abuse treatment.
- Medical transportation for the three services listed above.
- Personal care services.
- School-based services.

The health plan is responsible for providing up to 45 days of restorative health care which is intermittent or short-term, restorative or rehabilitative nursing care.

The health plan may also provide services that are not covered by Medicaid.

DCH has contracted with Magellan Medicaid Administration, Inc., to be the pharmacy benefits manager for its fee-for-service health programs and pregnancy-related pharmacy services for Maternity Outpatient Medical Services (MOMS) beneficiaries. The pharmacy benefits manager is responsible for all of the following:

- Prior authorizing certain drugs.
- Processing pharmacy claims.
- Approving payment to pharmacies.
- Other administrative functions to ensure that appropriate payments are being made.

Magellan Medicaid Administration, Inc., does not prior authorize or pay claims for Medicaid contracted health plans.

Prior Authorization

Drugs that require prior authorization appear on the Michigan Pharmaceutical Products List (MPPL). Physicians or other prescribers may request prior authorization by contacting First Health Services.

Magellan Medicaid Administration, Inc.
MAP Department
4300 Cox Road
Glenn Allen, VA 23060
Telephone: 1-877-864-9014
Fax: 1-888-603-7696 or 1-800-250-6950

Hearing Rights

A beneficiary is notified in writing within 10 calendar days of a prior authorization denial. The notice tells the beneficiary how to apply for a DCH administrative hearing. The DCH hearings application form and a stamped envelope are included with the notice.

Benefits Monitoring Program

DCH regularly reviews utilization of MA benefits. Some beneficiaries may be restricted to a primary provider.

A beneficiary subject to the restricted provider control mechanism is identified by LC code 13 or 14. With the exception of life threatening emergency care, only the beneficiary's provider may render or approve services.

For further information or to make a referral contact:

Department of Community Health
Benefits Monitoring Program
Box 30479
Lansing, MI 48909-7979
Phone: (517) 335-5060

The EPSDT/Well Child Program consists of well-child visits, immunizations and early detection and treatment of diseases for beneficiaries under age 21. The objective of this preventive health care is early intervention to detect and treat mental or physical disease.

The same components of a well-child visit and the same interval schedule are used regardless of whether the child is in a health plan or is fee-for-service.

MDCH Publication (795), Michigan Free Health Check-ups for persons 21 and younger, explains the well-child visits. http://www.michigan.gov/ mdch

Twelve Month Billing Exceptions

Enrolled providers are aware of the covered and excluded services available to Medicaid beneficiaries. Providers must use Medicaid billing procedures to obtain payment for services performed. Billings should be submitted within 12 months from the date of service.

Exceptions to the 12 month billing policy can be made if the delay is caused by agency error or as a result of a court or administrative hearing decision. Agency errors are limited to:

Delayed coding, including level of care changes.

- MRT review.
- MAHS decision.
- Administrative review.
- Delayed eligibility determination.

Exceptions cannot be granted due to provider delays in billing or failure of a recipient or provider to obtain prior authorization.

Form MSA-1038, Request for Exception to the Twelve Month Billing Limitation for Medical Services, is an internal document and must be completed by local office staff to begin the exception process. The completed MSA-1038 should be sent to: 1038@michigan.gov.

A DHS supervisor, district manager, or other office designee must be copied on the email. A copy of the hearing decision is no longer required; however, the hearing registration number must be indicated on the MSA-1038.

DCH will notify the specialist within 30 days of their decision. If approved DHS will notify providers to bill Medicaid as usual but to enter in the comments section of the claim "MSA 1038 approval on file".

DHS staff are not expected to be the primary source of information for Medicaid covered services. The providers of medical services are best equipped to determine medical needs and whether those services are covered by Medicaid as specified in the Medicaid provider manuals.

The provider is required to bill all other insurances prior to billing Medicaid.

Providers must be appropriately licensed and/or certified before entering into an agreement with DCH to participate in the Medicaid program.

Enrolled providers receive direct payment for services rendered but must agree to provide services according to the policies published in the Medicaid provider manuals.

Certain medical/dental services require the provider to obtain prior approval from DCH. Refer to Medicaid Provider Manual for copay information.

The provider is required to accept payments received from MA as payment in full, except for patient-pay amounts authorized by DCH and co-payments.

The provider may seek payment from a beneficiary for services not covered if the beneficiary elects to receive the services with the prior knowledge that such services are not covered.

Institutional and nursing home providers holding a beneficiary's funds in trust are accountable to the beneficiary and may not require the deposit of such funds with the facility. The management of such funds is subject to review by DCH.

Local offices may obtain more information on medical/dental care coverage by consulting the Medicaid provider manuals or contacting DCH at:

Department of Community Health
Provider Inquiry
PO Box 30479
Lansing, MI 48909-7979
Phone: 1-800-292-2550

MEDICAL/DENTAL SERVICES IN ANOTHER STATE

A Michigan Medicaid beneficiary may receive medical/dental care outside of Michigan. The areas beyond the Michigan borders are classified as either borderland or beyond borderland. Borderland and beyond borderland providers must comply with applicable Michigan Medicaid policies and procedures, including prior authorization, to be reimbursed for services.

Borderland Areas

The borderland areas are the out-of-Michigan counties which are adjacent to the Michigan border and certain cities beyond these adjacent counties.

A beneficiary is covered for medical/dental services rendered in a borderland area to the same extent that such services are covered in Michigan.

Borderland providers are considered to be Michigan providers. They must be enrolled in Michigan Medicaid and adhere to the same policies as Michigan providers.

Beyond Borderland Areas

The beyond borderland areas are all areas of the U.S. outside of Michigan which are not borderland areas.

Beyond borderland medical/dental services received by a Michigan Medicaid/AMP recipient will be covered only when:

- The individual is temporarily out-of-state and the services are necessary because the individual's health would be endangered if he was required to travel to Michigan,.
- The individual is temporarily out-of-state and the services are necessary because of a medical/dental emergency (as defined by the program).

The service is prior authorized by DCH as more readily available in another state.

Certain services provided by borderland providers require prior authorization the same as services requiring prior authorization by Michigan providers.

Except in emergencies, the services of a beyond borderland provider must be prior authorized. The recipient's local physician should submit the following to DCH: documentation of the need for beyond borderland services, beneficiary identification, and eligibility data.

The address to submit the above information is:

Department of Community Health
Review and Evaluation Division
400 S. Pine
PO Box 30170
Lansing, MI 48909-7979

The individual's physician and the local office may also make telephone inquiries regarding beyond borderland services when it appears that time is of the essence.

Phone: 1-800-622-0276

The Prior Authorization and Review Section may request information from local offices when evaluating the need for beyond borderland services. Prompt assistance from the local offices is appreciated. A copy of the prior authorization decision will be sent to the appropriate local office.

Refer non-enrolled provider questions about borderland or beyond borderland coverage and billings to:

Department of Community Health
Provider Inquiry
400 S. Pine
PO Box 30239
Lansing, MI 48909-7979

Providers may phone:
1-800-292-2550

Claims

Medicaid will pay non-enrolled Michigan and borderland providers for Emergency services, and nonemergency services with prior approval.

The following occurs when nonemergency services claims are submitted by a non-enrolled provider: the miscellaneous transactions unit will process the claim and send a letter to the provider with a Medical Assistance Provider Enrollment/Trading Partner Agreement form.

If the provider elects not to complete the Medical Assistance Provider Enrollment/Trading Partner Agreement form the claim will not be paid.

Reimbursement for services not paid by Medicaid is between the beneficiary and the provider. The provider must notify the beneficiary prior to rendering the service that it is not covered by Medicaid.

Borderland providers who are not enrolled and all beyond borderland providers should submit claims to:

Department of Community Health
Provider Enrollment
Medicaid Payments
PO Box 30238
Lansing, MI 48909

Beneficiary information is available to medical/dental providers through an automated system called the Eligibility Verification System (EVS). Currently, it is Emdeon.

The telephone number is: 1-888-696-3510.

EVS provides the following eligibility information for Medicaid, MOMS, and CSHCS for the date of service:

- Details on program codes; scope/coverage; patient-pay amounts; DHS district, section, unit, specialist ID and phone numbers; social security claim number; and pending eligibility.
- Other insurance information, carrier ID number, other insurance code, policy number, contract number, service codes, employer and policyholder name.
- Level of care information, health plan enrollments, nursing home residence, and beneficiary monitoring program.

Additional information is not available through EVS.

Refer provider questions about Medicaid Health Plans to: Provider Inquiry: 1-800-292-2550.

After consulting the Medicaid provider manuals, providers may call the following number to verify covered services or to receive billing assistance: Provider Inquiry: 1-800-292-2550.

Refer beneficiary questions about Medicaid covered services or billing problems to: Medicaid Beneficiary Helpline: 1-800-642-3195.

Refer beneficiary questions about Medicaid Health Plans, including available providers in their area and enrollment to:

Michigan Enrolls: 1-888-367-6557.

Refer beneficiary complaints and questions about Medicaid providers to:

Medicaid Beneficiary Helpline: 1-800-642-3195.

Department of Community Health
Enrollment Services Section
PO Box 30470
Lansing, MI 48909-9753

Refer complaints about enrolled providers to:

Department of Community Health
Comprehensive Health Plan Division
400 S. Pine Street
PO Box 30479
Lansing, MI 48909-7979

Michigan Department of Attorney General
Health Care Fraud Division
PO Box 30218
Lansing, MI 48909
24 hour hotline:1-855-643-7283 (1-855-MI FRAUD)
E-mail: hcf@michigan.gov

The following are general categories of Medicaid covered services. This listing should be used for reference purposes only. Some of the services listed are available only to certain age groups, may be limited in their scope or may require prior approval.

Local office staff are not expected to be the beneficiary's primary source of information for Medicaid covered services. The beneficiary should be advised to contact the medical services provider directly whenever information is needed regarding Medicaid covered services.

- Covered Services
- Allergy Testing/Treatment
- Ambulance Services
- Chiropractic Services
- Dental Services
- Diabetic Patient Education Program
- EPSDT/Well Child Services
- Family Planning Services
- Hearing Aid Dealers
- Hearing & Speech Center Services
- Home and Community-Based Waiver Services
- Home Health Services
- Hospice Services
- Hospital Services (Inpatient/Outpatient)
- Laboratory & X-Ray Services
- Long-Term Care (LTC)
- Maternal Infant Health Program
- Medical Supplies and Equipment
- Mental Health Services
- Methadone Maintenance Treatment
- Nurse-Midwife and Nurse Practitioner Services
- Orthotics, Prosthetics and Special Shoes
- Personal Care Services
- Pharmacy Services
- Physician Services (MD/DO)
- Podiatric Services
- Psychiatric Care
- School-Based Services
- Substance Abuse Treatment Services
- Therapy (Occupational, Physical, Speech)
- Transportation
- Vision Services

CHAPTER 15 INSTITUTIONAL STATUS

Residents of institutions can qualify for certain program benefits in limited circumstances.

15.1 DEFINITIONS

Institution means an establishment furnishing food, shelter and some treatment or services to more than three people unrelated to the proprietor.

Institution for Mental Diseases means a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases.

Government-operated facility means a facility over which a governmental unit has responsibility or exercises administrative control. It includes a facility owned or leased by a governmental agency and administered through the agency's salaried staff.

Public nonmedical institution means a government-operated facility that does not provide medical care (e.g., jail or prison). A community residence facility for fewer than 17 people or a school is not considered a public nonmedical institution.

Psychiatric facility means a private or government-operated institution engaged primarily in diagnosing or caring for persons with mental disease. It does not include the psychiatric ward of a hospital or a facility for the mentally retarded.

Entire calendar month means a period that begins any time on the first day of a calendar month and ends any time on the last day of that month.

15.2 JAILS OR PRISONS

An individual can remain eligible and an applicant can be determined eligible for Medicaid during a period of incarceration.

Medicaid coverage is limited to off-site inpatient hospitalization only.

The facility is responsible for all other medical services provided to these individuals. The case should be maintained in the local office in which the individual resided before the incarceration.

A person is in jail or prison until released:

- On bail,
- As not guilty,
- On parole,
- On pardon,
- Upon completing the sentence, or
- Under home detention (tethered).

Contact the Medicaid exception unit (1-800-292-9570) to enter or remove a level of care (LC) code 32 to identify a person who is incarcerated. Remove level of care code 32 when the individual is no longer incarcerated.

If the individual is incarcerated in a county jail, provider ID 9999980, the local office specialist may change the level of care without contacting the exception unit at DCH.

15.3 OTHER PUBLIC NONMEDICAL INSTITUTIONS

A resident of a public nonmedical institution (other than a jail or prison) can qualify for Medicaid if:

The individual was placed there on an emergency basis pending a suitable placement; or

The individual was, or is expected to be, a resident for less than the entire calendar month being tested.

The individual is a resident of such an institution until he is away to receive medical care or leaves and is not expected to return.

INSTITUTION FOR MENTAL DISEASES

An individual between the ages of 21 and 65 who is a resident of an Institution for Mental Diseases (IMD) may be eligible for Medicaid

If the individual is an inpatient of an IMD when he turns age 21, he is eligible to continue as an inpatient until age 22.

IMDs in Michigan are:

- Walter Reuther Psychiatric Hospital.
- Caro Regional Hospital.
- Kalamazoo Psychiatric Hospital.
- Centers for Forensic Psychiatry.
- Hawthorne Center (for children).

PSYCHIATRIC FACILITIES

An individual aged 22 through 64 in a psychiatric facility can qualify for Medicaid if he was, or is expected to be, a resident for less than the entire calendar month being tested.

The individual is a resident of such a facility until discharged or absent for a convalescent leave to experience living outside the facility.

CHAPTER 16 GLOSSARY/DEFINITIONS

ACA - Affordable Care Act of 2010 (which is the collective term for the Patient Protection and Affordable Care Act (Pub. L. 111-148) and the Health Care and Education Reconciliation Act (Pub L. 111-152).
APTC-advanced premium tax credit.
CHIP-children's health insurance program.
CMS-Centers for Medicare and Medicaid Services.
COE- category of eligibility.
Core Relative- parent including step or grand, sibling, niece, nephew. May also be referred to as a specified or qualified relative.
CSR- cost sharing reduction.
DHS- Department of Homeland Security or Department of Human Services.
FFM-federally facilitated marketplace.
FPL-Federal poverty level, also known as the federal poverty guideline, is an administrative measure used to determine financial eligibility for certain federal programs.
Health insurance marketplace- a tool used to shop for and purchase health insurance.
HMP-Healthy Michigan Plan, Medicaid expansion group.
Insurance affordability programs- Medicaid, CHIP, APTC.
IRC-internal revenue code.
LPR- lawful permanent residence.
MAGI-modified adjusted gross income. The total of adjusted gross income plus any foreign earned income excluded from taxes, tax exempt interest, and tax exempt social security income.
MIChild- Health coverage for children under the age of 19 who are not income eligible for Medicaid and have no other health insurance. Funded through CHIP.
Minimum essential coverage- insurance coverage includes the ten essential health benefits as determined by the federal government.
QHP-qualified health plan.
SAVE- systematic alien verification for entitlements.
Self-attestation- no documentation is required. The individual's statement is sufficient.
SHOP- small business health options program.
SOM- State of Michigan.
SSA-Social Security Administration.
Tax dependent- an individual claimed as a dependent on a tax filer's federal income tax return.
USCIS- United States Citizenship and Immigration Service