JENNIFER M. GRANHOLM
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF HUMAN SERVICES
LANSING

ISMAEL AHMED
DIRECTOR

July 23, 2010

The Honorable Bill Hardiman, Chair
Senate Appropriations Subcommittee on DHS
Michigan State Senate
Lansing, MI 48933

The Honorable Dudley Spade, Chair
House Appropriations Subcommittee on DHS
Michigan House of Representatives
Lansing, MI 48933

Dear Senator Hardiman and Representative Spade:

Section 273(1) of 2009 Public Act No. 129 (Enrolled Senate Bill No. 248) requires the Department of Human Services (DHS) to report policy changes made to implement provisions of enacted legislation including the DHS budget act. Attached is the report for policy released in June 2010.

The report contains the bulletin number of the policy release as well as the effective date, subject and summary of the policy.

If you have any questions about the attached material, please contact Judith Galant, online manual coordinator, at (517) 241-7084.

Sincerely,

Susan Kangas

for Ismael Ahmed

Attachment
c: Senate and House Standing Committees on Human Services
Senate and House Appropriations Subcommittee on DHS
State Budget Office

ADB 2010-002 Adoption Services Interim Bulletin Monthly Caseworker Visits.

EFFECTIVE **Immediately upon receipt.**

Issued June 22, 2010.

SUBJECT

1. Visit requirements.
2. Documentation.
3. Manual Maintenance

1) Visit Requirements

Adoption Services Monthly Caseworker Visits

Per federal child welfare policy, children who are in adoptive placement but not yet in a finalized adoption are considered to be in foster care until the PCA 321, Order of Adoption, is signed by the court. In order to meet the caseworker visit requirements, the following policies are added to the Adoption Services manual.

ADM 950

Post Placement and Finalization Procedures

Adoption Supervision - Caseworker Visits

During the period of adoptive placement supervision and until the PCA 321, Order of Adoption, is signed by the court, the adoption worker must visit the adoptive parent(s) and child according to the requirements described below.

Visit Requirements

- Each **child** and at least one adoptive parent must have a face-to-face adoption worker visit a **minimum of once each calendar month.** If there are two adoptive parents, the adoption worker must have a face-to-face visit with the child and the second adoptive parent in the child's residence at least once each quarter.
- The adoption worker visit with the child and adoptive parent must take place in the child's residence at least every other month.
- Each child visit must include a private meeting between the child and the adoption worker.
- During the monthly visit the areas to be discussed must include, but are not limited to, the following:

  Child Visit:

  - Child's medical, dental, and mental health and physical appearance.
  - Child's feelings/observations about the adoptive placement.

- Education.
- Sibling/relative visitation plans.
- Extracurricular/cultural activities/hobbies since last visit.
- Permanency plan.
- Any issues or concerns expressed by the child.

Adoptive Parent Visit:

- Date of child's last physical and dental exam.
- Medication dosages and diagnoses for the child.
- Medical/dental/mental health concerns, appointments, treatment, follow-up care and therapy updates.
- Child behaviors, concerns, developmental milestones.
- Education, school status, performance, behaviors and services provided.
- Adoptive parent tasks to meet child's needs.
- Adoptive family's adjustment to the child's placement.
- Permanency plan.
- Any Children's Protective Services complaints made since the last visit.

General Information:

- Type of visit.
- Visit location.
- Names of all persons present at the visit.
- The worker's observation of the child's bedroom.

2) Documentation **Documenting Visit Information**

The information gathered during the monthly child visit must be documented in the child's case record. The information must be included in the DHS-613, Adoption Supervisory Report and the DHS-222, Adoption Closing Summary.

Caseworker Visit Tools

Two caseworker visit tools have been developed to assist workers in gathering the above required information during a monthly visit. The tools are:

- DHS-904, Foster Care/Adoption/Juvenile Justice Caseworker Visit Quick Reference Guide. This is a guide that contains the information that must be covered in a monthly visit but is not intended for recording notes.
- DHS-904A, Foster Care/Adoption/Juvenile Justice Caseworker Visit Tool. This form may be used to take notes during the visit.

The caseworker visit tools provide structure and reminders of required topics. The tools are not to be used as documentation in the case record. Visits must still be documented using the DHS-613, Adoption Supervisory Report, and DHS-222, Adoption Closing Summary.

Timely Entry of Caseworker Visits in SWSS FAJ

Social work contacts include face-to-face caseworker visits with children, foster parents/relative caregivers and adoptive parents.

DHS direct workers must enter all face-to-face contacts with children, foster parents/relative caregivers and adoptive parents into SWSS FAJ **within 5 calendar days of the visit**. Select adoptive home in SWSS FAJ as the location of a visit in the child's residence.

All private agency adoption caseworkers must submit all face-to-face contacts with children, foster parents/relative caregivers and adoptive parents to the DHS monitor/direct worker by the **third business day of every month for every visit that occurred during the previous month.**

DHS private agency monitors must enter all face-to-face contacts with children, foster parents/relative caregivers and adoptive parents into SWSS FAJ **within 5 calendar days** of the receipt of the contact information from the private agency adoption worker. Select adoptive home in SWSS FAJ as the location of a visit in the child's residence.

3) Manual Maintenance This policy will be added to the Adoption Services Manual during the next policy release.

ASB 2010-002 Adult Services Interim Policy bulletin Independent Living Services (ILS) Provider Agreement.

EFFECTIVE **July 1, 2010.**

Issued June 21, 2010.

SUBJECT Independent Living Services Provider Agreement MSA 4678.

Medical Assistance Home Help Provider Agreement MSA 4678

Federal regulations require that all providers of Medicaid covered services complete and sign a provider agreement that states they will abide by Medicaid policies in providing services to program clients and in receiving payment from the program. In order to meet this requirement, the Department of Community Health (DCH) has developed the Medical Assistance Home Help Provider Agreement (MSA 4678).

All Home Help individual and agency providers must have a completed and signed MSA 4678 on file with DCH in order to receive payment for covered services.

1. New individual or agency providers must complete the MSA 4678 Provider Agreement **before** any services may be provided.

2. Current individual providers will complete the MSA 4678 **at the next review or redetermination visit.**

3. Current approved agency providers on the home help agency approval list as of June 1, 2010 will receive a copy of the MSA 4678 **in the mail to complete and return within 90 days.**

Each home help individual and agency provider will only need to complete **one** MSA 4678 provider agreement.

MSA 4678 Signature Date

The provider signature date must be entered into Bridges under the provider services detail screen. The adult services specialist will write the provider signature date on a DHS 2351X on line 28 and submit to the administrative support staff in the local office for inputting.

MSA 4678 Submission to DCH

The adult services specialist must write the provider ID number in the official use box on **all** the MSA 4678 provider agreements, review the agreement to make sure it is complete with signature, and batch the agreements to be mailed to DCH. The address to send the batched MSA 4678 agreements via ID mail or regular mail is:

DCH Provider Enrollment
Attn: Teri Chamberlain
320 S. Walnut, 3rd floor Lewis Cass Bldg.
Lansing, MI 48913

Statement of Employment MSA 4676

The Medical Assistance Home Help provider agreement (MSA 4678) does not replace the Statement of Employment (MSA 4676). The MSA 4678 is an agreement between DCH and the provider. The MSA 4676 is an agreement between the client and the provider.

Online Manual Pages

The Adult Services Manual (ASM) will be updated to reflect these changes with the conversion of online manuals to SharePoint. In the

meantime, a note will be added to ASM referencing this interim bulletin and corresponding L-Letter.

BPB 2010-012 Bridges Interim Policy Bulletin Ex Parte Reviews.

EFFECTIVE **July 1, 2010.**

Issued June 23, 2010.

SUBJECT **Ex Parte Reviews of Medicaid (MA) Closures**

All MA Categories

Effective July 1, 2010, individuals who are no longer eligible for Medicaid under their current MA category will be reviewed for eligibility in all other Medicaid categories before the individual's current Medicaid coverage ends. The review will be ex parte (see definition with this bulletin) unless information needed to determine eligibility in another category is required from the individual. The ex parte review will be based on the information currently found in the individual's case record and information available to the department. If the review determines there is no eligibility in another category, the current coverage will be allowed to end. If the individual is found eligible for MA coverage in another category, the case will transfer to the new category and notice of continued eligibility will be sent to the individual.

BAM 115, APPLICATION PROCESSING

All Programs

When recipients request benefits they are **not** currently receiving, you may use the DHS-1171 on file **if** it was approved within the last 12 months.

- Update the application and data collection to add or change information to transfer:

  •• Among MA-categories.
  •• From FIP, SDA or MA to AMP.

  The client does **not** have to re-sign the application.

- For other transfers, update the application **and** have it re-signed; see WHEN THE DHS-1171 IS NOT NEEDED in this item. Register the new program using the date the application form was re-signed as the application date.

Eligibility for a new program or MA category is limited to the redetermination or end date already in Bridges.

Exception: When an ex parte review of a client's current Medicaid eligibility case file shows the recipient indicated or demonstrated a disability (see glossary), continue Medicaid until information needed to proceed with a disability determination has been requested and reviewed. Continue Medicaid coverage until the review of possible eligibility under other Medicaid categories has been completed; see BAM 210 and BAM 220.

MA Only

A recipient losing Medicaid under a category for which a DHS 1171 is not needed may need to complete a DHS 1171 in order to transfer to another MA category if an 1171 has not been approved for another program within the past 12 months. Always give the recipient a reasonable opportunity to complete the DHS 1171 and to provide verification of eligibility under other categories **before** terminating MA; see BAM 220.

Exception: Transitional MA eligibility is 12 months from the date of LIF ineligibility; see BEM 111, Transitional MA.

Updating the Application

All Programs

An application is **never** returned to the client or authorized representative (AR) to update.

While an application is considered valid, the client may update the current application rather than complete a new one to add or transfer programs or add a member.

Exception: When the current application is the DCH-0373, you must send a DHS-1171 to the client to transfer to a non-Healthy Kids MA category or start additional benefits.

BAM 210, REDETERMINATION/EX PARTE REVIEW

Ex Parte Review

MA Only

An ex parte review (see glossary) 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 MA categories; see BAM 115 and 220.

Redetermination Cycle

MA and TMAP

Benefits continue until a redetermination of eligibility under all categories has been completed; see BAM 220. **The redetermination month**

is 12 months from the date the most recent complete application was submitted.

In a Group 2 Persons Under 21 case, if a member will reach age 21 **before** the month the case is scheduled to be redetermined, an ex parte review (see glossary) should begin at least 90 days prior to the date the member turns age 21; see BAM 220.

In a Special N Support, Title IV-E or FCTMA case, an ex parte review should begin at least 90 days prior to the date the case is scheduled to close; see BAM 220.

BAM 220, CASE ACTIONS

Ex Parte Review

MA Only

An ex parte review (see glossary) must be completed at least 90 days (when possible) prior to the close of any Medicaid.

- When the ex parte review shows the recipient does have eligibility for Medicaid in another category, change the coverage.
- When the ex parte review shows that a recipient may have continued 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 client fails to provide requested verification or if a review of the information provided establishes that the recipient is not eligible under any MA 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 a recipient will no longer meet the eligibility criteria for FIP related Medicaid, because of an actual or anticipated change, determine whether the recipient has indicated or demonstrated a disability (see glossary) as part of the ex parte review (see glossary).

- If the ex parte review reveals the recipient 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 recipient's Medicaid eligibility under the disability based Medicaid category for which the recipient is otherwise eligible.
- If, during the ex parte review it is determined a recipient has indicated or demonstrated a disability, request from the recipient addi-

tional information needed to proceed with a disability determination. Pending the determination, continue the recipient's Medicaid.

- If the recipient 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 person is not eligible for disability based Medicaid as well as FIP related categories.
- If, following the disability determination process, the recipient 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 person is not eligible for disability based Medicaid as well as FIP related categories.
- If, following the disability determination process, the recipient is determined disabled for purposes of qualifying for disability based Medicaid categories continue the recipient's Medicaid under the disability based Medicaid category for which the recipient is otherwise eligible.

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

Case Closure

All Programs (Except SER)

When a recipient is no longer eligible or requests case closure, do **all** of the following:

- Enter all appropriate information, including verification sources, in Bridges to document ineligibility, or the client's request that the program(s) be closed.
- Run EDBC in Bridges and certify the eligibility results.
- Make appropriate referrals for other programs or services.

BEM 105, MEDICAID OVERVIEW

MA-Only Terminations

Consider eligibility under all other MA-only categories before terminating benefits under a specific category. Begin with an ex parte review and request additional information or verification if needed; see BAM 210 and 220. In addition, when Group 1 eligibility does not exist but all eligibility factors except income are met for a Group 2 category, activate deductible status; see BEM 545.

Exception: Close the case without an ex parte review when benefits are terminating:

BAM 106, WAIVER FOR ELDERLY AND DISABLED

Eligibility

Special MA policies to use in the eligibility determination are:

- A waiver participant is a group of one even when he lives with his spouse; see BEM 211.
- The special MA asset rules in BEM 402 apply.
- MA divestment policy in BEM 405 applies to waiver participants.
- The extended-care category is available to waiver participants; see BEM 164.
- Income must be at or below 300 percent of the SSI federal benefit rate.

A waiver client may no longer qualify for waiver services, however, they may still qualify for MA.

An ex parte review (see glossary) 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 MA categories; see BAM 115 and 220.

BEM 110, LOW INCOME FAMILY

Low Income Family Termination

You **must** determine if MA eligibility exists under any other category before terminating MA for LIF or FIP recipients. Commonly applicable policies are mentioned below.

An ex parte review (see glossary) 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 MA categories; see BAM 115 and 220.

BEM 111, TRANSITIONAL MA

Continued Eligibility

TMA eligibility continues until the end of the 12-month TMA period unless:

- FIP is approved; or
- A change is reported, such as decreased income, and the family is eligible for LIF; or

Note: The family might qualify for TMA or Special N/Support if they again become ineligible for LIF.

- For individual members, information is reported indicating that a member does not meet the MA requirements in:

  - BEM 220, Residence.

  - BEM 257, Third Party Resource Liability.

  - BEM 265, Institutional Status.

  - If a member loses TMA eligibility during the 12-month period based on BEM 220, 257 or 265, but the reason for ineligibility ceases, TMA eligibility exists again. Eligibility restarts the month ineligibility ceased and continues for the remainder of the 12-month period. The client is responsible for reporting the change that reestablishes eligibility and must update the following items on the DHS-1171, Assistance Application: Section A. Address Information.

  - Section C. Information About You and Your Household (complete one household block for each person living in the home).

  - Section F. Medical Coverage (third party resource liability).

  - Section V. Representative, Guardian, Conservator or Person Helping With Application.

  - Section W. Affidavit. The client is to read the affidavit before signing the application.

An ex parte review (see glossary) 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 MA categories; see BAM 115 and 220.

BEM 113, SPECIAL N SUPPORT

Eligibility

During the four-month period, each Special N/Support group member remains eligible unless it is reported that he is no longer a Michigan resident according to the MA policy in BEM 220. A group member who

leaves home but remains a Michigan resident is still eligible for Special N/Support.

If Special N/Support eligibility is lost during the four-month period due to residence and the group member regains Michigan residence during the four-month period, Special N/Support eligibility exists beginning the month Michigan residency is regained and extends for the remainder of the four-month period. The client is responsible for reporting his return to Michigan and must update the following items on the DHS-1171, Assistance Application:

- Section A. Address Information.
- Section C. Information About You and Your Household (complete one household block for each person living in the home).
- Section F. Medical Coverage (third party liability).
- Section V. Representative, Guardian, Conservator or Person Helping With Application.
- Section W. Affidavit. The client is to read the affidavit before signing the application.

Note: Newborns eligible under BEM 145 may be added to the Special N/Support case but are **not** Special N/Support recipients.

An ex parte review (see glossary) 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 MA categories; see BAM 115 and 220.

BEM 118, FOSTER CARE TRANSITION MEDICAID (FCTMA)

Department Policy

MA Only

As explained in detail below, the following persons are automatically eligible for Group 1 MA.

- Department wards.
- Title IV-E foster care recipients.
- Children with title IV-E adoption assistance agreements.
- Special needs children with adoption assistance agreements.

Adoption assistance agreements are also called adoption support subsidy agreements.

Other children, such as court wards, may be eligible under other categories, such as Healthy Kids; see BEM 105. MA coverage for court wards is not automatic. Local office specialists are responsible for opening and maintaining these cases.

An ex parte review (see glossary) 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 MA categories; see BAM 115 and 220.

Continued Eligibility

Eligibility must continue unless one of the following occurs:

- Death.
- Moves out-of-state.
- Case closure is requested.
- Another MA program is more beneficial.

Clients can contact (517) 335-3627 for change of address, etc., or fax a copy of the change to (517) 335-6112.

An ex parte review (see glossary) 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 MA categories; see BAM 115 and 220.

BEM 124, PLAN FIRST!

Ongoing Eligibility

Once eligible, eligibility continues until redetermination unless the woman:

- Reaches age 45, or
- Moves out of state, or
- Is ineligible due to Institutional Status (BEM 265), or
- Obtains comprehensive health insurance, or
- Dies.

An ex parte review (see glossary) is required before Medicaid closure 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 MA categories; see BAM 115 and 220.

BEM 125, HEALTHY KIDS FOR PREGNANT WOMEN

Income Eligibility

Income eligibility exists when net income does not exceed 185 percent of the poverty level. The income limit is in RFT 246.

Disregard all parental income for all pregnant women applying for or receiving MA under the Healthy Kids for Pregnant Women category.

Apply MA policies in BEM 500, 531, and 536 to determine net income.

Applications for Healthy Kids. A woman who is income eligible for one calendar month based on the income limit is automatically income eligible for each following calendar month through the second calendar month after the month her pregnancy ends.

Category Transfer. An income test is not required when determining continuing eligibility for a pregnant woman whose eligibility under another MA category (including FIP and SSI) is terminating. This includes a woman who is Group 2 eligible for only a portion of a month due to incurred medical expenses (see BEM 545). The woman who is eligible for and receiving under another MA category is automatically income eligible for Healthy Kids through the second calendar month after the month her pregnancy ends

Note: Pursue eligibility for other MA categories when a client's coverage based on pregnancy is ending. When the current application is the DCH-0373-D, you must send a DHS-1171 to the client to transfer to a non-Healthy Kids MA category or start additional benefits.

Note: An ex parte review (see glossary) 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 MA categories; see BAM 115 and 220.

BEM 126, GROUP TWO PREGNANT WOMEN

Postpartum Extension

The postpartum extension period is the two calendar months following the month a pregnancy ends. The postpartum extension of MA eligibility is available to a woman who:

- Was eligible for, and receiving, MA (including FIP) on the day her pregnancy ended; **and**

- Meets the nonfinancial eligibility factors in this item except pregnancy; **and**
- Is not currently eligible for MA under any category other than postpartum extension.

Note: The woman who is eligible for and receiving under another MA category is automatically income eligible for Healthy Kids through the second calendar month after the month her pregnancy ends.

An ex parte review (see glossary) 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 MA categories; see BAM 115 and 220.

BEM 129, HEALTHY KIDS UNDER AGE 1

Ongoing Eligibility

Once eligible, a recipient's eligibility continues until redetermination unless the child:

- Reaches age 19.
- Moves out of state.
- Is ineligible due to BEM 265, Institutional Status.
- Dies.

Continue using HK1 **Income Eligibility at** redetermination when a child:

- Is eligible for and receiving MA under this category, and
- Is an inpatient in a hospital or in LTC, and
- Attained age one while in the facility.

Note: The stay in the facility must be uninterrupted since age one.

An ex parte review (see glossary) 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 MA categories; see BAM 115 and 220.

BEM 131, OTHER HEALTH KIDS

Ongoing Eligibility

Once eligible, eligibility continues until redetermination unless the person:

- Reaches age 19, or
- Moves out of state, or
- Is ineligible due to BEM 265, Institutional Status, or
- Dies.

BEM 546 instructs you how to determine the post-eligibility patient-pay amount if the month being tested is an L/H month and eligibility exists.

An ex parte review (see glossary) 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 MA categories; see BAM 115 and 220.

BEM 132, GROUP 2 PERSONS UNDER AGE 21

Age Notification

Persons (except pregnant women) who will reach the age limit in the following month are listed on Report AA-712, Age Notification.

Consider eligibility for all other MA categories when a person reaches age 21 or otherwise becomes ineligible for this category.

An ex parte review (see glossary) 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 MA categories; see BAM 115 and 220.

BEM 135, GROUP 2 CARETAKER RELATIVES

Nonfinancial Eligibility Factors

A caretaker relative is a person who meets all of the following requirements:

- Except for temporary absences, the person lives with a dependent child; see BEM 135.
- The person is:
  - The parent of the dependent child; **or**
  - The specified relative (other than a parent) who acts as parent for the dependent child; see BEM 135. Acts as parent means provides physical care and/or supervision.

- The person is not participating in a strike; and, if the person lives with his spouse, the spouse is not participating in a strike. Use the FIP striker policy in BEM 227.

- The **MA** eligibility factors in the following items must be met.

  - BEM 220, Residence.
  - BEM 221, Identity.
  - BEM 223, Social Security Numbers.
  - BEM 225, Citizenship/Alien Status.
  - BEM 255, Child Support.
  - BEM 256, Spousal/Parental Support.
  - BEM 257, Third Party Resource Liability.
  - BEM 265, Institutional Status.
  - BEM 270, Pursuit of Benefits.

When a dependent child lives with both parents, both parents may be caretaker relatives.

Occasionally, a specified relative (other than a parent) who claims to act as parent for the dependent child and the child's parent both live with the child. The client's statement regarding who acts as parent must be accepted. If both the parent and other specified relative claim to act as parent, assume the parent is the caretaker relative. When only the other specified relative claims to act as parent, both the other specified relative and the parent(s) may be caretaker relatives.

Except as explained in the two preceding paragraphs, a child can have only one caretaker relative. This means that if a person is an MA applicant or recipient based on being a caretaker relative, no other person can apply for or receive MA based on being a caretaker relative for the same dependent child.

An ex parte review (see glossary) 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 MA categories; see BAM 115 and 220.

BEM 145, NEWBORNS

Redetermination

Determine eligibility for all other MA categories no later than the month of the child's first birthday. Proof of U.S. citizenship is not required at redetermination.

An ex parte review (see glossary) 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 MA categories; see BAM 115 and 220.

BEM 154, SPECIAL DISABLED CHILDREN

Initial Eligibility

Immediately reopen MA for anyone identified as meeting all the following criteria (see ***Exception*** below). Do **not** delay reopening MA for any additional information.

- The person's MA terminated before February 1998.
- The person was receiving MA from Michigan when MA terminated.
- The Social Security Administration considers the person as having been paid SSI benefits on August 22, 1996, and to have become ineligible as a result of the 1996 change in the definition of disability.

  Recipient level Program Type (PT) code 9 identifies such persons. The code is entered by central office based on information provided by the Social Security Administration.

  See **VERIFICATION REQUIREMENTS below** if a person claims to meet this eligibility factor, but does **not** have recipient level PT code 9.

Exception: Do **not** reopen MA if the previous termination was due to residence (BEM 220) or death.

Authorize MA back to July 1, 1997 for any month the person has **not** already received MA under another category. Set the redetermination date as July 1998.

An ex parte review (see glossary) 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 MA categories; see BAM 115 and 220.

BEM 503, INDIVIDUALS

Nonfinancial Eligibility Factors

- The person must:
  - Currently receive RSDI benefits, **and**
  - Have stopped receiving SSI benefits after April 1977, **and**

- Have been entitled to RSDI benefits in the last month he was eligible for and received SSI.

Note: RSDI benefits paid retroactively can be considered. An SSI recipient who receives retroactive RSDI benefits does **not** become retroactively ineligible for SSI even when the retroactive RSDI monthly benefit was more than his SSI benefit.

- The person must be:
  - Age 65 or older (BEM 240), or
  - Blind (BEM 260), or
  - Disabled (BEM 260).
- The MA eligibility factors in the following items must be met:
  - BEM 220, Residence.
  - BEM 221, Identity.
  - BEM 223, Social Security Numbers.
  - BEM 225, Citizenship/Alien Status.
  - BEM 255, Child Support.
  - BEM 256, Spousal/Parental Support.
  - BEM 257, Third Party Resource Liability.
  - BEM 265, Institutional Status
  - BEM 270, Pursuit of Benefits.

An ex parte review (see glossary) 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 MA categories; see BAM 115 and 220.

BEM 156, COBRA WIDOW(ER)S

Countable RSDI

Countable RSDI for the COBRA widow(er) is his gross RSDI benefit amount for December 1983 which was received in his January 1984 check. Gross RSDI means the amount before any deductions such as Medicare. The standard Medicare Part B premium in December 1983 was $12.20 per month.

For all other persons, countable RSDI is the person's gross RSDI for the month being tested.

An ex parte review (see glossary) 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 MA categories; see BAM 115 and 220.

BEM 157, EARLY WIDOW(ER)S

Countable RSDI

Exclude all RSDI benefits for the early widow(er).

For all other persons, countable RSDI is the person's gross RSDI for the month being tested. Gross RSDI means the amount before any deductions such as Medicare.

An ex parte review (see glossary) 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 MA categories; see BAM 115 and 220.

BEM 163, AD CARE

Countable RSDI

Gross amount means the amount of RSDI before any deduction such as Medicare.

Countable RSDI for fiscal group members is the gross amount for the previous December when the month being tested is January, February or March. Federal law requires that the cost-of-living increase received in January be disregarded for these three months. For all other months, countable RSDI is the gross amount for the month being tested.

For all other persons whose income must be considered, countable RSDI is always the gross amount for the month being tested.

An ex parte review (see glossary) 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 MA categories; see BAM 115 and 220.

BEM 164, EXTENDED CARE

Third Party Liability

Complete MSA-1354 for clients with other insurance including long term care/nursing home insurance and submit with a copy of insurance card if available.

An ex parte review (see glossary) 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 MA categories; see BAM 115 and 220.

BEM 165, MEDICARE SAVINGS PROGRAM

Countable RSDI and Bridges

Enter countable RSDI for the month being tested. When the month being tested is January, February or March Bridges automatically:

- Computes and deducts the RSDI cost-of-living increase for fiscal group members, and
- Uses the limits for the preceding December.

An ex parte review (see glossary) 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 MA categories; see BAM 115 and 220.

BEM 166, GROUP 2 AGED, BLIND AND DISABLED

Income Eligibility

Income eligibility exists when net income does **not** exceed the Group 2 needs in BEM 544. Apply the MA policies in BEM 500, 530, 540 (for children) or 541 (for adults), and 544 to determine net income.

If the net income exceeds Group 2 needs, MA eligibility is still possible per BEM 545.

An ex parte review (see glossary) 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 MA categories; see BAM 115 and 220.

BEM 167, PROGRAM OF ALL INCLUSIVE CARE FOR THE ELDERLY

Income

Income eligibility exists when gross income does not exceed 300 percent of the federal benefit rate. Income eligibility cannot be established with a patient- pay amount or by meeting a deductible.

An ex parte review (see glossary) 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 MA categories; see BAM 115 and 220.

BEM 169, QUALIFIED DISABLED WORKING INDIVIDUALS

Coverage

The only MA benefit is payment of Medicare Part A premiums. The mi health card, is **not** issued.

An ex parte review (see glossary) 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 MA categories; see BAM 115 and 220.

BEM 170, HOME CARE CHILDREN

Local Office Responsibilities

Do not authorize MA under this category without a MSA-1785 instructing you to do so. Use this category when the child is *not* an SSI or FIP recipient. Use this category before using a Group 2 category.

If a MSA -1785 is received for a child who is **not** an MA applicant or recipient, treat the MSA -1785 as a request for assistance. Contact the child's parents concerning an MA application for the child.

Determine if the child meets the MA eligibility factors in the following items:

- BEM 220, Residence.
- BEM 223, Social Security Numbers.
- BEM 225, Citizenship/Alien Status.
- BEM 257, Third Party Resource Liability.
- BEM 270, Pursuit of Benefits.

Local offices are responsible for disability reviews; see BEM 260.

An ex parte review (see glossary) 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 MA categories; see BAM 115 and 220.

BEM 171, CHILDREN'S WAIVER

Local Office Responsibilities

Do *not* authorize MA under this category without a DHS-49-A and MSA-1785 instructing you to do so. Use this category when the child is *not* an SSI or FIP recipient. Use this category before using a Group 2 category.

Treat the MSA-1785 as a request for assistance, if it is received for a child who is **not** an MA applicant or recipient.

Determine if the child meets the MA eligibility factors in the following items:

- BEM 220, Residence.
- BEM 223, Social Security Numbers.
- BEM 225, Citizenship/Alien Status.
- BEM 257, Third Party Resource Liability.
- BEM 260, MA Disability/Blindness.
- BEM 270, Pursuit of Benefits.

Note: DCH is responsible for obtaining medical evidence and certifying disability on the DHS-49-A; see BEM 171.

An ex parte review (see glossary) 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 MA categories; see BAM 115 and 220.

BEM 172, CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCE WAIVER (SED)

Local Office Responsibilities

Do not authorize MA under this category without a MSA-1785 and DHS-49-A instructing you to do so. Use this category when the child is not an SSI or FIP recipient. Use this category before using a Group 2 category.

Treat the receipt of the MSA-1785 as a request for assistance, if it is received for a child who is not an MA applicant or recipient.

Determine if the child meets the MA eligibility factors in the following items:

- BEM 220, Residence.
- BEM 223, Social Security Numbers.
- BEM 225, Citizenship/Alien Status.
- BEM 257, Third Party Resource Liability.
- BEM 260, MA Disability/Blindness.
- BEM 270, Pursuit of Benefits.

DCH is responsible for obtaining clinical evidence and for certifying disability on the DHS-49-A; see BEM 171.

Note: An ex parte review (see glossary) 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 MA categories; see BAM 115 and 220.

BEM 173, BREAST AND CERVICAL CANCER PREVENTION AND TREATMENT PROGRAM

BCCPTP and Other Medical Assistance

A woman who is already receiving MA (coverage code F or E) will **not** be approved for BCCPTP.

If a woman receiving BCCPTP is found eligible for FIP, notify DCH by:

- Calling the BCCPTP coordinator, Michele Barton at (517) 241-8164.
- Sending an DHS-45, DHS to DCH/MIChild/FTW Transmittal. The address is on the form or fax form to (517) 373-9305.

If a woman found eligible under BCCPTP is in MA deductible status, DCH will end the MA deductible status, open BCCPTP and notify the local office.

An ex parte review (see glossary) 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 MA categories; see BAM 115 and 220.

BEM 174, FREEDOM TO WORK (FTW)

FTW Referrals

If you determine that a client's earned income exceeds 250 percent of the FPL and meets all other financial and non-financial factors in this item, use a DHS-45, DHS to DCH/MIChild/FTW Transmittal, and send a legible photocopy of the FTW budget sheet to the address below:

Freedom to Work
PO Box 30412
Lansing, MI 48909

FTW will use the budget information to determine the premium payment. When the client's income increases to the point they would be required to pay a different premium amount, send a copy of the new budget to the above address.

Use a DHS-14, MIChild/Freedom to Work Referral, to inform the client of the referral to FTW. This notice also informs the client if a premium is required.

Do **not** end the client's medical assistance on CIMS. FTW will notify the client of the premium payment and collection process. If the premium is not paid, DCH's Exception Unit will close the case and notify DHS staff.

An ex parte review (see glossary) 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 MA categories; see BAM 115 and 220.

BEM 630, REFUGEE ASSISTANCE PROGRAM

RAPC and RAPM

Bridges uses the following guidelines when determining eligibility for RAP:

- Bridges determines eligibility for FIP and MA before determining eligibility for RAPC and/or RAPM.

  Note: Excess income for MA resulting in a deductible is **not** considered MA eligible.

- Bridges determines FIP and MA eligibility when a RAP recipient reports a change that indicates potential FIP or MA eligibility (for example, when RAP recipient becomes pregnant).

See RAP EXTENDED MEDICAL COVERAGE in this item about when RAPM may be extended.

An ex parte review (see glossary) 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 MA categories; see BAM 115 and 220.

BEM 647, TRANSITIONAL MA PLUS (TMA-PLUS)

Ongoing Eligibility

During each 12-month period between redeterminations, eligibility continues unless:

- Premiums are **not** paid on or before the due date; see **PREMIUM PAYMENTS**.

  Note: A TMA-Plus eligible group member may choose to end his/her eligibility without affecting the eligibility of other members.

- Payment received is less than the full premium amount or considered to be non-sufficient funds (NSF).

- The TMA-Plus group no longer contains a child who meets age and school attendance requirement.

- Other comprehensive health insurance is obtained or is available from an employer for the same or less than the TMA-Plus premium amount.

- Residence/institutional status factors in **NONFINANCIAL ELIGIBILITY FACTORS are** no longer met by a TMA-Plus eligible group member.

- A TMA-Plus eligible group or group member is approved for an MA category including FIP. A pregnant woman must be transferred to Healthy Kids for Pregnant Woman (HKP). She may regain her TMA-Plus eligibility after the pregnancy ends.

A group member who loses TMA-Plus eligibility **cannot** re-enroll in TMA-Plus unless the group member is once again TMA eligible.

An ex parte review (see glossary) 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 MA categories; see BAM 115 and 220.

GLOSSARY

Ex Parte Review	A determination made by the department without the involvement of the recipient, the recipient's parents, spouse, authorized representative, guardian, or other members of the recipient's household. It is based on a review of all materials available to the specialist that may be found in the recipient's current Medicaid eligibility case file.
Indicated or Demonstrated a Disability	Information in the recipient's current Medicaid eligibility case file shows the recipient has alleged a serious mental or physical impairment or injury. A condition, impairment, or injury will not be considered serious if information in the case file shows it is so minor it cannot reasonably be expected to interfere with the individual's mental or physical functioning, or cannot reasonably be expected to last more than a year, or to result in death. An individual who has indicated or demonstrated a disability may or may not, following a disability review, be determined to meet the definition of disability used to determine eligibility for Medicaid under SSI-related disability based Medicaid TOAs.
Medicaid (MA) Eligibility Case File	All written information received or maintained electronically in the eligibility determination system or in hard copy by the worker at any time in the last 24 months, including all information available regarding all SSI or SSDI claims and including any information in the MRT packet.
BPB 2010-013	Bridges Policy Bulletin Ex Parte Reviews.
EFFECTIVE	**July 1, 2010.**
Issued	June 29, 2010.

SUBJECT **Ex Parte Reviews of Medicaid (MA) Closures**

All MA Categories

Effective July 1, 2010, individuals who are no longer eligible for Medicaid under their current MA category will be reviewed for eligibility in all other Medicaid categories before the individual's current Medicaid coverage ends. The review will be ex parte (see definition with this bulletin) unless information needed to determine eligibility in another category is required from the individual. The ex parte review will be based on the information currently found in the individual's case record and information available to the department. If the review determines there is no eligibility in another category, the current coverage will be allowed to end. If the individual is found eligible for MA coverage in another category,

the case will transfer to the new category and notice of continued eligibility will be sent to the individual.

Ex Parte review policy has been added to the following items:

1. BAM 115, Application Processing.
2. BAM 210, Redetermination/Ex Parte Review.
3. BAM 220, Case Actions.
4. BEM 105, Medicaid Overview.
5. BAM 106, Waiver for Elderly and Disabled.
6. BEM 110, Low Income Family.
7. BEM 111, Transitional MA.
8. BEM 113, Special N Support.
9. BEM 118, Foster Care Transition Medicaid (FCTMA).
10. BEM 124, Plan First!
11. BEM 125, Healthy Kids for Pregnant Women.
12. BEM 126, Group Two Pregnant Women.
13. BEM 129, Healthy Kids Under Age 1.
14. BEM 131, Other Health Kids.
15. BEM 132, Group 2 Persons Under Age 21.
16. BEM 135, Group 2 Caretaker Relatives.
17. BEM 145, Newborns.
18. BEM 154, Special Disabled Children.
19. BEM 503, Individuals.
20. BEM 156, Cobra Widow(er)s.
21. BEM 157 Early Widow(er)s.
22. BEM 163 AD Care.
23. BEM 164, Extended Care.
24. BEM 165, Medicare Savings Program.

25. BEM 166, Group 2 Aged, Blind and Disabled.
26. BEM 167, Program of All Inclusive Care for the Elderly.
27. BEM 169, Qualified Disabled Working Individuals.
28. CBEM 170, Home Care Children.
29. BEM 171, Children's Waiver.
30. BEM 172, Children with Serious Emotional Disturbance Waiver (SED).
31. BEM 173 Breast and Cervical Cancer Prevention and Treatment Program.
32. BEM 174, Freedom To Work (FTW).
33. BEM 630, Refugee Assistance Program.
34. BEM 647, Transitional MA Plus (TMA-Plus).

Excerpt from OCS Memorandum 2010-016

MEMORANDUM 2010-016

EFFECTIVE June 24, 2010.

Subject Fiscal Year (FY) 2009 and 2010 Federal Financial Participation (FFP) Percentages and Applicable Catalog of Federal Domestic Assistance (CFDA) Numbers Needed for the U.S. Federal Office of Management and Budget (OMB) Circular A-133

Guidance for Risk Assessment per OMB Circular A-133

FY 2009 and FY 2010 Reporting Requirements Under the American Recovery and Reinvestment Act of 2009 (ARRA) Related to the Use of Federal Performance Incentives As IV-D Matching Funds

PURPOSE: This IV-D Memorandum replaces and obsoletes Action Transmittal (AT) 2006-037, which was issued on April 21, 2006. This IV-D Memorandum:

- Updates the previous policy to identify FFP percentages, State of Michigan general fund/general purpose (GF/GP) funding, CFDA numbers, and guidance for preparation of the Schedule of Expenditures of Federal Awards (SEFA) for FY 2009 and FY 2010;
- Eliminates references to medical support contracts;

- Updates the previous policy to inform OCS contractors and auditors of the audit requirements and program risk information for FY 2009 and FY 2010. (The program risk information is not intended to be all-inclusive); and
- Informs OCS contractors and auditors of the reporting requirements under ARRA related to the use of federal performance incentives as IV-D matching funds.

Excerpt from OCS Memorandum 2010-012

MEMORANDUM 2010-012.

EFFECTIVE June 25, 2010

Subject New Title IV-D Genetic Testing Contract.

This IV-D Memorandum introduces information and procedures related to the new genetic testing contract with Orchid Cellmark, Inc. (Orchid), which was also the previous vendor. This memorandum:

- Provides the new contract rates;
- Updates genetic testing procedures to accommodate the contractual changes;
- Institutes a requirement to include genetic testing reimbursement in court orders; and
- Provides an overview of the terms of the new Orchid genetic testing contract and related procedural information to assist PA and FOC establishment personnel in their use of the genetic testing contract.