HOUSE BILL NO. 5462

October 21, 2021, Introduced by Reps. Outman, Markkanen, Meerman, Eisen, Yaroch, Beeler, Bezotte and Wozniak and referred to the Committee on Families, Children, and Seniors.

A bill to amend 1939 PA 280, entitled

"The social welfare act,"

by amending section 105c (MCL 400.105c), as added by 2013 PA 107.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

Sec. 105c. **(1)** The director of the department ~~of community health~~ shall submit a recommendation to the senate majority leader, the speaker of the house, and the state budget office on how to most effectively determine ~~medicaid~~ **Medicaid** eligibility and enrollment for all applicants by January 1, 2015. The department ~~of~~

~~community health~~ may delegate this function to another state agency, perform the function directly, or contract with a private or nonprofit entity, consistent with state law.

(2) The department shall enter into a data matching agreement with the bureau of state lottery, Michigan gaming control board, and any other relevant state board or agency to, on at least a monthly basis, identify households with lottery or gambling winnings of $3,000.00 or more. On at least a monthly basis, the department shall review this information and the case and adjust or terminate eligibility as necessary.

(3) On at least a monthly basis, the department shall receive and review information from the state registrar, including, but not limited to, death records, concerning individuals enrolled in medical assistance that indicates a change in circumstances that may affect eligibility.

(4) On at least a quarterly basis, the department shall receive and review information from the unemployment insurance agency concerning individuals enrolled in medical assistance that indicates a change in circumstances that may affect eligibility, including, but not limited to, changes in employment or wages. The unemployment agency shall provide information required under this subsection to the department each quarter in compliance with section 11 of the Michigan employment security act, 1936 (Ex Sess) PA 1, MCL 421.11.

(5) On at least a monthly basis, the department shall review information concerning individuals enrolled in medical assistance that indicates a change in circumstances that may affect eligibility, including, but not limited to, potential changes in residency as identified by out-of-state electronic benefit transfer

transactions.

(6) Notwithstanding other provisions of law, the department shall not accept eligibility determinations for medical assistance from an exchange established under 42 USC 18041(c). The department may accept assessments from an exchange established under 42 USC 18041(c), but shall verify eligibility and make eligibility determinations.

(7) If the department receives information concerning an individual enrolled in medical assistance that indicates a change in circumstances that may affect eligibility, the department must review the individual's case.

(8) The department may execute a memorandum of understanding with any other state department, agency, or division for information required to be shared between agencies outlined in this section. This section does not prohibit the department from contracting with 1 or more independent vendors to provide additional data or information that may indicate a change in circumstances that may affect eligibility.

(9) Unless required under federal law, the department shall not do any of the following:

(a) Designate itself as a qualified health entity for the purpose of making a Medicaid presumptive eligibility determination or for any purpose not expressly authorized by state law.

(b) Accept self-attestation of income, residency, age, household composition, caretaker or relative status, or receipt of other coverage without verification before enrolling in Medicaid.

(c) Request authority to waive checking or decline to periodically check any available income-related data sources to verify Medicaid eligibility.

(d) Request authority to waive or decline to comply with public notice requirements applicable to proposed changes to the state plan according to 42 CFR 440.386, 42 CFR 447.57, and 42 CFR 447.205.

(10) In making a presumptive eligibility determination, the hospital must do all of the following:

(a) Notify the department of each presumptive eligibility determination within 5 working days after the date the determination was made.

(b) Assist individuals determined to be presumptively eligible with completing and submitting a full Medicaid application form.

(c) Notify the applicant in writing and on all relevant forms with plain language and large print that if the applicant does not file a full Medicaid application with the department before the last day of the following month, presumptive eligibility coverage will end on that last day.

(d) Notify the applicant that if the applicant files a full Medicaid application with the department before the last day of the following month, presumptive eligibility coverage will continue until an eligibility determination is made on the application that was filed.

(11) The department must use the following standards to establish and ensure that accurate presumptive eligibility determinations are made by each qualified hospital:

(a) Was the Medicaid presumptive eligibility card received by the department within 5 working days after the determination date?

(b) Was a full Medicaid application received by the department before the presumptive eligibility period expired?

(c) If a full application was received, was the individual

found to be eligible for full Medicaid coverage?

(12) The first time a qualified hospital fails to meet a standard established for a presumptive eligibility determination that the hospital made, the department must notify the hospital in writing within 5 days after the department determines that the standard was not met. The notice must include the following:

(a) A description of the standard that was not met and an explanation of why it was not met.

(b) Confirmation that a second finding will require that all applicable hospital staff participate in mandatory training on hospital presumptive eligibility rules and regulations to be conducted by the department.

(13) The second time a qualified hospital fails to meet a standard established for a presumptive eligibility determination that the hospital made within 1 year of the first violation, the department must notify the hospital in writing within 5 days after the department determines that the standard was not met. The written notice must include all of the following:

(a) A description of the standard that was not met and an explanation of why it was not met.

(b) Confirmation that all applicable hospital staff are required to participate in a mandatory training on hospital presumptive eligibility rules and regulations to be conducted by the department, including the date, time, and location of the training as determined by the department.

(c) A description of available appellate procedures by which a qualified hospital may dispute the finding of failure and remove the finding by providing clear and convincing evidence that the standard was met.

(d) Confirmation that if the hospital again fails to meet 1 or more of the standards for presumptive eligibility for a determination, the hospital will no longer be qualified to make presumptive eligibility determinations.

(14) The third time a qualified hospital fails to meet a standard established for a presumptive eligibility determination that the hospital made within 1 year after the second violation, the department must notify the hospital in writing within 5 days after the department determines that the standard was not met. The written notice must include all of the following:

(a) A description of the standard that was not met and an explanation of why it was not met.

(b) A description of available appellate procedures by which a qualified hospital may dispute the finding of failure and remove the finding by providing clear and convincing evidence that the standard was met.

(c) Confirmation that, effective immediately, the hospital is no longer qualified to make Medicaid presumptive eligibility determinations.

(15) When the department receives funding for Medicaid contingent on temporary maintenance of effort restrictions or, for any reason, is limited in its ability to disenroll individuals, such as restrictions imposed by section 6008 of the families first coronavirus response act, Public Law 116-127, the department must do the following:

(a) Continue to conduct redeterminations as in the normal course of business and act on the redeterminations to the fullest extent permissible under the law.

(b) Within 60 days after the restrictions expire, complete a

full audit in which the department shall do all of the following:

(*i*) Complete and act on eligibility redeterminations for all cases that have not had a redetermination within the last 12 months.

(*ii*) Request federal approval from the Centers for Medicare and Medicaid Services for the authority to conduct and act on eligibility redeterminations for each individual enrolled during the period of restrictions enrolled for 3 or more total months and shall, within 60 days after approval, conduct and act on the redeterminations.

(*iii*) Carry out an additional check of all verification measures established under section 10f to verify eligibility and act on the information checked.

(*iv*) Submit a summary report of the audit to the speaker of the house of representatives and the senate majority leader.