



# OAG

Office of the Auditor General

201 N. Washington Square, Sixth Floor • Lansing, Michigan 48913 • Phone: (517) 334-8050 • [audgen.michigan.gov](http://audgen.michigan.gov)

**Doug A. Ringler, CPA, CIA**  
Auditor General

March 27, 2026

The Honorable Roger Victory  
Michigan Senate  
Connie Binsfeld Building, Suite 6400  
Lansing, Michigan

Senator Victory:

Enclosed are answers to six questions you posed regarding the State of Michigan's Medicaid spending. To develop our answers, we reviewed MDHHS policies and procedures, analyzed Medicaid eligibility and payment information, analyzed MDHHS expenditure data from SIGMA, reviewed MDHHS's contracts with vendors, and researched other states' Medicaid programs.

We appreciate the opportunity to assist you in answering questions regarding this topic. If you have further questions or a request for other services, please do not hesitate to contact our office.

Sincerely,

A handwritten signature in black ink that reads "Doug Ringler". The signature is written in a cursive, flowing style.

Doug Ringler  
Auditor General

Enclosures

**Report Fraud/Waste/Abuse**

Online: [audgen.michigan.gov/report-fraud/](http://audgen.michigan.gov/report-fraud/)

Hotline: (517) 334-8060, Ext. 1650



### Background:

The Michigan Department of Health and Human Services (MDHHS) has an approved State Plan to operate a State Medicaid program. MDHHS determines eligibility for individuals in need of Medicaid healthcare coverage. Medicaid eligibility requirements, for example income, assets, age, and disability, are outlined in MDHHS's Bridges Administrative Manual (BAM) and Bridges Eligibility Manual (BEM) (see Exhibit 1). BAM contains administrative policies related to eligibility, such as what must be maintained in the case record and data exchanges. BEM contains policies related to the eligibility factors for specific modified adjusted gross income (MAGI) and non-MAGI types of assistance (TOAs), such as Healthy Michigan Plan and AD-Care (see Exhibit 2). Specific healthcare coverage may vary depending on the Medicaid program (see Exhibit 3) and the applicant's citizenship status. For example, a noncitizen's medical coverage may be limited to emergency services.

MDHHS Economic Stability Administration (ESA) provides guidance, policy, training, technology, and leadership to MDHHS local offices, while MDHHS local office eligibility specialists are responsible for performing eligibility determinations for Medicaid healthcare coverage.

Eligibility specialists use the Bridges Integrated Automated Eligibility Determination System (Bridges) to assist in determining and documenting eligibility for individuals in need of Medicaid healthcare coverage. For eligibility determinations, eligibility specialists use the electronic case file within Bridges to maintain supporting documentation, such as applications, social security cards, and income and asset verifications. For MAGI eligibility determinations, MDHHS uses federal income tax return data from the Internal Revenue Service (IRS) to verify a beneficiary's income information on the application when no other recently verified income information is readily available in the case file or through other electronic data sources, such as state wage data.

Medicaid eligibility redeterminations are required at least once every 12 months for beneficiaries previously determined eligible. Automatic renewals occur when all pertinent information exists, either in the case file or from federal data sources, for an individual and can be used to renew eligibility, without requesting information from the individual.

Eligibility and benefit records from Bridges interface with the Community Health Automated Medicaid Processing System (CHAMPS) on a daily basis. CHAMPS is a medical assistance claims processing system and includes functions such as provider enrollment, claims status, prior authorization, and provider verification. Once determined eligible, an individual is enrolled either in a fee-for-service (FFS) arrangement or in a Managed Care Organization (MCO) and entered into CHAMPS. CHAMPS is used to process the majority of Medicaid medical claims and payments.

MDHHS's Bureau of Medicaid Care Management administers the Medicaid Eligibility Quality Control program, which designs and conducts projects known as pilots, to evaluate the processes that determine an individual's eligibility for Medicaid, specifically focusing on vulnerable or error-prone areas.

Questions and Answers:

**Q1:** How does the State ensure individuals covered under Michigan's Medicaid program are qualified recipients and receiving the appropriate services?

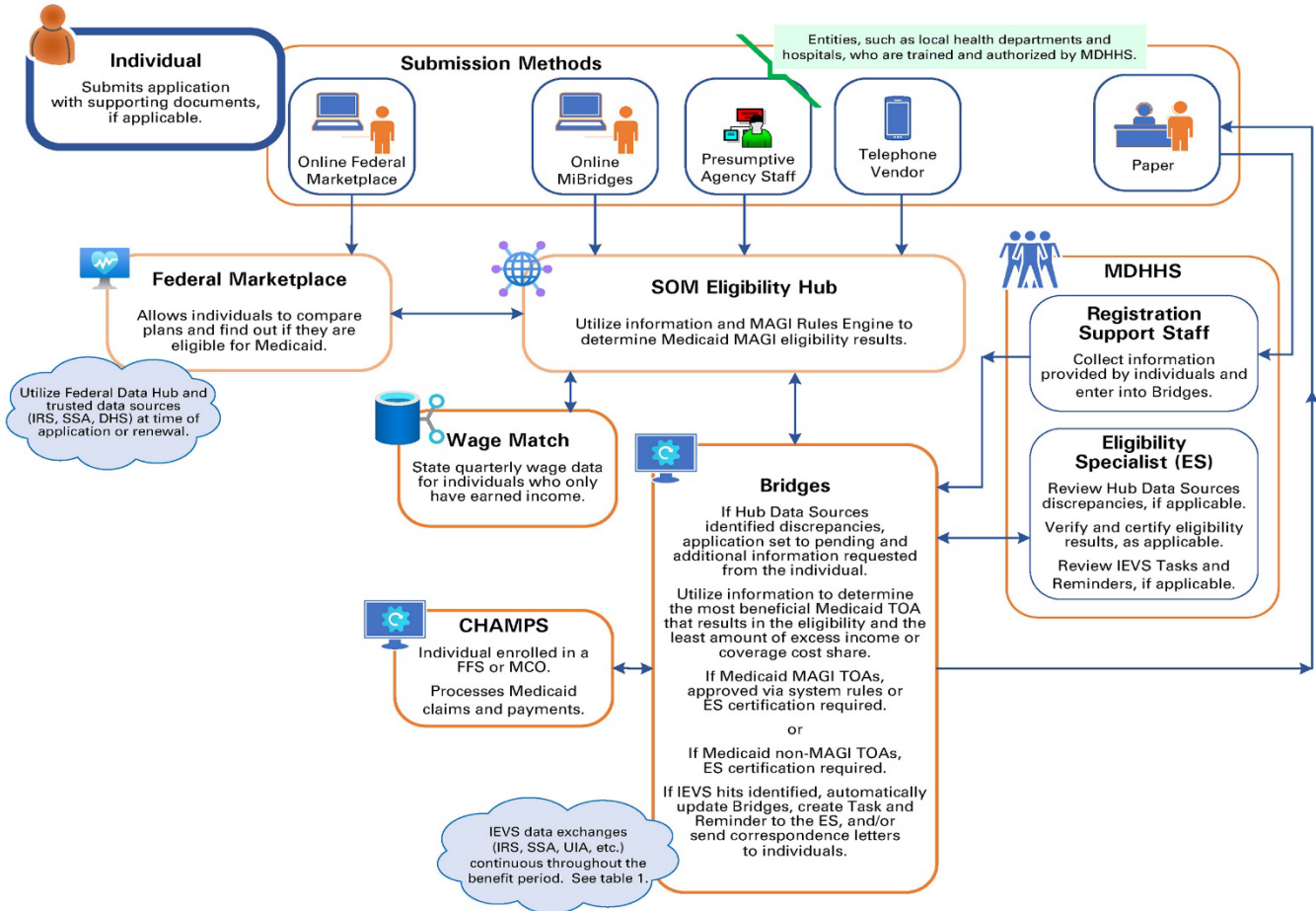
**A1:** MDHHS is responsible for establishing eligibility and utilizes management information systems to ensure only certified individuals receive Medicaid benefits. MDHHS conducts multiple data exchanges with federal and State agencies, such as the Social Security Administration (SSA) for citizenship and social security number verification, IRS for income verification, U.S. Department of Homeland Security (DHS) for lawful presence of noncitizens, and Michigan Unemployment Insurance Agency (UIA) for earned income. These data exchanges may occur at the time of application, renewal, or continuously throughout the benefit period. See table 1 for Medicaid Income and Eligibility Verification System (IEVS) data exchanges occurring throughout the year.

**Table 1: Medicaid IEVS Data Exchanges**

Data Exchange Source	Specific Data Exchange	Frequency		Description
		Applicants	Recipients	
SSA	Beneficiary Data Exchange System (BENDEX)	Monthly	Daily	Information on recipients of Retirement, Survivors, and Disability Insurance (RSDI) and Medicare benefits.
	State Data Exchange (SDX)	Two Weekends per Month		Information on applicants and recipients of Supplemental Security Income (SSI).
	Enumeration Verification System	Daily	Not Applicable	Matches social security numbers (SSNs) entered in Bridges with SSA records.
	Deceased Recipient Match	Monthly		Compares active recipient SSNs to SSA's death records.
	Prisoner Match	Quarterly		Identifies pending and active clients in prison or jail.
Michigan Unemployment Insurance Agency (UIA)	Wage Match	Quarterly		Cross matches MDHHS recipient data with work history records submitted by Michigan employers.
	Unemployment Compensation	Weekly		Cross matches MDHHS recipient data with UIA recipient data.
Michigan New Hire Operations Center	State New Hires	Daily		Cross matches active MDHHS recipients with the New Hire database which is from W-4 tax records (or other new hire reporting formats) submitted by employers for new employees.
IRS	IRS Unearned Income Match	At Application	Month prior to Redetermination	Cross matches unearned income data from MDHHS applicants and recipients with unearned income reported to the IRS.
	IRS Wage and Pension Match	At Application	Yearly	Cross matches income data from MDHHS applicants and recipients with certain income reported to the IRS.
Michigan Department of Corrections	Incarceration Match	Daily		Match identifying incarcerated individuals who are active for any program.
Michigan Lottery	Lottery Match	Monthly	Biweekly	Match identifies clients who won \$1,000 or more in the previous week.
Public Assistance Reporting Information System (PARIS)	PARIS Interstate Match	Quarterly		Matching service used to help determine if a client has received duplicate benefits in two or more states.

The method in which the individual applied or reapplied for medical services determines the approval process. After MDHHS confirms the individual's Medicaid eligibility and TOA, the individual is enrolled in either an FFS arrangement or MCO and can begin to receive medical services from Medicaid providers. See figure 1:

**Figure 1: Approval Process for Medicaid Eligibility**



(Click on figure to enlarge.)

During fiscal year 2024, MDHHS utilized approximately 1,000 CHAMPS claims edit rules to help prevent payments for FFS claims not fully supported or which required further information. The disposition of the claim edit rule will determine the outcome. See table 2 for examples of claim edit rules and the associated disposition:

**Table 2: Examples of CHAMPS Claim Edit Rules and Dispositions**

Claim Edit Rule	Disposition
Procedure is not covered by MDHHS based on the date of service.	Deny claim; payment is not issued.
Submitted gender does not match eligibility gender.	Pay and report; payment is issued but error is reported to the provider to fix in the future.
The date of death is prior to the date of service.	Suspend claim; manual review required before payment is issued.

MDHHS's Managed Care Plan Division and Office of Inspector General perform quality reviews and collect performance data on MCOs. MDHHS reviews MCO encounter data, claims, and network of providers. MCOs are required to monitor their network of providers to ensure it meets the enrollees' healthcare needs. Also, at a minimum, MCOs must provide enrollees with a full range of covered services but may choose to provide the enrollees with additional services.

While the above describes some controls related to MDHHS ensuring individuals are qualified for Medicaid healthcare coverage and receiving appropriate services, the OAG has historically and consistently identified individuals who do not meet Medicaid eligibility and for whom MDHHS issued improper payments during the State of Michigan Single Audit and performance audits (see Exhibit 4).

**Q2:** Does the State utilize third-party vendors to provide services? If so, what processes are in place to ensure transparency exists and services paid for are provided?

**A2:** Yes, MDHHS utilizes third-party vendors to provide beneficiary services, including a State enrollment contractor, pharmacy benefits manager (PBM), Medicaid Health Plans (MHPs), Prepaid Inpatient Health Plans (PIHPs), and School Services Program.

MDHHS's contracts with the vendors outline the type of monitoring activities that will be performed. The monitoring activities can include, but are not limited to, progress report reviews, annual audits, on-site visits, compliance examinations, and biannual meetings.

While MDHHS conducts certain monitoring activities of vendors, the OAG historically has identified exceptions related to vendors (see Exhibit 4).

The OAG conducted performance audits of MDHHS's Efforts to Monitor Established Service Level Agreements for the Medicaid PBM contract ([391-0117-25](#)) and School Services Program ([391-0741-25](#)). The OAG released these audit reports in March 2026.

**Q3:** How has MDHHS structured its administration of the program? Do duplication of efforts exist or opportunities to streamline the administration of the program?

**A3:** MDHHS is the single State agency responsible for the administration of the Medicaid program. MDHHS's Bureau of Policy and Strategic Engagement (BPSE) and ESA are primarily responsible for the administration of Medicaid.

BPSE administers the Michigan Medicaid State Plan and develops Medicaid policy (BEM and BAM - see background).

ESA determines Medicaid eligibility and maintains the client's case record. ESA's Business Service Centers provide guidance in process, policy, training, technology, and leadership to MDHHS local offices. MDHHS local office eligibility specialists complete client eligibility determinations.

Healthcare services covered by Medicaid are offered through either an FFS or MCO model. Various MDHHS organization units oversee the FFS and MCO providers. MDHHS contracts with MCOs, which are responsible for providing a full continuum of physical health services through a network of providers to their enrollees. See question 2 regarding third-party vendors. Individuals not

enrolled in an MCO have their medical costs paid on an FFS basis and can seek any Medicaid-enrolled provider willing to treat them. Enrollees use the mihealth card to receive services, such as nursing facility, hospital, physician, and pharmacy, and MDHHS pays the providers.

During our limited inquiry, we did not specifically identify duplication of efforts or opportunities to streamline the administration of the Medicaid program. Because of the complexities involved with Medicaid, the administration and oversight are organized depending on the type and associated requirements of providers. As discussed in question 6, Michigan's administration of the Medicaid program is comparable to other states.

**Q4:** What is the total cost of coverage on a per-beneficiary basis? What part of that is the actual cost of benefits versus administrative costs?

**A4:** We obtained Bridges, CHAMPS, and Statewide Integrated Governmental Management Applications (SIGMA) beneficiary and expenditure data from October 1, 2023 through August 31, 2025. In the table below, we summarized the annual cost of coverage per beneficiary by fiscal year.

**Table 3: Benefit and Administrative Costs**

	Fiscal Year 2024	Fiscal Year 2025 Through August 31, 2025
Number of Beneficiaries	3,126,470	2,743,725
<b>Benefit Costs</b> (in billions)	\$19.2	\$19.3
Average per Beneficiary	\$6,159	\$7,026
<b>Administrative Costs</b> (in billions)	\$0.9	\$0.6
Average per Beneficiary	\$272	\$227
<b>Total Benefit and Administrative Costs</b> (in billions)	\$20.1	\$19.9
Average per Beneficiary	\$6,431	\$7,254

**Q5:** What processes are in place to prevent, detect, and address instances of fraud, waste and abuse?

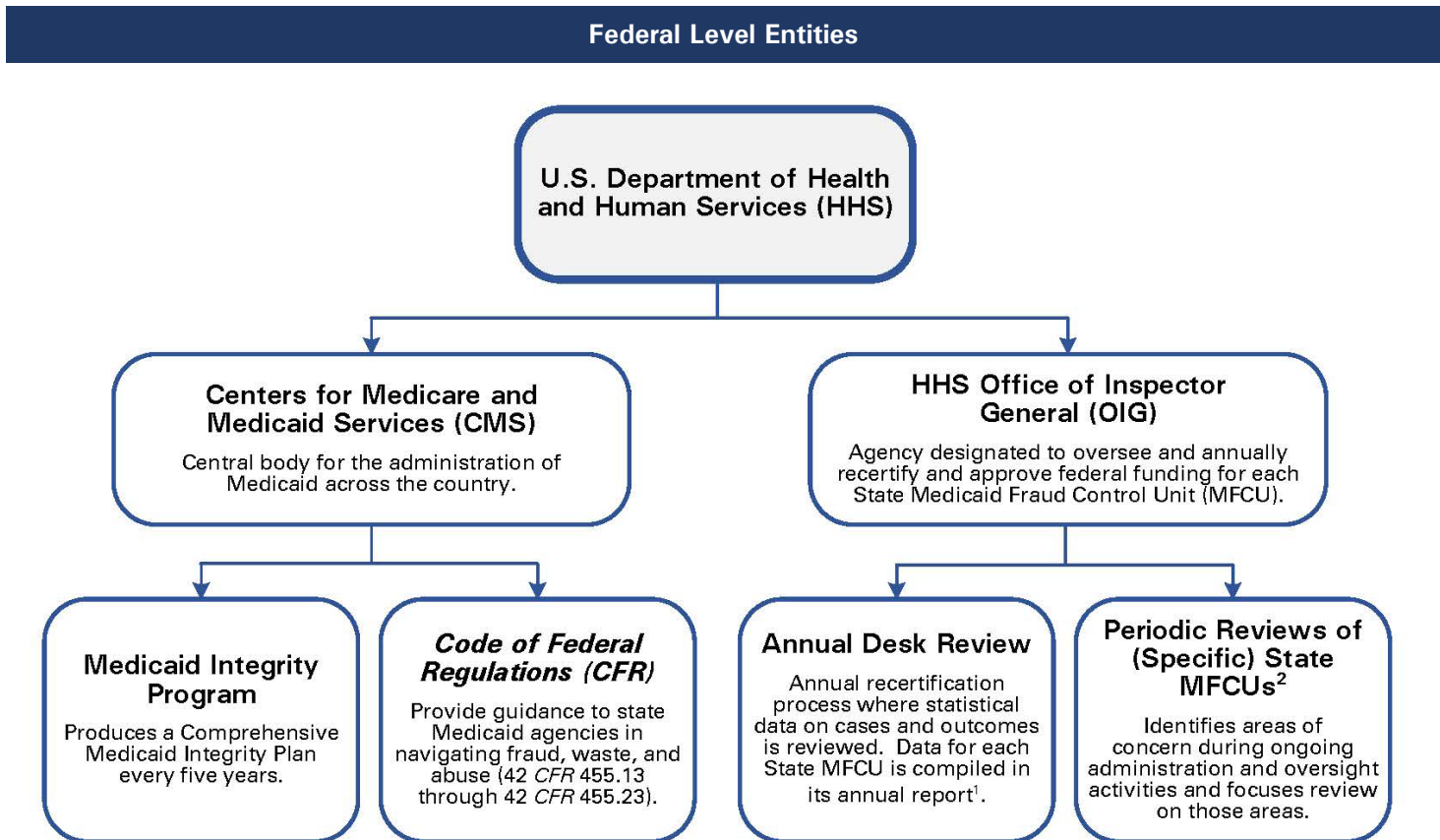
**A5:** Medicaid is administered and monitored at the federal and state level. The federal government provides funding, sets guidelines, and monitors compliance. Individual states are responsible for establishing and maintaining an administrative body to manage their Medicaid program.

**Federal Level Entities**

The two primary federal level entities with oversight to prevent, detect, and address instances of Medicaid fraud, waste, and abuse are the U.S. Department of Health and Human Services (HHS) Centers for Medicare and

Medicaid Services (CMS) and the HHS Office of Inspector General (OIG). In figure 2, we summarized some of the key processes at the federal level.

**Figure 2: Key Federal Entities and Processes for Preventing, Detecting, and Addressing Fraud**



<sup>1</sup> For the fiscal year 2024 annual report and statistical chart, see: <https://oig.hhs.gov/reports/all/2025/medicaid-fraud-control-units-annual-report-fiscal-year-2024/>

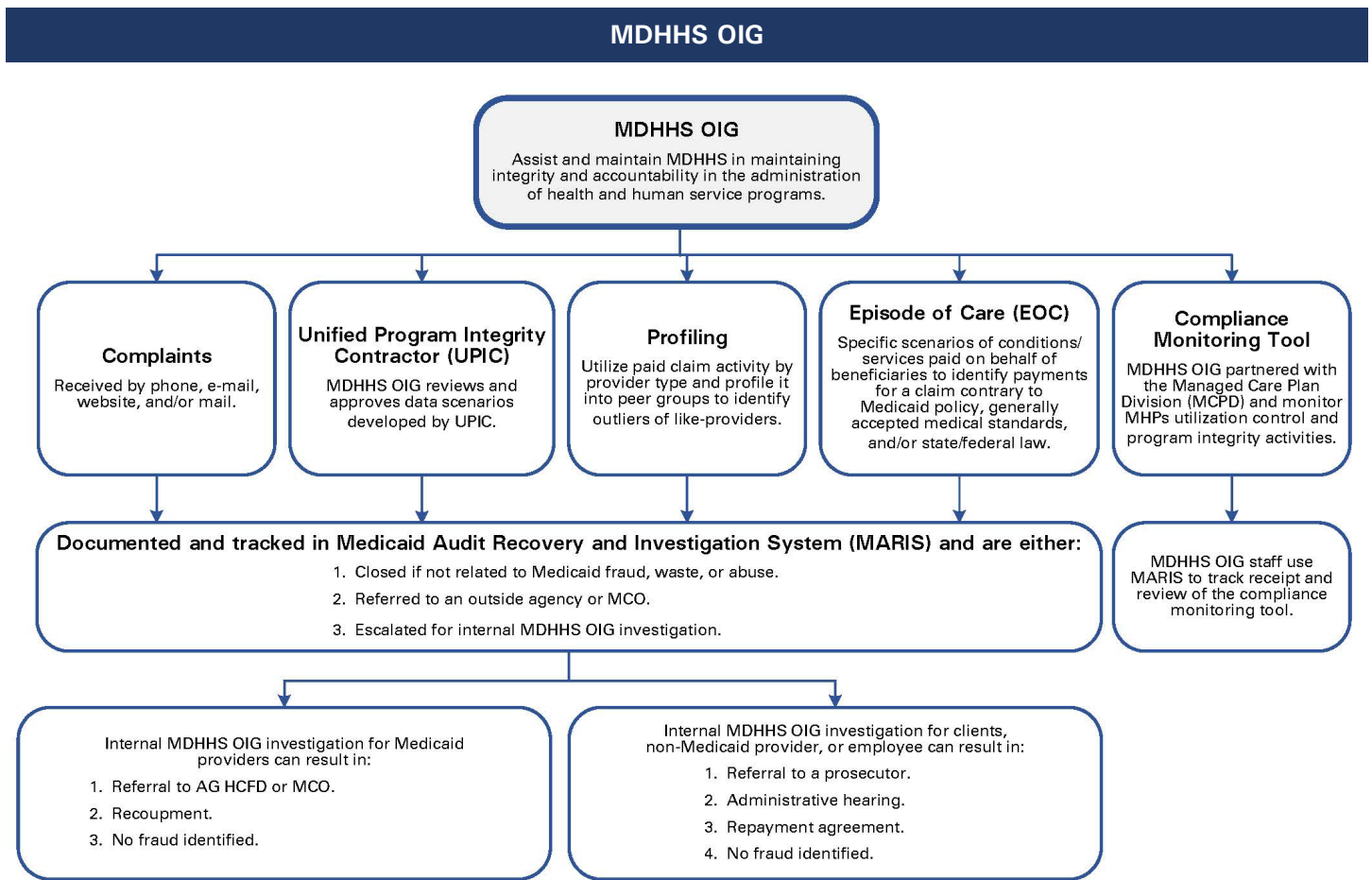
<sup>2</sup> For the most recent Michigan MFCU review (2021), see: <https://oig.hhs.gov/reports/all/2022/michigan-medicaid-fraud-control-unit-2021-review/>

**State Level Entities**

The two primary State level entities with oversight to prevent, detect, and address instances of Medicaid fraud, waste, and abuse are the MDHHS OIG and the Department of Attorney General (AG) Health Care Fraud Division (HCFD). MDHHS OIG and AG HCFD have an agreement outlining each entity's responsibilities. The agreement specifically states the two entities will "cooperate with and assist each other to ensure the highest levels of service, efficiency, and fraud and abuse control in Medicaid initiatives by agreeing that MDHHS OIG will refer all credible allegations of provider fraud and fraud in the administration of the Medicaid program to the HCFD and the HCFD will refer all

cases of non-prosecutable program abuse and improper payments to MDHHS OIG." In figures 3 and 4, we summarized some of the key processes at the State level.

**Figure 3: MDHHS OIG Key Processes for Preventing, Detecting, and Addressing Fraud**



**Figure 4: Michigan Department of Attorney General (AG) Health Care Fraud Division (HCFD) Key Processes for Preventing, Detecting, and Addressing Fraud**

**AG HCFD**  
Michigan's MFCU, which investigates and prosecutes Medicaid provider fraud and complaints of abuse and neglect in residential care facilities.

**Annual Certification**

U.S. OIG certifies the State MFCUs annually by assessing MFCUs' compliance with federal requirements and OIG guidance. As part of the recertification, MFCUs are required to submit relevant data, which U.S. OIG collects and presents.

See the following table for select statistics from the fiscal year 2024 annual report and statistical chart, as it relates to Michigan's MFCU compared with other states' MFCUs.

**Periodic Reviews**

U.S. OIG conducts periodic reviews of State MFCUs. The inspections and reviews result in public reports of findings and recommendations for improvement. U.S. OIG will also provide training and technical assistance.

U.S. OIG most recently issued a review of Michigan's MFCU in September 2022. See the following table for the results of the review.

**Figure 4: Continued**

**U.S. OIG MFCU Annual Report  
Fiscal Year 2024<sup>1</sup>**

	Michigan MFCU	Other States' MFCUs (Average)
Investigations	489	327
Indictments	15	26
Convictions	13	23
Staff on Board	34	43
Total Recoveries	\$ 4.8 million	\$27.4 million
MFCU Grant Expenditures	\$ 7.1 million	\$ 7.8 million
Total Medicaid Expenditures	\$25.4 billion	\$18.7 billion

**U.S. OIG Michigan Medicaid Fraud Control Unit:  
2021 Periodic Review<sup>2</sup>**

9 findings and 9 corresponding recommendations, for example:

- Increase fraud referrals from MDHHS OIG.
- Assess the adequacy of existing staffing levels.
- Seek opportunities to investigate more joint cases with federal partners.

8 of the 9 recommendations were implemented and closed between 2023 and 2024.

- The open recommendation is related to implementing a new, comprehensive case management system.

<sup>1</sup> For the fiscal year 2024 annual report and statistical chart, see: <https://oig.hhs.gov/reports/all/2025/medicaid-fraud-control-units-annual-report-fiscal-year-2024/>

<sup>2</sup> For the most recent Michigan MFCU review (2021), see: <https://oig.hhs.gov/reports/all/2022/michigan-medicaid-fraud-control-unit-2021-review/>

**Other Processes - Oversight of Providers**

**Provider Screening**

All providers who serve Medicaid beneficiaries are required to be screened and enrolled in CHAMPS. The Provider Credentialing System, within CHAMPS, screens the providers against multiple data sources including, but not limited to, State and federal vital records, Licensing and Regulatory Affairs licensing information, and U.S. OIG List of Excluded Individuals and Entities. The screenings verify licensure, review for suspension and debarment, and check criminal backgrounds. When a provider has a "hit" on the screenings, it results in automatic closure or management review. Providers that are closed and end-dated in CHAMPS do not receive payments for services provided.

**CHAMPS Edits**

MDHHS developed certain CHAMPS edits to identify and reject improper FFS claims. For example, edits identify and reject claims not covered by Medicaid, claims missing pertinent coding information, other insurance not billed before Medicaid, and duplicate claims. For additional information and examples regarding CHAMPS claims edit rules, see question 1.

**Predictive Modeling**

MDHHS utilizes a predictive modeling (PM) software to analyze Medicaid data. PM utilizes statistical analysis models to identify and flag Medicaid CHAMPS FFS claims on a daily basis. PM was implemented to identify billing irregularities prior to payment of a claim. When a claim is flagged for PM, a request for the medical records is issued and the provider must submit the proper documentation for review by Medicaid Claim Processing Section staff and the claim is resolved.

### FFS Explanation of Benefits (EOB) Process

MDHHS sends EOB documents to a sample of FFS beneficiaries monthly who received services in the prior month. The EOB document identifies various information, such as services rendered, provider charges, and allowed charges. The EOB document requests the beneficiary notify the MDHHS OIG only if the EOB contains incorrect information, such as services not performed, wrong quantity units, and incorrect dates of service. Upon receipt, MDHHS OIG logs the complaint into MARIS and assigns the case to an analyst for preliminary investigation, if warranted. MDHHS OIG staff use MARIS to track and investigate complaints alleging Medicaid fraud, waste, and abuse.

### Other Processes - Oversight of Recipients

#### Front End Eligibility (FEE) Program

The goal of the FEE program is to obtain and maintain a partnership between the MDHHS FEE OIG agent and local office eligibility specialists early in the eligibility determination process to reduce errors and mispayments. Under FEE, local office eligibility specialists may request a pre-eligibility investigation by a FEE OIG agent when applications or re-certifications contain suspicious or error prone information. FEE OIG agents complete the investigations and provide the local office eligibility specialists with their findings. The investigations are completed prior to opening the case or recertifying the applicant for benefits.

#### Benefits Monitoring Program (BMP)

The purpose of MDHHS's BMP is to closely monitor Medicaid program utilization and identify beneficiaries appearing to abuse, i.e., overuse and/or misuse, their Medicaid services and benefits. The objectives of the BMP are to promote medically necessary and appropriate healthcare services; promote patient safety through reduction of drug interaction, possible drug abuse, and/or duplication of medical services; and to improve the continuity of care and service coordination by preventing fragmentation of services.

To accomplish the program objectives, BMP performs the following functions:

- Identifies beneficiaries who appear to be over-utilizing and/or misusing covered services via review of flagged records in CHAMPS, referral by the MDHHS OIG High Risk Medicaid Unit, and/or referral from other areas of MDHHS.
- Evaluates utilization of covered services to determine whether the services are appropriate to a beneficiary's medical condition(s).
- Educates beneficiaries regarding appropriate utilization.
- Monitors utilization patterns and institutes interventions to optimize program effectiveness.

The beneficiary may be subject to utilization control mechanisms if it is determined the beneficiary overused and/or abused Medicaid services. When a beneficiary is enrolled in the BMP, they will remain in the program even as they may move between enrollment in FFS and MHP settings. Responsibility for administration of the BMP functions transfers between FFS and MHP settings when a beneficiary's enrollment status changes. The MHP contracts outline the BMP requirements and guidelines.

IEVS

MDHHS utilizes various data exchanges to assist in the verification of income, assets, and other eligibility factors for Medicaid recipients and applicants. For more information, see question 1.

While MDHHS has processes in place to prevent, detect, and address instances of fraud, waste, and abuse, the OAG has reported an issue with MDHHS not accurately or timely reporting the federal share of fraud, waste, and abuse overpayments (see Exhibit 4).

**Q6:** How does the State's administration of Medicaid compare to other states?

**A6:** The Medicaid and CHIP Payment and Access Commission's (MACPAC's) December 2024 edition of *MACStats: Medicaid and CHIP Data Book* compiled a broad range of Medicaid statistics into a single, end-of-year publication. The publication included various fiscal year 2023 Medicaid spending exhibits utilizing the states' CMS-64 Financial Management Report net expenditure data as of May 29, 2024.

In the table below, we summarized key expenditure data related to the State of Michigan's Medicaid spending compared to other states. Based on our analysis, we determined the State of Michigan administers the Medicaid program similar to all other states.

**Table 4: Medicaid Cost by Category in Michigan Compared to All Other States**

Medicaid Cost Category	Cost (Percent) in Michigan (in millions)	Average Cost (Percent) in All Other States (in millions)
<b>Benefit Costs:</b>		
Managed Care and Premium Assistance	\$15,540 (68%)	\$ 9,668 (57%)
Fee-for-Service	7,001 (30%)	7,186 (43%)
Other Benefit Costs <sup>1</sup>	450 ( 2%)	52 (0.3%)
<b>Total Benefit Costs</b>	<b>\$22,991</b>	<b>\$16,906</b>
<b>Administrative Costs:</b>		
Medicaid Management Information System and Eligibility Systems	\$ 344 (46%)	\$ 275 (41%)
Other Functions, federal match of 50% <sup>2</sup>	384 (51%)	377 (56%)
Other Administrative Costs <sup>3</sup>	22 ( 3%)	26 ( 4%)
<b>Total Administrative Costs</b>	<b>\$ 750</b>	<b>\$ 679</b>
Administrative Costs as a Percentage of Total Costs	3%	4%

<sup>1</sup> Other benefit costs include Medicare premiums and coinsurances and collections.

<sup>2</sup> Other administrative costs with a 50% federal match such as general Medicaid administration, general Medicaid eligibility determination and redetermination processes, determining presumptive eligibility, and costs related to determining if an individual is blind or disabled.

<sup>3</sup> Electronic health record incentive payments to providers, other administrative costs include those with a federal match above 50% and collections. Other administrative costs with a federal match above 50% such as skilled medical professionals, MFCU, and medical and utilization reviews.

**Medicaid-Related BAMs and BEMs**

**Bridges Administrative Manual (BAM)**

Policy	Description
BAM 105	Lists client's rights and responsibilities and requires MDHHS local offices determine eligibility, calculate the level of benefits, and protect client rights.
BAM 110	Requesting assistance, responding to requests, describing which application(s) should be used, and registering applications.
BAM 115	Application processing for all programs, including Medicaid.
BAM 120	Responsibility of local offices and Medicaid Services Administration for Medicaid programs.
BAM 125	Requires MDHHS provide voter registration services to clients in specific situations.
BAM 130	Identifies the types of acceptable verification obtained from the client.
BAM 205	Reinstatement restores a closed program to active status without completion of a new application. Closed programs may be reinstated for many reasons, such as closed in error, timely hearing request, and redetermination packet not logged.
BAM 210	Requires a completed eligibility redetermination for applicable beneficiaries at least once every 12 months.
BAM 220	Case action requirements for initial applications, redeterminations, and reinstatements, including notices, processing changes, ex parte reviews, and case closure.
BAM 300	Case record must contain the required documents provided by the client or produced in Bridges to support the pertinent information used in determining eligibility.
BAM 301	Local office management resources should be invested in case reading activities to help improve the accuracy and efficiency of program management.
BAM 305	Describes the assignment, reassignment, and transfer of cases in Bridges.
BAM 310	Information contained in all program case records is confidential and may be released only under limited circumstances for five general purposes: program administration, other government officials' access, charitable organization access, general public access, and client access.
BAM 400	Timeframes and other instructions to open, change, or terminate Medicaid benefits.
BAM 402	Contains Medicaid enrollment information and covered services for MAGI and SSI-related beneficiaries.
BAM 600	Contains client rights to contest MDHHS decisions affecting eligibility and benefit levels.
BAM 700	Overpayment types, responsibilities, and processing timeframes.
BAM 710	Recoupment of Medicaid overissuances due to client error or intentional program violation.
BAM 720	Establishment and disqualifications for intentional program violation.
BAM 800	Contains the data exchanges which assist in the verification of income, assets, and other eligibility factors for MDHHS recipients and applicants.
BAM 801	Data exchanges with SSA.
BAM 802	Data exchanges with the Michigan Department of Labor and Economic Opportunity (LEO) and UIA used to identify potentially current and past employment income.
BAM 803	Data exchanges with the IRS for applicants and prior to redeterminations.
BAM 804	Incarceration match with the Michigan Department of Corrections and prisoner match with SSA.

**Bridges Administrative Manual (BAM), *Continued***

Policy	Description
BAM 805	Types of funeral contracts and impact on Medicaid eligibility.
BAM 806	MDHHS access to Secretary of State (SOS) system to verify ownership of SOS-titled assets.
BAM 807	Data exchange and information from the Michigan New Hire Operations Center (obtained through the Office of Child Support) which is used to determine current income sources for active MDHHS clients.
BAM 808	Matches with the State Master Death File and the Federal Death File to identify individuals who are deceased and no longer eligible to receive benefits.
BAM 809	Data exchange with the Michigan Bureau of Lottery.
BAM 810	Medicaid coverage includes Medicare cost-sharing benefits, in which Medicaid pays premiums, coinsurances, and deductibles for certain Medicaid recipients.
BAM 814	Matches with PARIS to determine if a client has received duplicate benefits in two or more states.
BAM 815	Disability Determination Services develops and reviews medical evidence for disability and/or blindness and certifies the client's medical eligibility for assistance.
BAM 825	References the Medicaid Provider Manual for administration of Non-Emergency Medical Transportation.

**Bridges Eligibility Manual (BEM)**

Policy	Description
BEM 101	Coding elements for programs, including program code and other insurance codes.
BEM 105	Provides a Medicaid overview, including BEMs, monthly determinations, and applications/renewal forms.
BEM 106	Provides details on the MI Choice Waiver Program, including the targeted group, waiver process, MDHHS responsibilities, eligibility factors, and waiver service agents and counties served.
BEM 110	Eligibility factors for Low-Income Families Medicaid.
BEM 111	Eligibility factors for Transitional Medical Assistance (TMA).
BEM 113	Eligibility factors for Special N/Support.
BEM 117	Eligibility factors for Group 1 Medicaid, including department wards, foster care recipients, and children with adoption assistance agreements.
BEM 118	Eligibility factors for Foster Care Transition Medicaid.
BEM 124	Eligibility factors for Plan First Medicaid.
BEM 125	Eligibility factors for pregnant women.
BEM 126	Eligibility factors for Group 2 pregnant women.
BEM 129	Eligibility factors for children under age 1.
BEM 131	Eligibility factors for Other Healthy Kids.
BEM 132	Eligibility factors for Group 2 persons under 21.

**Bridges Eligibility Manual (BEM), *Continued***

Policy	Description
BEM 135	Eligibility factors for Group 2 caretaker relatives.
BEM 136	Provides details on presumptive eligibility.
BEM 137	Eligibility factors for the Healthy Michigan Plan (HMP).
BEM 145	Eligibility factors for newborns.
BEM 148	Eligibility factors for individuals served by the Flint water system.
BEM 150	Eligibility factors for SSI.
BEM 155	Eligibility factors for 503 which is an SSI-related Group 1 Medicaid category.
BEM 157	Eligibility factors for early widow(er)s who would qualify for this SSI-related Group 1 Medical Assistance (MA).
BEM 158	Eligibility factors for individuals receiving disabled adult children benefits for this SSI-related Group 1 MA.
BEM 163	Eligibility factors for Ad Care Medicaid.
BEM 164	Eligibility factors for individuals aged, blind, or disabled who would qualify for this SSI-related Group 1 Medicaid.
BEM 165	Eligibility factors for the four Medicare Saving Program categories.
BEM 166	Eligibility factors for individuals who are aged, blind, or disabled and do not meet eligibility requirements under BEMs 155-164, 170, or 171.
BEM 167	Eligibility factors to determine if individuals qualify for the Program of All Inclusive Care for the Elderly (PACE). <i>NOTE: PACE is not a Medicaid category, but there is special eligibility rules for clients approved for PACE services.</i>
BEM 168	Eligibility factors, administration, and enrollment for the MI Health Link program, which is a managed care program.
BEM 169	Eligibility factors for qualified disabled working individuals, which is an SSI-related MA category in which Medicaid pays only the recipients Medicare Part A premium.
BEM 170	Eligibility factors for children who require institutional care but can be cared for at home for less cost. It is an SSI-related Group 1 Medicaid category.
BEM 171	Eligibility factors for children who require care in an Intermediate Care Facility for Individuals with Intellectual Disability but can be cared for at home for less cost. It is an SSI-related Group 1 Medicaid category.
BEM 172	Eligibility factors for children who meet the criteria for admission to a state psychiatric hospital and/or who are at risk of hospitalization without waiver services. It is an SSI-related Group 1 Medicaid category.
BEM 173	Eligibility factors for the Breast and Cervical Cancer Prevention and Treatment program. <i>NOTE: MDHHS does not determine eligibility. Eligibility is related to screening through a health department program.</i>
BEM 174	Eligibility factors for this SSI-related Group 1 MA category for clients with disabilities age 16 through 64 who have earned income.
BEM 211	Group composition for MAGI-related categories, family size, tax filers and non-tax filers, core relatives, and examples of household composition.

**Bridges Eligibility Manual (BEM), *Continued***

Policy	Description
BEM 220	Medicaid residency requirements.
BEM 221	Applicants and beneficiaries of Medicaid are not required to verify identity, but identity must be verified for applicants of all other programs.
BEM 222	Applicable restrictions when an individual receives assistance from multiple programs for the same time period.
BEM 223	As a condition of eligibility, individuals must supply their SSN, cooperate in obtaining an SSN, or be excused from supplying and obtaining an SSN.
BEM 225	Citizenship status requirements for eligibility of all MDHHS programs, including Medicaid.
BEM 225A	Systematic Alien Verification for Entitlements (SAVE) program enables government agencies and licensing bureaus to obtain immigration status information needed to determine a noncitizen applicant's eligibility for many public benefits.
BEM 240	An individual remains eligible with respect to age for the entire month in which they reach the maximum age.
BEM 255	Requirements for cooperating with child support and reasons of good cause.
BEM 256	Provides situations in which spousal/parent support may need to be obtained for those applying/receiving Medicaid.
BEM 257	Requirements for third party resource liability.
BEM 260	Establishing disability and/or blindness for Medicaid purposes.
BEM 265	Eligibility for individuals with an institutional status.
BEM 270	Individuals must apply for any state and/or federal benefits for which they may be eligible.
BEM 271	Discusses process when a referral for an individual comes from SSA for potential Medicaid eligibility.
BEM 400	Requirements for considering assets when determining Medicaid eligibility.
BEM 401	Medicaid policies for trusts depend on the terms of the trust and when the trust was established.
BEM 402	Discusses what assets are countable, asset eligibility, asset transfer, initial asset assessment, protected spousal amounts, and period of eligibility.
BEM 405	Penalty periods for divestment and types of divestments.
BEM 500	Requirements for considering income when determining Medicaid eligibility.
BEM 501	Identifies which types of income from employment are considered earned, and which types are excluded or counted for each TOA.
BEM 502	Identifies guidelines for determining if an individual's income from self-employment, allowable expenses of producing self-employment income, and self-employment income types.
BEM 503	Identifies unearned income types, definition of each unearned income type, and whether an unearned income type is countable or excluded for each TOA.

**Bridges Eligibility Manual (BEM), *Continued***

Policy	Description
BEM 504	States Bridges will determine if the income from rental or room and board is countable (allowing expenses when appropriate) and if the income is counted as unearned, earned, or self-employment. This is for all programs except MAGI Medicaid.
BEM 530	Determining income eligibility and post-eligibility patient-pay amounts on a calendar month basis.
BEM 536	Outlines a multi-step process to determine a fiscal group member's income and fiscal group's net income.
BEM 540	Determining an SSI-related child's income.
BEM 541	Income deductions when determining Medicaid eligibility.
BEM 544	Protected income level, health insurance premiums, and remedial services policies for Group 2 Medicaid categories.
BEM 545	Group 2 Medicaid income eligibility process and when income eligibility exists.
BEM 546	Determining post-eligibility patient-pay amounts.
BEM 547	Discusses responsibility for entering medical services authorizations for different types of beneficiaries.
BEM 610	Eligibility requirements and exceptions for migrants and seasonal farmworkers.
BEM 657	Eligibility factors and application process for Maternity Outpatient Medical Services.

Source: The OAG prepared this exhibit based on information obtained from MDHHS.

Medicaid Healthcare Coverage Programs

The Medicaid program is composed of several sub-programs or categories. At a very high level, Medicaid programs can be broken into either modified adjusted gross income (MAGI) or non-MAGI TOAs. To receive coverage under a MAGI TOA, MDHHS relies on federal tax information and uses a methodology based on IRS rules to determine the individual's financial eligibility for Medicaid. Examples of individuals eligible for MAGI TOAs include children under 19, parents or caretakers of children, pregnant or recently pregnant women, former foster children, the Flint Water Group, and the Healthy Michigan Plan. Generally, to receive coverage under a non-MAGI TOA, the individual must be aged 65 or older, blind, disabled, entitled to Medicare, or formerly blind or disabled. In the table below, we identified the 8 most common Medicaid TOAs based on the number of Medicaid beneficiaries between October 1, 2023 and September 30, 2024:

TOA <sup>1</sup>	MAGI or Non-MAGI	Applicable BEM <sup>2</sup>	Percentage of Beneficiaries <sup>3</sup>
Healthy Michigan Plan	MAGI	137	31%
Low-Income Families	MAGI	110	24%
Transitional Medicaid	Non-MAGI	111	10%
Other Healthy Kids	MAGI	131	10%
SSI Recipients	Non-MAGI	150	7%
Plan First for Family Planning Services Medicaid	MAGI	124	6%
AD-Care	Non-MAGI	163	4%
Newborns	MAGI	145	3%

<sup>1</sup> The table does not represent a full listing of Medicaid TOAs. We excluded the following:

- TOAs with less than 3% of beneficiaries.
- Limited coverage TOAs, which require the beneficiary to meet a deductible prior to Medicaid benefits.
- Medicare Savings Program TOAs, which designate Medicaid and Medicare dual coverage, where Medicaid typically pays Medicare premiums, coinsurances, and deductibles.
- Children's Health Insurance Program (CHIP) TOAs; however, some individuals in the Other Healthy Kids TOA are transferred to CHIP. We included only the Medicaid Other Healthy Kids beneficiaries within the table.

<sup>2</sup> See Exhibit 1 for a complete listing and description of Medicaid related BEMs.

<sup>3</sup> The percentage of beneficiaries is not based on a unique count of beneficiaries eligible for Medicaid because beneficiaries shift between TOAs depending on changing eligibility factors. For example, during fiscal year 2024, it is likely some beneficiaries received Medicaid coverage under the Low-Income Families TOA and Transitional Medicaid TOA and would be included in both counts and percentages.

Source: The OAG prepared this exhibit based on information obtained from Bridges.

**MAGI Medicaid Full Coverage Categories**

TOA <sup>1</sup>	BEM	Unique Nonfinancial Eligibility Factor			
		Parent/Caretaker Relative	Under 19	Aged 19 Through 64	Impacted by Flint Water
Low-Income Families	110	X	X		
Other Healthy Kids	131		X		
Healthy Michigan Plan	137			X	
Newborns	145		X		
Impacted by Flint Water	148				X

<sup>1</sup> Table does not include the limited coverage MAGI TOAs.

**Non-MAGI SSI Related Medicaid Full Coverage Categories**

TOA <sup>1</sup>	BEM	Unique Nonfinancial Eligibility Factor					Health Department Cancer Screening
		Aged, Blind, or Disabled	Appealing SSI Termination	Blind or Disabled	Aged or Disabled	Disabled	
SSI Recipients	150	X					
Terminated SSI	150		X				
503	155	X					
Early Widow(er)s	157			X			
Disabled Adult Children	158	X					
AD-Care	163				X		
Extended Care	164	X					
Home Care Children	170					X	
Children's Waiver	171					X	
Breast and Cervical Cancer Prevention and Control Program	173						X
Freedom to Work	174					X	

<sup>1</sup> Table does not include group 2 or limited coverage TOAs, which require the beneficiary to meet a deductible prior to Medicaid benefits. In addition, the table does not include the Medicare Savings Program TOAs, including Special Low-Income Medicare Beneficiaries, Qualified Medicare Beneficiaries, Additional Low-Income Medicare Beneficiaries, and Additional Low-Income Medicare Beneficiaries 2.

Source: The OAG prepared this exhibit based on information obtained from MDHHS.

**Fiscal Year 2024 • State of Michigan Single Audit Report (000-0100-25)  
 Selected Medicaid-Related Findings**

Finding Title	Finding Summary
Bridges Interface Controls (2024-002)	Department of Technology, Management, and Budget (DTMB) did not always ensure its interface controls over the Bridges data exchanges were operating as prescribed.
Income Eligibility and Verification System (2024-005)	MDHHS and DTMB did not request and obtain IEVS information for all recipients. In addition, MDHHS did not ensure county/district office caseworkers considered and used IEVS information when making eligibility and benefit level determinations for various programs, including Medicaid.
CHAMPS Eligibility Interface Errors (2024-007)	MDHHS did not maintain documentation to support eligibility records with identified errors were properly investigated, corrected, and resubmitted for processing. Our sample of 15 daily interface runs identified 7 (47%) which had been excluded from eligibility interface processing.
Beneficiary Eligibility (2024-012)	MDHHS did not ensure or demonstrate compliance with federal laws and regulations relating to beneficiary eligibility for 7 (12%) of 60 Medicaid cases reviewed. Our review disclosed: <ul style="list-style-type: none"> <li>• MDHHS did not determine beneficiary eligibility in accordance with eligibility requirements for 2 (3%) of 60 Medicaid cases reviewed.</li> <li>• MDHHS did not maintain case file documentation supporting the beneficiary eligibility determination; examples of documentation include MAGI-based income verification results, other income support, and signed applications for 4 (7%) of 60 Medicaid cases reviewed.</li> <li>• MDHHS did not determine beneficiary eligibility within the required time frame for 1 (2%) of 60 Medicaid cases reviewed.</li> </ul>
Expenditure Processing for Medical Payments (2024-013)	MDHHS did not ensure Bridges and CHAMPS contained the correct Medicaid Cluster and CHIP eligibility information to record expenditures to the appropriate program at the time of payment and to ensure the related federal draw was accurate and timely.
Provider Eligibility (2024-014)	MDHHS did not obtain all required disclosures and/or ensure disclosures were timely and accurately updated and approved in CHAMPS for the PIHP entities, MI Choice Waiver Program (MI Choice) entities, MHP entities, Dental Health Plan entities, Integrated Care Organization entities, a home help provider, or the PBM during the audit period. In addition, MDHHS did not monitor its MI Choice entities' network of providers to ensure the providers entered into provider agreements and made required disclosures.
Refunding of Federal Share of Overpayments (2024-015)	MDHHS did not accurately and timely report the federal share of fraud, waste, and abuse overpayments made to providers on the quarterly statement of expenditures reports.
Medical Loss Ratio (2024-016)	MDHHS did not ensure 5 of 8 sampled managed care entities' medical loss ratio (MLR) reports contained a comparison of the amounts used in the MLR calculation with the audited financial reports.
Managed Care Periodic Audits (2024-017)	MDHHS did not ensure an independent audit of its managed care entities encounter and financial data was completed and submitted for all significant components necessary to meet audit requirements. Also, MDHHS did not ensure the audits were posted to its website at least once every three years.
Transitional Medicaid Eligibility (2024-039)	MDHHS did not ensure renewals were processed on a timely basis for beneficiaries receiving transitional medical assistance Medicaid coverage.

**Fiscal Year 2024 • State of Michigan Single Audit Report (000-0100-25)  
 Selected Medicaid-Related Findings, *Continued***

Finding Title	Finding Summary
Payments on Behalf of Ineligible Beneficiaries (2024-040)	MDHHS did not ensure beneficiary eligibility was updated in CHAMPS. As a result, MDHHS issued \$3,373 for 11 (37%) of 30 payments sampled from a \$2,001,375 population of beneficiary payments with no corresponding Medicaid coverage.
Ineligible HHP Payments (2024-041)	MDHHS did not prevent or timely recover payments, totaling \$342, for 3 (20%) of 15 sampled clients who were hospitalized while receiving Home Help Program (HHP) services and no longer met eligibility requirements.
Ineligible Home Help Assistance (2024-042)	MDHHS did not obtain an updated medical needs form to ensure the HHP beneficiary met eligibility requirements for 1 of 3 HHP payments sampled.
Practitioner Reimbursement (2024-043)	MDHHS did not ensure proper payment of practitioner FFS claims. We noted MDHHS paid \$724,105 for 10,836 FFS claims for beneficiaries simultaneously enrolled in an MHP.

**March 2022 • Medicaid and Children's Health Insurance Program  
 Client Eligibility Determinations (391-0710-19)  
 Selected Medicaid-Related Findings**

Finding Title	Finding Summary
Improvements needed to ensure MDHHS completes accurate eligibility determinations and maintains documentation (Finding 1)	MDHHS did not always accurately determine beneficiary eligibility or maintain documentation to support eligibility was processed in accordance with federal and State requirements. Our review of 147 Medicaid payments found: <ul style="list-style-type: none"> <li>• 16 (11%) beneficiaries were ineligible with estimated improper payments totaling \$1.5 billion.</li> <li>• 9 (6%) beneficiaries had missing case file documentation to support eligibility with estimated improper payments totaling \$818 million.</li> </ul>
Improvements needed in processing TMA (Finding 3)	MDHHS did not accurately process eligibility determinations or timely discontinue healthcare coverage for beneficiaries receiving TMA, resulting in approximately \$24.2 million in known improper Medicaid payments.
Improvements needed to ensure required SSN verifications are completed (Finding 4)	MDHHS did not complete the required SSN verifications for Medicaid beneficiaries, resulting in \$48.4 million in known improper payments.
Improvement needed in alien status verification (Finding 5)	MDHHS did not ensure all Medicaid beneficiaries had an acceptable alien status to receive full healthcare coverage. MDHHS issued an estimated \$43.6 million in improper payments.
Improvements needed in determining eligibility for HMP beneficiaries concurrently enrolled in Medicare (Finding 6)	MDHHS did not accurately determine beneficiary eligibility in accordance with federal eligibility requirements for some HMP beneficiaries concurrently enrolled in Medicare, resulting in an estimated \$24.2 million in improper Medicaid payments.
Improved controls needed to prevent or recover healthcare payments issued on behalf of incarcerated individuals (Finding 7)	MDHHS could improve its controls to prevent or recover Medicaid healthcare coverage payments issued on behalf of incarcerated individuals who no longer meet eligibility requirements. MDHHS issued approximately \$3.6 million in known improper capitated payments for incarcerated Medicaid beneficiaries.

**March 2022 • Medicaid and Children's Health Insurance Program  
Client Eligibility Determinations (391-0710-19)  
Selected Medicaid-Related Findings, *Continued***

Finding Title	Finding Summary
Improvements needed to ensure accurate information for SSI-related Medicaid beneficiaries (Finding 8)	MDHHS did not ensure all Medicaid beneficiaries who automatically received full healthcare coverage because of their SSI status had current and accurate beneficiary information documented in Bridges. This resulted in \$11.7 million in fiscal year 2019 improper payments that would likely continue each year until MDHHS corrects the information.
Enhancements needed in MDHHS's monitoring of beneficiary eligibility for Medicaid and CHIP (Finding 9)	MDHHS did not have a sufficient process in place, limiting its ability to improve the accuracy and efficiency of the \$14.7 billion Medicaid payments issued on behalf of beneficiaries during fiscal year 2019.
Improvements needed to ensure MDHHS timely completes Bridges tasks and reminders (Finding 10)	MDHHS had not established an effective process to monitor the eligibility specialists' completion of the Bridges non-UCL tasks and reminders. As a result, MDHHS could not ensure eligibility for healthcare coverage was always appropriately determined using accurate information.
Improvements needed in MDHHS's monitoring of the timely completion of eligibility redeterminations (Finding 11)	MDHHS did not sufficiently monitor the timeliness of Medicaid eligibility redeterminations which could help prevent MDHHS from issuing payments on behalf of ineligible beneficiaries.
Improvements needed in MDHHS's training program for Medicaid and CHIP eligibility determinations (Finding 12)	MDHHS should improve its training program and consider instituting continuous education requirements for its eligibility specialists and supervisors.
Improvements needed in MDHHS's process to address policy questions and clarifications (Finding 13)	MDHHS should consider improving its processes for tracking, reviewing, and sharing policy questions and clarifications.

Source: The OAG prepare this exhibit based on selected Medicaid-related findings from our Fiscal Year 2024 State of Michigan Single Audit Report ([000-0100-25](#)) and March 2022 performance audit of Medicaid and Children's Health Insurance Program Client Eligibility Determinations, Michigan Department of Health and Human Services ([391-0710-19](#)).

<b>AG</b>	Michigan Department of Attorney General.	<b>MACPAC</b>	Medicaid and CHIP Payment and Access Commission.
<b>BAM</b>	Bridges Administrative Manual.	<b>MAGI</b>	modified adjusted gross income.
<b>BEM</b>	Bridges Eligibility Manual.	<b>MCO</b>	Managed Care Organization.
<b>BENDEX</b>	Beneficiary Data Exchange.	<b>MDHHS</b>	Michigan Department of Health and Human Services.
<b>BMP</b>	Benefits Monitoring Program.	<b>MHP</b>	Medicaid Health Plan.
<b>BPSE</b>	Bureau of Policy and Strategic Engagement.	<b>MI Choice</b>	MI Choice Waiver Program.
<b>Bridges</b>	Bridges Integrated Automated Eligibility Determination System.	<b>MLR</b>	medical loss ratio.
<b>CHAMPS</b>	Community Health Automated Medicaid Processing System.	<b>OIG</b>	Office of Inspector General.
<b>CHIP</b>	Children's Health Insurance Program.	<b>PACE</b>	Program of All Inclusive Care for the Elderly.
<b>CMS</b>	Centers for Medicare and Medicaid Services.	<b>PARIS</b>	Public Assistance Reporting Information System.
<b>DHS</b>	U.S. Department of Homeland Security.	<b>PBM</b>	pharmacy benefits manager.
<b>DTMB</b>	Department of Technology, Management, and Budget.	<b>PIHP</b>	Prepaid Inpatient Health Plan.
<b>EOB</b>	explanation of benefits.	<b>PM</b>	predictive modeling.
<b>ESA</b>	Economic Stability Administration.	<b>RSDI</b>	Retirement, Survivors, and Disability Insurance.
<b>FEE</b>	front end eligibility.	<b>SAVE</b>	Systematic Alien Verification for Entitlements.
<b>FFS</b>	fee-for-service.	<b>SDX</b>	State Data Exchange.
<b>HCFD</b>	Health Care Fraud Division.	<b>SIGMA</b>	Statewide Integrated Governmental Management Applications.
<b>HHP</b>	Home Help Program.	<b>SOS</b>	Michigan Secretary of State.
<b>HHS</b>	U.S. Department of Health and Human Services.	<b>SSA</b>	Social Security Administration.
<b>HMP</b>	Healthy Michigan Plan.	<b>SSI</b>	Supplemental Security Income.
<b>IEVS</b>	Income Eligibility Verification System.	<b>SSN</b>	social security number.
<b>IRS</b>	Internal Revenue Service.	<b>TMA</b>	Transitional Medical Assistance.
<b>LEO</b>	Department of Labor and Economic Opportunity.	<b>TOA</b>	type of assistance.
<b>MA</b>	medical assistance.	<b>UIA</b>	Unemployment Insurance Agency.