MDHHS Michigan Department of Health & Human Services

Medical Services Administration

BULLETIN MSA

Bulletin Number: MSA 20-06

Distribution: All Providers

Issued: February 28, 2020

Subject: Updates to the Medicaid Provider Manual; Clarification on Co-Pays for Prescriptions Filled in a Federally Qualified Health Center, Rural Health Clinic, or Tribal Health Center

Effective: As Indicated

Programs Affected: Medicaid, Healthy Michigan Plan, Children's Special Health Care Services, Children's Waiver, Maternity Outpatient Medical Services, MI Choice Waiver

Updates to the Medicaid Provider Manual

The Michigan Department of Health and Human Services (MDHHS) has completed the April 2020 update of the online version of the Medicaid Provider Manual. The manual will be available April 1, 2020 at www.michigan.gov/medicaidproviders >> Policy, Letters & Forms >> Medicaid Policy Manual.

If changes were made in a chapter, a note will appear in the affected section/subsection title of that chapter's table of contents. If both technical and bulletin incorporation changes apply to the section/subsection, color coding will be limited to reflect a bulletin-related change.

Please refer to the online version of this bulletin at www.michigan.gov/medicaidproviders >> Policy, Letters & Forms to view the attachments that describe the changes made, the location of the changes within the manual and, when appropriate, the reason for the change.

Clarification on Co-Pays for Prescriptions Filled in a Federally Qualified Health Center, Rural Health Clinic, or Tribal Health Center

Co-pays for prescriptions filled within a Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC), or Tribal Health Center (THC) should continue to be collected according to current Medicaid policy. Beneficiaries and drugs exempted from co-pays are listed in the General Information for Providers Chapter and/or the Pharmacy Chapter of the Medicaid Provider Manual. Reimbursement of FQHC and RHC services under the prospective payment system (PPS) applies to ambulatory/outpatient clinical services. Reimbursement of THC services under the all-inclusive rate payment methodology applies to ambulatory/outpatient clinical services. Claims for prescriptions are not part of the PPS or all-inclusive payment methodology.

Manual Maintenance

If utilizing the online version of the manual at www.michigan.gov/medicaidproviders >> Policy, Letters & Forms, this bulletin and those referenced in this bulletin may be discarded. If using a CD version of the Medicaid Provider Manual, providers should retain all bulletins issued since the version date of the CD. Providers are encouraged to use the Michigan Medicaid Provider Manual on the MDHHS website; the online version of the manual is updated on a quarterly basis.

Questions

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Health and Human Services, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mail at ProviderSupport@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, NPI number, and phone number so you may be contacted if necessary. Typical Providers may phone toll-free 1-800-292-2550. Atypical Providers may phone toll-free 1-800-979-4662.

Approved

Kate Massey, Director
Medical Services Administration

Michigan Department of Health and Human Services

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
General Information for Providers	9.1 Prior Authorization Certification Evaluation Review (PACER)	The 1st paragraph was revised to read: Elective admissions, all readmissions within 15 days of discharge, continued stays (when appropriate), and all transfers for surgical or medical inpatient hospital services to and from any in-state or borderland hospital enrolled in the Medicaid program require authorization through the ACRC. This includes transfers between an acute care hospital, an enrolled distinct part rehabilitation unit of the same hospital, or a Long Term Acute Care Hospital (LTACH). Authorization requirements for out-of-state/beyond borderland hospitals can be found in the Out-of-State/Beyond Borderland Providers subsection of this chapter. All cases are screened using the Medicaid approved Severity of Illness/Intensity of Services (SI/IS) criteria sets and the clinical judgment of the review coordinator. An ACRC physician/dentist makes all adverse decisions.	To clarify out-of-state/beyond borderland hospitals do not need a PACER and must follow PA requirements stated later in the chapter.
General Information for Providers	11.2.A. Beneficiaries Excluded from Copayment Requirements	The subsection title was revised to read: 11.2.A. Beneficiaries Excluded From Medicaid Copayment Requirements In the 1st paragraph, the 9th bullet point was revised to read: • Services provided by a Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC), or Tribal Health Center (THC). Copays for prescriptions filled in an FQHC, RHC, or THC are only exempt based on the beneficiary's eligibility and/or specific drug exclusions listed in the Medicaid Copayments subsection of the Pharmacy Chapter.	To clarify we mean excluded from only Medicaid copayments, not Medicare or commercial copayments. To clarify copay exemptions for prescriptions filled in an FQHC, RHC, or THC.
Billing & Reimbursement for Institutional Providers	6.6 Transplants	The 1st paragraph and 1st bullet point were revised to read: Heart, ~~bone marrow,~~ liver, lung, simultaneous pancreas/kidney, kidney, and pancreas transplants are reimbursed at the hospital's Medicaid cost-to-charge ratio. • Organ acquisition costs are reimbursed at 100% of charges when billed using either revenue code 0811 or 0812. This applies to heart, ~~kidney,~~ liver, lung, simultaneous pancreas/kidney, kidney, or pancreas transplants. ~~This does not apply to bone marrow transplants. All bone marrow transplant charges are reimbursed at the hospital's cost-to-charge ratio.~~	Update from bulletin MSA 15-30.

* Technical Updates/Clarifications are always highlighted in yellow in the online manual.

CHAPTER	SECTION	CHANGE	COMMENT
Behavioral Health and Intellectual and Developmental Disability Supports and Services	4.3 Essential Elements	Under **"Team Composition and Size"**, the following bullet points were revised: • ***(1st bullet point)*** ~~A full-time team leader with a minimum of a Master's degree in a relevant discipline and with appropriate licensure or certification to provide clinical supervision to the ACT team staff, plus a minimum of two years post-degree clinical experience with adults who have serious mental illness is required. The ACT team leader is a Qualified Mental Health Professional (QMHP) or Mental Health Professional (MHP). The ACT team leader also provides direct services to beneficiaries in the community within their scope of practice.~~ A full-time team leader whose experience includes at least two years post-degree clinical work with adults who have a serious mental illness, and is fully licensed, minimally possessing a master's degree in a relevant discipline, with appropriate licensure to provide clinical supervision to the ACT team staff. The ACT team leader leads the team, provides clinical supervision to team members, and provides direct services to beneficiaries in the community within their individual scope of practice. The fully licensed ACT team leader also meets the requirements of a MHP. • ***(6th bullet point)*** ~~A case or care manager with a minimum of a Bachelor's degree in a human services discipline with appropriate licensure to provide the core elements of case or care management, with at least one year of experience providing services to adults with a mental illness, is required. This individual shall be a Qualified Mental Health Professional (QMHP).~~ ~~If the case or care manager has a Bachelor's degree, but is without the specialized training or experience, the case or care manager must be supervised by a QMHP who does possess the training or experience.~~	The description for the ACT team leader was revised to address QMHP changes in Provider Qualifications -- the requirement for full licensure remains and reference to QMHP was deleted.

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		A case or care manager, possessing minimally a bachelor's degree in a human services discipline, who possesses appropriate licensure to provide the core elements of case or care management with at least one year of experience providing services to adults with a mental illness, and is a QMHP. If the case or care manager has a bachelor's degree but is without one year of experience working with adults with serious mental illness or co-occurring disorders and otherwise meets the requirements of the QMHP, documentation of clinical supervision is provided in the beneficiary record.	The description for the case or care manager was revised to address QMHP changes in Provider Qualifications.
		• *(7th bullet point)* ~~A Qualified Mental Health Professional (QMHP) with a clinically prepared Master's Degree shall provide individual/family counseling.~~ Individual/family/group counseling provided by a MHP, including a limited-licensed master's degree social worker who is supervised by a licensed master's degree social worker.	The description for ACT staff who provide counseling was revised to address QMHP changes in Provider Qualifications, reference to QMHP was deleted.
		Text for **"Staff-to-Beneficiary Ratio"** was revised to read: The ACT team's staff-to-beneficiary ratio shall be at least one FTE ACT staff to a maximum of 10 ACT beneficiaries, a 1:10 staff-to-beneficiary ratio. Teams serving large service areas, highly complex beneficiaries, or very high acuity beneficiaries may find a lower staff-to-beneficiary ratio better meets beneficiary needs and retains team capacity to quickly address emerging or acute treatment needs and adjust service contacts. With the exceptions of the limitations on paraprofessionals and certified peer support specialists described above, the staff ratio includes all ACT team members, excluding the clerical support staff and physicians, nurse practitioners, physician assistants, and clinical nurse specialists.	"certified" and "staff" inserted for clarity. 'physician assistants' was inadvertently omitted in 1-1-2020 version.

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CHAPTER	SECTION	CHANGE	COMMENT
Behavioral Health and Intellectual and Developmental Disability Supports and Services Non-Physician Behavioral Health Appendix	Section 5 – Clams Processing and Reimbursement Amounts	The 2nd paragraph was revised to read: Non-physician behavioral health payment rates are established by MDHHS as a fee screen for each procedure. ~~Reimbursement is based on the Medicaid Practitioner fee schedule.~~ Services performed by non-physician behavioral health providers are reimbursed at a percentage of the ~~non-facility~~ Medicaid practitioner fee schedule rate. Refer to the Medicaid Non-Physician Behavioral Health fee schedule or the Community Health Automated Medicaid Processing System (CHAMPS) Medicaid Rate and Reference tool for additional information. The fee schedule is reviewed and updated at least annually.	Language updated to clarify reimbursement.

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Hospital Reimbursement Appendix	12.3 Appeal Process	The 5th and 6th paragraphs were deleted. ~~Hospitals wishing to proceed to the next level of the appeal process have two options:~~ ~~• The hospital may elect to appeal through an administrative hearing as provided in MDHHS Administrative Rules, R400.3406 through R400.3424. Administrative appeal requests must be sent to MOAHR. (Refer to the Directory Appendix for contact information.)~~ ~~• The hospital may waive its right to appeal through the administrative rules, R400.3406 through R400.3424, and instead elect to request a hearing before the State Hospital Appeals Panel. A waiver statement, signed by a duly authorized representative of the hospital, must accompany the appeal request. Appeals to this panel must be sent to MDHHS State Hospital Appeals Panel Coordinator. (Refer to the Directory Appendix for contact information.)~~ ~~Only issues raised at the conference are accepted for review at either of the two hearing processes. Appeal requests must be received by MDHHS within 30 calendar days from the date of the final determination notice sent to the hospital subsequent to the conference. Failure to submit an appeal request within 30 calendar days shall be deemed an abandonment by the hospital of all further administrative appeal rights.~~ The following text was added: Hospitals may elect to appeal an adverse action by requesting an administrative hearing as provided in MDHHS Provider Hearing Rules, R 400.3402 through R400.3404. Requests for hearing must be sent to MOAHR. Appeal requests must be made in writing and received within 30 calendar days of the notice of adverse action. If an appeal is not made in a timely manner, the notice of adverse action is final.	Clarification.

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Medical Supplier		The presentation order of material was revised – material previously labeled as 2.3 Diabetic Equipment and Related Supplies (including 2.3.A., 2.3.B. and 2.3.C.) was relocated and labeled as 2.10 Diabetic Equipment and Related Supplies (including 2.10.A., 2.10.B. and 2.10.C.). Applicable re-numbering of other affected subsections was done to reflect relocation.	Re-organization of material.
Nursing Facility Certification, Survey & Enforcement Appendix	2.1 Dual Certification	The 7th paragraph was revised to read: Facilities granted a Certificate of Need (CON) for special population beds, as defined in the Certificate of Need Review Standards for Nursing Home and Hospital Long-Term Care Unit Beds (HLTCU), are also required to dually certify ~~some types of~~ these special population beds (e.g., ventilator dependent care beds, behavioral, traumatic brain injury/spinal cord injury [TBI/SCI]). ICF/IID or MI beds need not be dually certified. The following text was added: All beds approved pursuant to CON Review Standards for nursing home and HLTCU beds must be dually certified for Medicare and Medicaid. Beds approved under this subsection shall not be converted to or utilized as general nursing home use without a CON for nursing home and hospital long-term care unit beds; and shall not be offered to individuals other than the special populations they were initially approved for.	Updated based on the updated version of the CON Review Standards for Nursing Home and HLTCU beds effective 9/21/17.

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Nursing Facility Certification, Survey & Enforcement Appendix	2.3 Criteria for Evaluation of Medicaid Bed Certification Applications	In the 1st paragraph, the 2nd bullet point was revised to read: • The nursing facility's historical and current survey performance demonstrates no regulatory deficiencies or only deficiencies with minimal impact on residents. The nursing facility has not been subject to one of the following actions or concerns within ~~two calendar years or~~ the preceding eight full quarters (or as noted) of the filing of an application for Medicaid bed certification: In the 1st paragraph, 2nd bullet point, the 7th sub-bullet point was revised to read: ➢ A number of citations ~~resulting from abbreviated surveys~~ at Level Two or above on the scope and severity grid resulting from abbreviated surveys during the ~~two~~ preceding ~~calendar years~~ full eight quarters that exceeds twice the statewide average number of ~~abbreviated survey~~ citations.	Updated from previous technical change of 10/1/19 to be consistent with two calendar years and eight quarters. Consistency between 6th and 7th sub-bullet points.
Nursing Facility Cost Reporting & Reimbursement Appendix	Section 2 – Definitions	Revision of: **Hospital ~~– Attached~~ Long Term Care Unit (HLTCU)**	
Nursing Facility Cost Reporting & Reimbursement Appendix	8.14 Medical Supplies, Durable Medical Equipment (DME), Orthotics, and Prosthetics	In the 1st paragraph, the 4th bullet point was deleted: • ~~Continuous positive airway pressure (CPAP) device~~	Correcting an error: CPAP devices are an allowable cost.
Nursing Facility Cost Reporting & Reimbursement Appendix	10.7.D.3. QMI Payment Methodology	In the 5th paragraph, under "Examples", the 2nd bullet point was revised to read: • For rate year October 1, 2017, Nursing Facility B has an average NHC rating of 2 stars, a Medicaid utilization rate of 32%, 45 licensed nursing facility beds, and meets all the payment eligibility requirements. The NHC per-bed amount for a 2-star rating is $1,250, so the QMI Gross Adjustment = (($1,250) x (~~50%~~ 32%) x (45))/12 = ~~$2,343.75~~ $1,500/month.	Clarification.

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Practitioner	3.21 Weight Reduction	The 2nd paragraph was revised to read: The request for PA must include the medical history, past and current treatment and results, complications encountered, all weight control methods that have been tried and have failed, and expected benefits or prognosis for the method being requested. Medicaid policy is generally based on CMS guidelines for Medicare coverage of bariatric surgery. If surgical intervention is desired, a psychiatric evaluation of the beneficiary's willingness/ability to alter his lifestyle following surgical intervention must be included.	Clarification.
Acronym Appendix		Addition of: SCI – Spinal Cord Injury	
Forms Appendix	MSA-0725; Application for Payment of Health Insurance Premiums	Form was revised to reflect change in address for form submission.	Update.

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MSA 19-17	11/1/2019	MI Choice Waiver		MI Choice Waiver Chapter was revised in its entirety.
MSA 19-24	11/1/2019	Billing & Reimbursement for Institutional Providers	8.20 State Veterans' Homes	The 2nd paragraph was revised to read: Revenue code 0022 must be reported on the same service line as each HIPPS code. ~~The HIPPS code consists of the three-digit Resource Utilization Group (RUG) category followed by the two-digit Assessment Indicator (AI).~~ The five-digit HIPPS code reported on the claim represents (in this exact order) the PT/OT score, the Speech-Language Pathology (SLP) score, the Nursing score, the Non-Therapy Ancillary (NTA) score and the Minimum Data Set (MDS) assessment type. HIPPS codes for the PT/OT, SLP, Nursing and NTA scores can be found in the Medicare Claims Processing Manual. The MDS assessment type should always be an Omnibus Budget Reconciliation Act (OBRA) assessment which has a value of 6, so the fifth digit of the HIPPS code should always be 6 on the claim. The service units on the service line must contain the number of covered days for each HIPPS code. ~~RUG~~ Patient Driven Payment Model (PDPM) categories and AIs are determined by the MDS 3.0 and can be found in the MDS 3.0 Resident Assessment Instrument (RAI) Manual. (Refer to the Directory Appendix for RAI Manual information.) The 3rd paragraph was revised to read: The federally required ~~Omnibus Budget Reconciliation Act (~~OBRA~~)~~ ~~Minimum Data Set (~~MDS~~)~~ assessments listed in A0310A of the MDS 3.0 RAI Manual are the only assessments that may be used for billing ~~RUGs.~~ PDPM. In the 7th paragraph, the 1st sentence was revised to read: Non-routine ~~occupational therapy (~~OT~~)~~, ~~physical therapy (~~PT~~)~~ and ~~speech-language pathology (~~SLP~~)~~ services are included in the ~~RUG~~ PDPM rates paid to State Veterans' Homes.

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				A new paragraph (eight) was added and reads: The revenue code, HIPPS code, number of covered days for each HIPPS code, occurrence code 50, and the MDS ARD may be reported in the claim notes.
		Hospice	7.3.H. Room and Board to Nursing Facilities	In the 1st paragraph, 6th bullet point, the 1st sentence was revised to read: • **State Veterans' Homes.** MDHHS pays the hospice 100 percent of the beneficiary-specific ~~Resource Utilization Group (RUG)~~ Patient Driven Payment Model (PDPM) Medicaid rate for room and board in a State Veterans' Home, and payments will be made through gross adjustments.
		Nursing Facility Coverage	10.36 Therapies	In the last paragraph, the 1st sentence was revised to read: Non-routine OT, PT and ~~ST~~ SLP services are included in the ~~Resource Utilization Group (RUG)~~ Patient Driven Payment Model (PDPM) rates paid to State Veterans' Homes.

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		Nursing Facility Cost Reporting & Reimbursement Appendix	Section 2 - Definitions	The following definitions were added: **Case-Mix Category –** System that categorizes residents based on their clinical conditions and resource consumption into different groupings. Residents with similar clinical conditions and resource consumption are grouped into the same case-mix category. **Patient Driven Payment Model (PDPM) –** Classification system used to place nursing facility (NF) residents into different case-mix categories as determined by the Minimum Data Set (MDS) and used to set payment rates for Class VII facilities. PDPM consists of four case-mix categories and six rate components. The physical therapy (PT) and occupational therapy (OT) component, the speech-language pathology (SLP) component, the non-therapy ancillary (NTA) component, and the nursing component represent the four case-mix categories. PDPM rates are comprised of a PT component, OT component, a SLP component, an NTA component, a Nursing component and a Non-Case-Mix component. The following definition was deleted: ~~**Resource Utilization Group (RUG)** – Classifications which NF residents may be placed into based on their clinical needs as determined by the MDS. RUG classifications are used in the rate setting of Class VII facilities.~~

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			10.11 Class VII Nursing Facilities – State Veterans' Homes	The 1st paragraph was revised to read: Reimbursement rates to State Veterans' Homes will be prospective, per patient day, and based on the ~~RUG~~ PDPM classification of each resident. MDHHS will utilize the ~~Resource Utilization Group RUG-IV 66 group~~ PDPM classifications used under the Medicare skilled nursing facility (SNF) prospective payment system (PPS) as calculated by the MDS 3.0. ~~Each RUG category will reflect a resident's needs and correspond to a specific payment rate.~~ PDPM consists of four case-mix categories and six rate components. The PT and OT component, the SLP component, the NTA component and the Nursing component represent the four case-mix categories. PDPM rates are comprised of a PT component, OT component, a SLP component, an NTA component, a Nursing component and a Non-Case-Mix component. The Variable Per Diem adjustment and the add-on payment for residents with AIDS under the Medicare SNF PPS are not included in this rate methodology. The formula for PDPM payments is as follows: *PDPM rate = PT rate + OT rate + SLP rate + NTA rate + Nursing rate + Non-Case-Mix rate* Refer to the Directory Appendix for website information regarding PDPM. In the 2nd paragraph, the 1st sentence was revised to read: The rate associated with an individual ~~RUG category~~ PDPM component will be set as a percentage of the rate paid by the Medicare ~~skilled nursing facility (~~SNF~~)~~ ~~Prospective Payment System (~~PPS~~)~~. In the 3rd paragraph, the 1st sentence was revised to read: The ~~RUG category~~ PDPM categories used for payments will be based on the applicable MDS assessment(s) to the billing period.

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		Acronym Appendix		Deletion of: ~~RUG- Resource Utilization Group~~ Addition of: NTA – Non-therapy ancillary PDPM – Patient Driven Payment Model
		Directory Appendix	Nursing Facility Resources	The following new contact is added and reads: Contact/Topic: Patient Driven Payment Model (PDPM) Mailing/Email/Web Address: www.cms.gov >> Medicare >> Skilled Nursing Facility PPS (under Medicare Fee-for-Service Payment) >> Patient Driven Payment Model Information Available/Purpose: Resources including PDPM overview, fact sheets, and available training.

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MSA 19-28	10/1/2019	Nursing Facility Cost Reporting & Reimbursement Appendix	Section 2 - Definitions	The following definitions were added: **Audit -** Review of the financial records used to complete a Medicaid cost report for compliance with allowable cost principles and other policy contained in the Medicaid Provider Manual. An audit includes, but is not limited to, a limited-scope audit or an on-site audit. **Audit Adjustment -** An adjustment to the cost report after an audit to correct items that are noncompliant with allowable cost principles or other policy contained in the Medicaid Provider Manual. Adjustments can be a direct adjustment (i.e., an adjustment only for the noncompliant item[s]), an extrapolation adjustment, or a combination of the two adjustment methods. **Audit Disallowance -** See Audit Adjustment definition. **Completed Audit -** Issuance of the Preliminary Summary of Adjustment Notice. Completed audit includes the Exit Meeting with the nursing facility provider unless the Exit Meeting is waived. **Extrapolation -** An audit adjustment methodology that projects an error rate (using valid statistical procedures) for expenses reported on the cost report through the audit of statistically sampled items. The error rate will solely or partially determine the provider's audit adjustments. **Filed Cost Report -** A cost report package is only considered filed when all the following conditions are met: • the package is complete; • the cost report calculations are mathematically accurate, reasonable, and consistent; • the completed electronic cost report (ECR) data uses the required software and specified format;

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				• MDHHS audit staff can generate a full cost report applicable to the cost year from the ECR file; • an electronic copy of the Certification Statement is completed and signed, and agrees with the submitted ECR file; • the data meets a set of validation checks contained within the ECR, plus the appropriate bed size and certification reporting requirements; • the submitted ECR file includes proper reporting of costs and related cost report allocations in accordance with prior year(s) audit adjustment determinations for like costs or cost reporting issues; and • the cost report preparation complies with Medicaid policy and cost reporting instructions. **Non-statistical Sampling -** An audit sampling method that does not meet the definition of statistical sampling. Under an audit using solely non-statistical sampling methods, extrapolation methods may not be used to determine audit adjustments. **Settlement -** The process of reconciling a nursing facility's interim rates based on filed cost report data to audited cost report data. A final settlement is computed after the cost report has been audited, a final rate based on audited data is issued, and all appeals have been adjudicated. **Statistical Sampling -** An audit sampling method that has the following characteristics: • random selection of the sampled items; • the use of probability theory to evaluate sample results; and • the use of valid statistical procedures. Under an audit that solely or partially uses the statistical sampling method, extrapolation methods may be used to determine audit adjustments.

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				Definitions were revised as follows: **Cost Report -** ~~A formal compilation of the nursing facility ownership, financial and statistical data in MDHHS prescribed format, and required on an annual basis for the reporting period generally extending over a 12-month period based on the nursing facility's fiscal year. Each nursing facility provider's cost report must include an itemized list of all expenses as recorded in the formal and permanent accounting records of the facility.~~ Reports submitted annually by a nursing facility that is participating in the Medicaid program at a utilization rate on average of at least six Medicaid residents must be on MDHHS cost reporting forms. A nursing facility provider with fewer than six Medicaid residents per day must file a "less than complete cost report" and is not subject to audit or rate setting purposes. **Fiscal Year - Facility** - For purposes of cost reporting, a nursing facility provider's financial reporting year for tax purposes, normally a 12-month period unless approved for exception. ~~due to change in provider ownership or fiscal period end date change.~~ Exceptions include, but are not limited to, a change in provider ownership, fiscal period end date change, or facility relocation to a replacement facility. **New Facility (for rate-setting purposes) -** A nursing facility provider that does not have a current Medicaid historical cost, including a newly constructed facility, ~~or~~ an existing facility that has never before participated in the Medicaid program, ~~or~~ a facility that has participated in Medicaid in a different provider class, or an existing facility that qualified as a "No Medicaid" or "Low Medicaid" activity cost reporting provider for two consecutive fiscal years. The consecutive fiscal years must cover a period of at least 24 months in total and may only cover dates in which the facility was enrolled in Medicaid and averaged six or more Medicaid residents per day. A nursing facility that has made physical plant additions ~~and/or~~ or renovations, including a total replacement, or a facility that has been sold or resold is not considered a new facility.

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			4.3 Cost Report Requirements	In the 2nd paragraph, the 3rd bullet point was revised to read: • A copy of the nursing facility's detailed general ledger and complete (no grouping or summary) trial balance of revenues and expenses. Both documents must be submitted as electronic Excel files. A 5th bullet point was added and reads: • Copies of supporting workpapers for all Worksheet 1-A and Worksheet 1-B adjustments as electronic Word or Excel files (invoices may be submitted as PDF files).
			4.4 Cost Report Acceptance	The following text was added: MDHHS shall accept a non-delinquent cost report no more than 60 calendar days after the cost report is filed.
			4.5.A. No Medicaid Utilization	Subsection text was revised to read: ~~A nursing facility that has not furnished any services to Medicaid beneficiaries during the entire cost reporting period does not need to submit a cost report to comply with Medicaid's cost reporting requirements. The nursing facility may replace the cost report with a letter signed by an authorized representative that identifies the cost reporting period to which the statement applies (includes the facility name and provider NPI number), and states that:~~ ~~• No covered services were furnished during the reporting period.~~ ~~• No claims for Medicaid reimbursement will be filed for this reporting period.~~ ~~The signed statement must be submitted to the RARSS within 30 calendar days following the date of the nursing facility cost report filing notice.~~ A nursing facility with no Medicaid utilization during a cost reporting period is required to submit a less than complete cost report.

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			4.5.B. Low Medicaid Utilization	The 1st paragraph was revised to read: ~~RARSS may authorize~~ A nursing facility with low Medicaid utilization during a cost reporting period is required to submit a less than complete cost report. ~~for a nursing facility with low utilization of Medicaid services in a reporting period.~~ "Low utilization" is defined as an average of ~~five or fewer~~ less than six Medicaid residents per day in the facility for the cost year, i.e., fewer than 1,825 Medicaid nursing days. The nursing facility must ….
			4.6.A. Corrected Cost Report Due Date	The 1st sentence was revised to read: If ~~the~~ a cost report is returned to the provider as unaccepted by the LTC Reimbursement and Rate Setting Section (RARSS), the provider is given ~~15 calendar~~ five business days from the date ~~that~~ of the RARSS ~~returned the~~ cost report return letter to submit a corrected cost report via File Transfer.
			4.9 Cost Report Delinquency	In the 1st paragraph, the 1st bullet point was revised to read: • ~~An accepted~~ The cost report ~~has~~ is not ~~been~~ received by RARSS ~~by the cost report due~~ within five business days of the date ~~and the cost report remains not filed with RARSS~~ on the Delinquency and Medicaid Payment Termination Notice.
			4.10 Amended Cost Report	In the last paragraph, the 1st sentence was revised to read: ~~The provider~~ Providers cannot amend an audited cost report or amend a filed cost report after the reimbursement rate period has ended (i.e., a 2017 year-end cost report cannot be amended after it is audited or after September 30, 2019, whichever comes first).

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			5.1 Plant Cost Certification Eligibility Criteria	The 1st bullet point was revised to read: • The nursing facility provider is constructing a new building or incurring physical plant improvements with Certificate of Need (CON) approval, or the asset costs are, on average, ~~$1500~~ $5,000 or more per licensed bed for a Class I facility or $3,000 or more per licensed bed for a Class III facility in capital expenditures in a single cost reporting period. Medicaid will update the capital expenditure per licensed bed amounts effective October 1, 2020 and biennially thereafter based on a construction cost index for steel frame buildings and rounded to the nearest $500 (i.e., $5,150 would round to $5,000, $5,250 would round to $5,500, etc.).
			5.2 Plant Cost Certification Submission	In the 3rd paragraph, the 1st bullet point was deleted: • ~~CON Approval Letter~~ In the 4th paragraph, the 1st bullet point was deleted: • ~~CON Approval Letter (if CON approval is required)~~ The 5th paragraph was revised to read: RARSS must receive the provider's completed Plant Cost Certification prior to the cost reporting period filing deadline, and providers must meet the qualifications to receive an interim reimbursement rate. The completed information and supporting documentation may be sent to RARSS by mail, delivery, or File Transfer. Inquiries relating to the submission of the data should be directed to the RARSS office. (Refer to the Directory Appendix for contact information.)

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			5.3 Plant Cost Certification Effective Period	The 3rd paragraph was revised to read: If a Plant Cost Certification is filed after the provider's cost report year end filing deadline but prior to the rate year beginning immediately after the filing deadline, the plant cost reimbursement rate change is only effective on a prospective basis in accordance with the period established by the Plant Cost Certification request receipt date. Plant Cost Certifications filed on or after the rate year beginning after the applicable cost report filing deadline will not be accepted (i.e., if a provider has a December 31, 2018 cost report year end and made a qualifying capital change in 2018, then the provider would need to submit a Plant Cost Certification prior to October 1, 2019 for it to be accepted).
			6.1.B. Audit Timeline (new subsection; following subsections were re-numbered)	New subsection text reads: MDHHS shall ensure that an audit of a cost report is completed no later than 21 months after the final acceptance of a cost report, and that the 21-month period does not include any time associated with any appeal or a charge of fraud filed against the provider. A cost report not audited within the 21 months will be accepted as filed and move to settlement.
			6.1.C. On-Site Audit (new subsection; following subsections were re-numbered)	New subsection text reads: MDHHS shall complete an on-site audit on an as-needed basis. The on-site audit shall not last more than 30 calendar days per cost report year for an individual nursing facility, and not more than 30 calendar days per cost report year per nursing facility for two or more commonly owned or controlled facilities up to a maximum of 180 calendar days per cost report year (i.e., the on-site audit could last 60 days per cost report year for two facilities, 90 days for three facilities, etc. up to a maximum of 180 days for six or more facilities), unless MDHHS and the nursing facility agree in writing to extend the timeline. An on-site audit will occur where the nursing facility's records are located, regardless of whether those records are located on the nursing facility's premises or elsewhere. A limited-scope audit shall be performed for cost reports in which an on-site audit is not performed.

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			6.1.D. Audit Sampling (new subsection; following subsections were re-numbered)	New subsection text reads: MDHHS shall use statistical sampling, non-statistical sampling, or a combination of sampling methods for selecting items to audit. If a combination of sampling methods is used, then the items that could be selected under the statistical sample cannot be included in the non-statistical sample and vice versa (i.e., if 29 items are selected through a statistical sample out of a possible 500 items, then the other 471 items cannot be included in a non-statistical sample).
			6.1.E. Scheduling an Audit (new subsection; following subsections were re-numbered)	New subsection text reads: MDHHS will submit an Intent to Audit – Scheduling Notice at least 30 calendar days prior to the intended audit start date. The audit start date may take place no more than 10 business days after the intended audit start date or on a date prior to the intended audit start date. The provider must provide a response to the notice within five business days, otherwise the audit will begin on the intended audit start date. If the intended audit start date does not work for the provider, then they must notify MDHHS within five business days of the notice and provide alternative dates for the audit. If a mutually agreed upon audit start date cannot be selected, then the audit will commence on the intended audit start date.

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			~~6.1.B.~~ 6.1.F. Availability of Information (existing subsection renumbered)	Subsection text was revised to read: The nursing facility must have an accounting and records maintenance system to provide accurate cost, revenue and statistical data, and other information that can be verified by ~~Medicaid auditors.~~ MDHHS Bureau of Audit staff or their designees. Documentation must be provided to support the actual expenditure of costs; non-actuarial estimates are not allowable supporting documentation. ~~MDHHS audit staff or their designees will not complete an audit if the nursing facility does not make required information available. If the required information is not released within 15 business days of a written request by an auditor during an audit, MDHHS may assess a financial penalty to the provider until the requested records are made available to the auditor. MDHHS will issue prior notice to the provider that they will assess the penalty equal to 20 percent of the facility's monthly Medicaid payments, effective in the first month following the expiration of the 15-day notice period. Waiver of the penalty assessment is only allowed by approval of the Medicaid Director following the provider's request for waiver consideration, including justification for the request and additional time to provide the records.~~ Prior to the audit start date, MDHHS staff will submit an Audit Engagement Notice to the provider via File Transfer. This notice will include a list of the required documentation and the consequences for unavailable documentation. The documentation required by the Audit Engagement Notice must be available to MDHHS within 15 business days. If none of the documentation requested in the notice is available within 15 business days, then MDHHS will move to schedule an Exit Meeting. If some of the documentation is available, then the provider will have two or five business days to submit the unavailable documentation; two business

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				days for an individual facility and five business days for two or more commonly owned or controlled facilities. If documentation is not released within the timeframes described in this paragraph, then the costs in question will be preliminarily disallowed and the provider may not submit the unavailable documentation until the Exit Meeting. ~~**NOTE**: A nursing facility provider that has been assessed a penalty is prohibited from collecting additional funds from Medicaid beneficiaries to compensate for the penalty.~~ ~~If, after the 15-day period, the records become available for auditor review, an authorized representative of the nursing facility must give written notice of record availability to the MDHHS Office of Audit. This acknowledgement to release the requested records must designate the contact person and record location. The payment penalty will be discontinued effective for the month following the date the auditor determines that the required records have been released and the dollar amount of penalty assessments will be refunded to the nursing facility provider. The auditor's determination that the requested records have been provided will be made within 60 calendar days of such written agreement to release the requested records.~~ ~~The auditor may determine that records necessary to verify specific cost report expenses are required to complete the audit. Failure to release the requested records within 15 business days of a written request will result in a disallowance of costs associated with the item in question. If the nursing facility disagrees with the disallowance, this disallowance can be appealed at the completion of the audit.~~

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				While reviewing available documentation, MDHHS may determine that additional documentation is necessary to support an expense. MDHHS will submit a written request to the provider, and the provider will have two or five business days to submit the additional documentation; two business days for an individual facility and five business days for two or more commonly owned or controlled facilities. If the documentation is not released within the timeframes described in this paragraph, then the costs associated with the item in question will be preliminarily disallowed and the provider may not submit the unavailable documentation until the Exit Meeting. MDHHS will move to schedule an Exit Meeting or audit other expenses after the timeframes described in this subsection have passed, even if requested documentation is not made available. (Refer to the Appeal Process Section of this appendix for additional information.)
			6.1.G. Extrapolation (new subsection; following subsections were re-numbered)	New subsection text reads: MDHHS may use extrapolation methods to determine audit adjustments for expenses included in the sampling universe (i.e., all items that have a chance to be sampled in a random sampling process) in a statistical sample. The provider will be notified if extrapolation methods were used in the Exit Meeting Summary of Audit Adjustments Notice, the Preliminary Summary of Audit Adjustments Notice, and the Final Summary of Audit Adjustments Notice. The notice will include the sampling selection methodology, the sample size, the disallowed expenses, and the extrapolation formulas and calculations. The Preliminary Summary of Audit Adjustments Notice will also include the provider's appeal rights, which include the ability to appeal the extrapolation methods used to determine the audit adjustment.

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			6.1.H. Exit Meeting (new subsection; following subsections were re-numbered)	New subsection text reads: An Exit Meeting is a meeting offered to the provider to be held within five business days after the completion of the audit work to communicate the audit results to the provider and to obtain the provider's comments on the proposed findings of the audit prior to the issuance of the Preliminary Summary of Audit Adjustments Notice. The offer to schedule an Exit Meeting will be sent to the provider in the Exit Meeting Summary of Audit Adjustments Notice. To schedule an Exit Meeting, a provider must specify dates and times for the meeting to take place that are within five business days of the written offer to schedule a meeting. An Exit Meeting may be scheduled prior to the issuance of the Exit Meeting Summary of Audit Adjustment Notice, but if the scheduled Exit Meeting does not occur within five business days of the issuance of the Exit Meeting Summary of Audit Adjustments Notice, then the meeting date must change to occur within five business days of the notice. An Exit Meeting may be held in person, via telephone, or via electronic correspondence (i.e., email, video chat, etc.). If a provider does not attend a scheduled Exit Meeting, then the provider forfeits their right to an Exit Meeting. The provider may designate an authorized representative to attend the Exit Meeting (e.g., their cost report preparer, etc.). In addition to the offer to schedule an Exit Meeting, the Exit Meeting Summary of Audit Adjustments Notice will contain a summary of MDHHS' proposed audit adjustments. The provider may submit additional information related to a proposed audit adjustment at the Exit Meeting and for up to two business days after the Exit Meeting (or within five business days of the Exit Meeting Summary of Audit Adjustments Notice if an Exit Meeting is not held). MDHHS will not consider any additional information related to a proposed audit adjustment after two business days have passed from the date of the Exit Meeting (or five business days from the issuance of the Exit Meeting Summary of Audit Adjustments Notice if an Exit Meeting is not held).

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			6.1.I. Completed Audit (new subsection; following subsections were re-numbered)	New subsection text reads: A completed audit is represented by the issuance of the Preliminary Summary of Audit Adjustments Notice. The Preliminary Summary of Audit Adjustments Notice will be issued after the Exit Meeting is held or waived.
			~~6.1.D~~ 6.1.J. Reopening Audit Determinations (existing subsection renumbered)	The last paragraph was revised to read: MDHHS will not reopen an audit determination for any reason other than fraud beyond ~~three years following the date of final settlement.~~ the 21-month period described in the Audit Timeline subsection of this appendix.
			7.3.A. Final Settlement Timeline (new subsection)	New subsection text reads: MDHHS shall issue a Notice of Program Reimbursement for a final settlement not more than 60 calendar days after the issuance of the Final Summary of Audit Adjustments Notice or no more than 60 calendar days after the Preliminary Summary of Audit Adjustments Notice becomes the Final Summary of Audit Adjustments Notice.
			8.8 Interest	A 10th bullet point was added and reads: • For loans issued on or after November 1, 2019, interest on loans, to be allowable, must reflect a principal balance payment on at least an annual basis if the loan is greater than four years old. For loans issued prior to November 1, 2019, interest on loans, to be allowable, must reflect a principal balance payment on at least an annual basis starting on November 1, 2023. Refinancing of a loan or refinancing of multiple loans is not considered a principal balance payment, nor is a refinanced loan considered a new loan for purposes of this section.

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			9.6.C. Related or Chain Organization Cost Allocation	The 6th, 7th, and 8th paragraphs were removed. The last two paragraphs were revised to read: For cost reports where the home office and the individual nursing facility's fiscal year ends are different, a provider ~~may~~ must elect to forego the inclusion of an allocation of the current year's home office costs in the current year's individual provider cost report. A written request must be submitted annually to RARSS, with the individual provider's cost report signed by the appropriate corporate official acknowledging that the cost report is being submitted with the prior fiscal year's home office costs. The written request must also indicate that the corporation is waiving the right to inclusion of any allocation of the current year's home office costs in the current year's individual provider cost report. For example, a home office fiscal year end (FYE) is ~~12/31~~ December 31 and the individual facility's FYEs are ~~05/31~~ May 31, ~~08/31~~ August 31, ~~09/30~~ September 30 and ~~12/31~~ December 31. For individual facility cost reporting for fiscal year 2018 ending in May, August, September and October, the individual facility ~~may~~ must elect to report only the home office costs from the FYE ~~12/31/2017~~ December 31, 2017 home office cost report. The home office allocation of costs from FYE ~~12/31/2017~~ December 31, 2017 to the individual facility would be reported and audited. During the audit of the individual facility cost report, adjustments to allocate actual FYE ~~12/31/2018~~ December 31, 2018 home office costs would not be made. For individual facilities with FYE ~~12/31/2018~~ December 31, 2018, the home office costs from the FYE ~~12/31/2018~~ December 31, 2018 cost report would be reported.

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			Section 10 – Rate Determination	The 5th paragraph was revised to read: Prospective payment rates are calculated using the facility's cost report ending in the previous calendar year. If ~~this cost report covers a period that~~ the cost reporting period of the Medicaid routine unit is less than seven months, the cost report used for rate setting is the most recent cost report available prior to the previous calendar year that covers a period of at least seven months. The cost reporting period may only cover dates the facility was enrolled in Medicaid and averaged six or more Medicaid residents per day.
			10.2 Retroactive Rate Changes	The 1st paragraph was revised to read: A retroactive rate change may be made for facilities that have interim prospective rates based on filed cost reports. ~~A retroactive~~ Retroactive rate changes may be made for, but are not limited to, the following: The 2nd, 3rd and 4th bullet points were revised to read: • facilities that filed timely and were approved for Plant Cost Certification due to capital cost changes, an approved non-available bed plan, ~~or~~ a plant rate affected by a DEFRA rate limitation for the cost report period~~.~~, or when an interim rate was incorrectly calculated; • audit adjustments that are required ~~as a result~~ because of an appeal; • audit adjustments that are required ~~as a result~~ because of fraud or facility failure to disclose required financial information~~.~~; and

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			10.3.B.7. Tenure Factor	The 1st and 2nd paragraphs were revised to read: The tenure factor is dependent on the nursing facility provider's number of full years of continued ~~licensure~~ Medicaid certification as of the beginning of the Medicaid rate year~~,~~ (i.e., months of continuous ~~licensure~~ Medicaid certification divided by 12 and ~~ignoring~~ disregarding fractions). The continuous Medicaid certification is based on the current ownership of the nursing facility. Continued ~~licensure~~ Medicaid certification is based on the number of full years that have elapsed from the effective date of a ~~nursing facility~~ provider's ~~license (issued by the SSA)~~ initial Medicaid certification to the beginning of the Medicaid rate year. For example, a provider that has been ~~licensed~~ Medicaid certified for 42 continuous months has, for purposes of the tenure factor, been ~~licensed~~ certified for three full years. The provider's years of ownership are translated into a tenure rate, and applicable rates are identified in the following table. The 6th paragraph was revised to read: When ~~licensure~~ ownership has changed but there has been no effective change in operator/provider, and there has been no transaction that would affect Medicaid reimbursement other than the tenure factor, the provider may request that Medicaid recognize the continuous tenure such that the ~~licensure~~ tenure schedule would not revert to zero years at the time of the ~~licensure~~ ownership change. The provider's written request must be submitted at the time ~~licensure~~ ownership is changed.

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				The last paragraph was revised to read: **Exception:** Where ~~licensure~~ ownership does not change after a sale of nursing facility assets, the nursing facility provider (new owner) must choose either to retain the original ~~licensure~~ tenure schedule and forego increased reimbursement for interest expense, or to receive increased reimbursement for interest expense, subject to the DEFRA Reimbursement Limit, and allow the ~~licensure~~ tenure schedule to revert to zero years and a tenure factor of .0250. Should the provider elect to retain the previous ~~licensure~~ tenure schedule, Medicaid will not recognize, for allowable cost and per diem rate determination purposes, any interest expense beyond the schedule of borrowings, principal amortization, and interest expenses that would have been incurred were the former owner's loans maintained or assumed by the new owner. This provision applies to all property transactions between lessors, lessees, and/or operators.
			10.4.B. Facility Plant Cost Limit per Resident Day	In the 2nd paragraph, the 3rd sentence was revised to read: The nursing facility must meet the filing requirements and complete the plant cost certification process to qualify for consideration of the update to the individual facility plant cost limit. A plant cost certification filed after the applicable period's cost report will not be accepted for calculation of an updated facility plant cost limit. The provider must meet the qualifying provisions …
			10.6 Class V Nursing Facilities – Ventilator Dependent Care (VDC) Units	In the last paragraph, the 4th sentence was revised to read: A new VDC ~~nursing~~ unit that has not previously participated in Medicaid for VDC services will have a reimbursement rate in the initial two years (24 months) of Medicaid operations (from the date of admitting the first Medicaid beneficiary) based upon the statewide average VDC unit reimbursement rate for the current year.

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			10.13.A.2. New Provider Nursing Facility Variable Cost Component	The 1st paragraph was revised to read: The Variable Rate Base for the new facility and provider will be determined using special methods. During the first two cost reporting periods, new facilities and facilities with a change of class will have a Variable Rate Base equal to the Class Average of Variable Costs. The first two cost reporting periods must cover a period of at least 19 months (the first cost reporting period must cover a period of at least seven months, and the second cost reporting period must cover a period of 12 months) and the facility must have averaged six or more Medicaid residents per day. This rate base will be used in the calculation of the nursing facility Variable Cost Component as outlined in the policy for the respective nursing class. In subsequent periods, the nursing facility's Variable Rate Base will be determined using the methods described in the ~~"Variable Cost Component" subsection~~ Rate Determination section of this appendix.
			10.13.F.1. Change of Ownership	Text was revised to read: A new owner may receive reimbursement for the balance of the facility's eligible years of participation in the FIDS program. The new owner must notify RARSS via File Transfer within 45 calendar days of the change of ownership if the facility is going to continue participation in the FIDS program, or RARSS will assume participation has been discontinued and end FIDS reimbursement supplemental payments. In order to receive the supplemental Medicaid payment, the new owner must continue the FIDS facility standards and culture change. If the new owner initially …
			10.14.A. Eligibility Criteria	In the last bullet point, last sub-bullet point, the 1st sentence was revised to read: ➢ ~~The provider's current Variable Rate Base is~~ A nursing facility may qualify for rate relief if all other applicable criteria is met and if their current actual variable costs are less than or equal to 60 percent of the corresponding rate year's Variable Cost Limit.

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			10.14.B. Rate Relief Petition Process	The 1st paragraph was revised to read: All petitions for rate relief must be in writing and submitted to RARSS. An authorized representative from the entity that holds the nursing facility license must sign the petition. A petition is not considered filed or complete unless all required supporting documentation is filed with the petition request.
			10.14.C. Rate Relief Agreement	The 1st paragraph was revised to read: If ~~the rate relief petition is approved, Medicaid will prepare a~~ RARSS issues a written notice of approval for rate relief, an authorized representative from ~~agreement to be signed by~~ the nursing facility ~~authorized representative and an authorized representative of Medicaid.~~ must sign and submit the rate relief approval agreement included in the letter to RARSS via File Transfer within 30 calendar days of the issuance of the notice. If the signed rate relief approval agreement is not submitted to RARSS within this time frame, then the rate relief approval is rescinded. Once the agreement is approved, the provider's Medicaid rate is adjusted consistent with the relief granted. The agreement outlines the rate relief granted, the effective date, and any conditions or requirements.
			10.14.D. Rate Relief Period	The 1st paragraph was revised to read: Rate relief is effective on a prospective basis beginning in the month after receipt of the request and all required supporting documentation by RARSS. No retroactive rate relief will be approved.

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			11.1 Audit Appeals	Subsection text was revised to read: Each nursing facility cost report is audited to ensure that expenses ~~attributable to allowable cost~~ were reported in adherence with Medicaid policy . Once the ~~audit report~~ Exit Meeting is completed or waived, the provider is given a Preliminary Summary of Audit Adjustments Notice via File Transfer. This notice outlines audit results, serves as the adverse action notice, and advises the ~~provider~~ nursing facility of ~~their~~ subsequent appeal rights, up to and including ~~the right to an Area Office Conference~~ an administrative hearing. The provider or their designee has 30 calendar days from the date of the Preliminary Summary of Audit Adjustments Notice to request a formal hearing in accordance with MDHHS rules for hearings. If the provider or the provider's designee does not respond to the Preliminary Summary of Audit Adjustments Notice within ~~15 business~~ 30 calendar days of the date of the notice, ~~the provider will receive a~~ then the Preliminary Summary of Audit Adjustments Notice will serve as the Final Summary of Audit Adjustments Notice. ~~The notice advises the nursing facility of subsequent appeal rights, up to and including an administrative hearing. The provider or their designee has 30 calendar days from the date of the Final Summary of Audit Adjustments Notice to request a formal hearing in accordance with MDHHS rules for hearings.~~ If the appeal process is exhausted, the provider will receive a Final Summary of Audit Adjustments Notice. The Final Summary of Audit Adjustments Notice outlines the final audit results and may not be appealed. A Preliminary Summary of Audit Adjustments Notice that serves as a Final Summary of Audit Adjustments Notice is also not appealable.

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				~~If a provider wants an Area Office Conference, the provider or the provider's designee must send a written request to the audit representative(s) within 15 business days of the Preliminary Summary of Audit Adjustments Notice date. The Area Office Conference is a forum for the provider or their designee to present documents and arguments contesting the Preliminary Summary of Audit Adjustments Notice. The audit representative(s) must schedule an Area Office Conference within 15 calendar days of the receipt of the provider's or provider designee's request. Within 15 calendar days after the Area Office Conference, the audit representative(s) must issue a Final Summary of Audit Adjustments Notice to the provider. The notice advises the nursing facility of subsequent appeal rights, up to and including an administrative hearing. The provider or their designee has 30 calendar days from the date of the Final Summary of Audit Adjustments Notice to request a formal hearing in accordance with MDHHS rules for hearings.~~ To ensure faster processing of final settlements, a provider should notify MDHHS via File Transfer if they are not appealing any of the audit adjustments in the Preliminary Summary of Audit Adjustments Notice. If a provider does not appeal or does not respond to the ~~Final~~ Preliminary Summary of Audit Adjustments Notice or other notices or processes related to a conference or hearing within the allotted timeframe, the provider has waived the right to any further administrative review.

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MSA 19-30	11/1/2019	Medical Supplier	2.30 Oxygen, Oxygen Equipment and Accessories	Under "Documentation", the 6th bullet point was revised to read: • Current pO2 or oxygen saturation level ~~or pO2 level~~ while on room air. The 2nd paragraph was deleted. ~~**After the initial prescription for home oxygen,** a six-month follow-up prescription and/or CMN must be obtained. At this time, a new oximetry or ABG test result must be obtained to substantiate the continued need for treatment. Thereafter, a prescription is only required on an annual basis. An updated lab test is required only when there is a change in equipment need or level of oxygen usage.~~ The following text was added: **Six-Month Recertification** - After the initial prescription for home oxygen therapy, a six-month follow-up certificate of medical necessity (CMN) must be obtained. At this time, a new pO2 or oxygen saturation test with the beneficiary on room air must be obtained and indicated on the CMN, along with the date of the test, to substantiate continued need for treatment. **Annual Recertification** - Following the first year of oxygen treatment, a new CMN and prescription are required annually. An updated lab test is not required unless there is a change in the level of oxygen usage or type of delivery system required. The most recent pO2 or oxygen saturation level and the date of the test must be documented on each annual CMN.
MSA 19-34	11/26/2019	Hearing Aid Dealers	1.3 Covered Services	The following text was added as a 2nd paragraph: Hearing aid batteries may also be provided by a Medical Supplier.

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			2.7.A. Standards of Coverage	Subsection text was revised to read: Medicaid covers replacement of disposable hearing aid batteries, as appropriate, up to a quantity of 36 batteries per hearing aid per ~~six months~~ date of service when dispensed by a hearing aid dealer, audiologist, hearing center, or medical supplier. A maximum of 72 batteries per hearing aid per year is covered. All batteries must be dispensed in the original packaging and must be dispensed at least one year before the expiration date shown on the package. The establishment of a "battery club", where batteries are automatically mailed to a beneficiary regardless of need, is not allowed. Hearing aid dealers and medical suppliers may not bill for replacement of disposable batteries for cochlear implant devices.
MSA 19-37	1/1/2020	General Information for Providers	Section 2 - Provider Enrollment	The 9th paragraph was deleted: ~~Providers of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) and Independent Diagnostic Testing Facilities and Portable X-ray Suppliers must be enrolled as a Medicare provider. Each DMEPOS provider must enter their Medicare Provider Transaction Access Number (PTAN) in the CHAMPS Provider Enrollment subsystem.~~
		Medical Supplier	Section 1 – Program Overview	The 2nd paragraph was deleted: ~~Providers of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) must be enrolled as a Medicare provider effective September 30, 2009. (Refer to the General Information for Providers Chapter for additional information.)~~

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			1.1.A. Provider Enrollment (new subsection)	New subsection text reads: Providers of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) must be enrolled as a Medicare provider effective September 30, 2009. Each DMEPOS provider must enter their Medicare Provider Transaction Access Number (PTAN) in the CHAMPS Provider Enrollment subsystem. (Refer to the General Information for Providers chapter for provider enrollment policy that applies to all providers.) To be eligible to enroll as a Medicaid DMEPOS provider, applicants must be compliant with policy indicated in the General Information for Providers chapter and all of the following: • The provider must be compliant with all federal and state licensing, certification and regulatory requirements. • The provider must have a national provider identifier (NPI) for each location and may not allow another entity to use that billing NPI (separate enrollment is required for each location serving Medicaid beneficiaries). • The provider must be accredited (separate accreditation per location) by one of the Centers for Medicare & Medicaid Services (CMS) approved accreditation organizations (AOs) and must indicate the specific DMEPOS items approved under that accreditation for that location (CMS-determined pharmaceutical exemptions apply). • The provider must permit MDHHS to conduct on-site inspections to evaluate the provider's compliance with State and Federal DMEPOS standards. • The provider must have a primary business telephone listed under the business name in a local directory or a toll-free number available through directory assistance. The exclusive use of a beeper, answering machine, answering service or cell phone during business hours is prohibited.

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				• The provider must fill orders from its own inventory or contract with other companies for the purchase of items necessary to fill orders. The provider may not contract with any entity that is excluded from Medicare, Medicaid or any other federally funded program. Provider use of distributors or contracted supply companies is acceptable if the provider follows Medicare DMEPOS standards and Medicaid policy regarding delivery, record keeping and education on the use of the item(s). • The provider must accept beneficiary returns of substandard, defective or unsuitable items. • The provider must notify the beneficiary of warranty coverage, honor all warranties under applicable State law, and repair or replace free of charge Medicaid-covered items under that warranty. • The provider must provide maintenance, replacement or repair at no charge to the beneficiary or Medicaid, either directly or through a service contract with another company, during the Medicaid rental period. • The provider is responsible for delivery, set-up and education on the use of the DMEPOS item(s) and must maintain proof of delivery and education in the beneficiary file. The delivery ticket must include the beneficiary's (or beneficiary guardian/appointee's) signature and date as confirmation of receipt. Provider use of courier or shipping services is acceptable if the DMEPOS provider follows current policy requirements for delivery, record keeping and education on the use of the item(s). • The provider must answer beneficiary questions, respond to complaints, and maintain documentation of such contact(s) in the beneficiary file.

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				• The provider must have a complaint resolution protocol to address beneficiary complaints. Records of complaints must be maintained at the physical location. The complaint record must include the name, address, telephone number and Medicaid ID number of the beneficiary, complaint summary, and actions taken to resolve the complaint. • All provider locations, whether owned or subcontracted, must meet the Medicare DMEPOS Supplier Standards (including, but not limited to, surety bond and liability insurance requirements) and Medicare quality standards. • The provider must display on-site all licensing, certifications and accreditations, as applicable (out-of-state and borderland providers must be licensed and/or certified by the appropriate standard-setting authority in the state they are practicing). • To be considered "in-state," the provider must have a physical storefront located within Michigan (or within the borderland areas of adjoining states). The location must be accessible to the public (including handicap accessible), be open for business for no less than 30 hours a week, be staffed during business hours, and maintain a visible sign with posted hours of business. Occupational therapists, physical therapists, and orthotic and prosthetic providers of custom orthotics and prosthetics are exempt from the 30 hour per week business rule but must comply with the accessibility and signage portions of the rule. (Out-of-state providers should refer to the Out of State/Beyond Borderland Providers subsection in the General Information for Providers Chapter for additional information.) • The location must contain space for and have beneficiary records on site. For electronic health records, it is preferred that electronic health record systems be contained on the Certified Health IT Product List (CHPL) as published and maintained by the Office of the National Coordinator for Health Information Technology (ONC). Records must be made available upon MDHHS request.

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				• The location must display equipment/supplies provided and have inventory on site (custom-made items are exempt). • The provider may not share space with other Medicare or Medicaid healthcare entities except for the following: ➢ The provider is also enrolled as a pharmacy and owned by the same entity; or ➢ The provider is hospital-owned and located within the hospital or a hospital-owned clinic. NOTE: Separately identified physical space (e.g., clearly identified suites) within the same building is not considered "sharing space" if each space/location is recognized by the United States Postal Service (USPS) as a separate physical address. Michigan Medicaid does not enroll warehouses or distribution centers as the function of these entities is to ship/store products and are not considered a storefront.
			1.10.A. Noncustom Versus Custom-Fabricated	The 2nd paragraph was revised to read: All orthotist and prosthetist providers must have facility accreditation through any of the CMS-approved AOs ~~the American Board for Certification in Orthotics, Prosthetics and Pedorthics, Inc. (ABC)~~ in order to furnish and bill for custom-fabricated P&O appliances. Providers must maintain their ~~ABC~~ accreditation and be able to provide proof upon request. Orthotic and prosthetic providers must only bill specific prefabricated and custom-fitted orthotics that may include simple or minor intervention.

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		Acronym Appendix		Addition of: AO – accreditation organization CHPL - Certified Health IT Product List USPS - United States Postal Service
MSA 19-38	1/2/2020	Non-Emergency Medical Transportation	Section 3 – Transportation Authorization	Text after the 3rd paragraph was revised to read: Reimbursement for special transportation requires a completed, original Medical Verification for Transportation (DHS-5330) to serve as documentation of medical need and must be retained in the beneficiary's file. Special transportation includes medically needing a wheelchair lift-equipped vehicle, Medi-Van vehicle, attendant, prior authorization, and other special circumstances supported by medical documentation. (For prior authorization requirements, refer to the Prior Authorization (PA) section of this chapter.) The DHS-5330 must be completed annually. A local MDHHS office can authorize NEMT without a DHS-5330 for beneficiaries who do not require special transportation. Additionally, verification of medical need is not required when the transportation is to obtain medical evidence (i.e., employability, incapacity, or disability) or to meet the needs of children for protective services.

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				~~Reimbursement for medical transportation requires~~ An initial verification of medical need for special transportation is required by the beneficiary's primary care physician (PCP). An original, completed DHS-5330 ~~(Medical Verification for Transportation)~~ signed by the beneficiary's PCP, or a physician's assistant or nurse practitioner working under the supervision of the PCP, serves as documentation of medical need and must be retained in the beneficiary's file. ~~The DHS-5330 must be completed annually. Verification of medical need is not required when the transportation is to obtain medical evidence (i.e., employability, incapacity, or disability) or to meet the needs of children for protective services.~~ In situations when a beneficiary's PCP, or a physician's assistant or nurse practitioner working under the supervision of the PCP, is unavailable and unable to complete an original DHS-5330 in a timely manner, another licensed provider may complete the form. Example providers include, but are not limited to, a physician specialist, clinical nurse specialist, certified nurse midwife, registered nurse, social worker, dentist, and other licensed providers. The licensed provider must be knowledgeable about the beneficiary's medical needs, capable of accurately completing the form, and providing direct medical, behavioral or dental services to the beneficiary. In situations when a completed, original DHS-5330 cannot be secured prior to a beneficiary's scheduled Medicaid-covered appointment, authorizing parties may approve and reimburse all necessary NEMT services if the DHS-5330 is completed and returned to the authorizing party within 10 business days of the appointment. Allowable circumstances include, but are not limited to, the beneficiary's first trip to their ~~primary care physician~~ PCP or medical appointment, or an inability by the beneficiary's physician's office to complete the form and secure the necessary signatures in a timely manner. Authorizing parties must retain the ….

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			4.1 Beneficiaries (new subsection; following subsections were re-numbered)	New subsection text reads: The minimum requirements for individuals who transport themselves include: • Valid driver's license appropriate to the class of vehicle being operated; • Compliant with Sections 304 and 319 of the Michigan Vehicle Code related to restricted driver's licenses as issued by the Michigan Secretary of State (MDHHS reserves the right to deny or revoke reimbursement of a provider due to a restricted or suspended license); • Motor vehicle insurance; and • Adherence to all public laws, ordinances, and regulations applicable to drivers and the vehicles that are used. Authorizing parties must confirm a beneficiary's eligibility to receive mileage reimbursement through an established process, including but not limited to, documented verbal attestation.

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