Michigan Medicaid Policy | MMP

BULLETIN

BEHAVIORAL AND PHYSICAL HEALTH AND AGING SERVICES ADMINISTRATION

MDHHS

Bulletin Number: MMP 22-25

Distribution: All Providers

Issued: August 31, 2022

Subject: Updates to the MDHHS Medicaid Provider Manual

Effective: October 1, 2022

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

The Michigan Department of Health and Human Services (MDHHS) has completed the October 2022 update of the online version of the MDHHS Medicaid Provider Manual. The Manual will be available October 1, 2022 at www.michigan.gov/medicaidproviders >> Policy, Letters & Forms >> Medicaid Provider 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.

Manual Maintenance

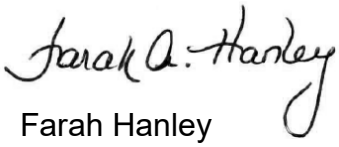
If utilizing the online version of the manual at www.michigan.gov/medicaidproviders >> Policy, Letters & Forms, this bulletin and those referenced in this bulletin may be discarded. If using a CD version of the MDHHS Medicaid Provider Manual, providers should retain all bulletins issued since the version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

An electronic copy of this document is available at www.michigan.gov/medicaidproviders >> Policy, Letters & Forms.

Approved



Farah Hanley
Chief Deputy for Health

Medicaid Provider Manual
October 2022 Updates

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Billing & Reimbursement for Professionals	2.3.D. Supervising Provider	Text was revised to read: The supervising physician NPI ~~is~~ may be a professional claim editing requirement ~~which must be included on claims when~~ for physician services ~~are~~ rendered by an enrolled non-physician practitioner, such as a physician's assistant or advanced practice registered nurse. ~~Physician supervision and oversight must be consistent with Michigan Public Act 368 of 1978, as amended. The supervising physician must be enrolled with the program.~~ When physician collaboration or supervision is required by State law or Medicaid policy, claims must include the Medicaid enrolled supervising physician NPI. Refer to the Practitioner Chapter for additional information related to program requirements for supervision or physician collaboration for services provided by non-physician practitioners.	Language updated for clarification.

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

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Behavioral Health and Intellectual and Developmental Disability Supports and Services	1.5 Programs Requiring Special Approval	The 1st paragraph was revised to read: Certain programs and sites require the PIHP to request specific approval by MDHHS prior to service delivery. Programs must be approved and certified by MDHHS prior to service provision in order to be reported as a Medicaid cost. (Refer to the Directory Appendix for contact information.) Programs previously approved by MDHHS and delivered by CMHSPs that are now affiliates do not need to be approved again unless otherwise directed by MDHHS. Programs requiring specific approval and certification are: • Assertive Community Treatment Programs • Clubhouse Psychosocial Rehabilitation Programs • Crisis Residential Programs • Day Program Sites • Drop-in Programs • Home-Based Services • Intensive Crisis Stabilization for Adults and Children • Wraparound and Children's Therapeutic Foster Care	Updated to transition from "enrollment" to "certification" language.

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

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Behavioral Health and Intellectual and Developmental Disability Supports and Services	3.29 Wraparound Services for Children and Adolescents	The 4th paragraph was revised to read: The Wraparound plan may also consist of other non-mental health services and supports that are secured from, and funded by, other agencies in the community. The Wraparound plan is the result of a collaborative team planning process that focuses on the unique strengths, values and preferences of the child/youth and family, and is developed in partnership with other community agencies. This planning process tends to work most effectively with children/youth and their families who, due to safety and other risk factors, require services from multiple systems and informal supports. ~~The Community Team, which consists of parents/guardians/legal representatives, agency representatives, and other relevant community members, oversees Wraparound from a system level.~~ The last paragraph was revised to read: Medicaid providers delivering Wraparound services (provided either as a 1915(b) Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) service or an SEDW service) must request approval to provide Wraparound from MDHHS through ~~an enrollment~~ a certification process defined by MDHHS, and ~~re-enrollment~~ certification must occur every three years. Programs are to be ~~re-enrolled~~ certified to ensure policy and Wraparound model fidelity adherence.	Updated to transition from "enrollment" to "certification" language.

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

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Behavioral Health and Intellectual and Developmental Disability Supports and Services	3.29.A. Organizational Structure	The last bullet point was revised to read: • If facilitators are assigned to other programs as well as Wraparound, the number of Wraparound child/youth and family teams they facilitate shall correlate to the percentage of their position dedicated to providing Wraparound facilitation. For example, if a ~~worker is a .50 FTE Wraparound facilitator, the number of teams assigned to that Wraparound facilitator shall not exceed six when one team is in transition. In addition, facilitators who have other roles shall not exceed a total of 15 families across programs.~~ facilitator is providing Wraparound to 5 or more youth in the Hello or Help phase, the caseload is to remain at 10-12, no more than 15 with mixed caseload. If a facilitator is providing Wraparound to less than 5 youth in the Hello or Help phase, the caseload is to remain at 10-12, no more than 20 with mixed caseload.	
Behavioral Health and Intellectual and Developmental Disability Supports and Services	3.29.C. Plans of Service	The last bullet point was revised to read: • Evidence that the child/youth and family team review and measure outcomes at least monthly ~~and present outcomes and measurement to the Community Team for their review at least quarterly~~.	
Behavioral Health and Intellectual and Developmental Disability Supports and Services	4.3 Essential Elements	Under "Availability of Services", the 2nd bullet point was revised to read: • The ACT team is responsible for performing the required pre-admission screen for all beneficiaries ~~enrolled~~ certified in an ACT program seeking inpatient psychiatric admission.	Updated to transition from "enrollment" to "certification" language.

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

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Behavioral Health and Intellectual and Developmental Disability Supports and Services	4.4 Eligibility Criteria	Under "Intensity of Service", the following bullet point was added: • The total number of contacts **averages** 120 minutes of face-to-face time each week for each beneficiary. Higher frequency with shorter visits is most effective and is determined and adjusted as needed within the flexibility identified in the Individual Plan of Service (IPOS) and case notes. Clearly documented clinical rationale is provided in exception cases where an average of 120 minutes for each beneficiary is clinically inappropriate.	Add clarification language.
Behavioral Health and Intellectual and Developmental Disability Supports and Services	4.4 Eligibility Criteria	Under "Discharge", 1st bullet point, the 3rd paragraph was revised to read: If a beneficiary requests transition to other service(s) because he/she believes maximum benefit has been reached in ACT, consideration for transition into less intensive services must be reviewed during the person-centered planning process. If clinical evidence supports the beneficiary's desire to transition, this evidence and the transition plan must be detailed in a revised IPOS developed through the person-centered planning process. The plan must identify what supports and services will be made available, and contain a provision for ~~re-enrollment~~ re-certification into ACT services, if needed.	Updated to transition from "enrollment" to "certification" language.
Behavioral Health and Intellectual and Developmental Disability Supports and Services	6.3 Provider Criteria	Text was revised to read: The PIHP must seek and maintain MDHHS approval through ~~an enrollment~~ a certification process for the crisis residential program in order to use Medicaid funds for program services.	Updated to transition from "enrollment" to "certification" language.

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

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Behavioral Health and Intellectual and Developmental Disability Supports and Services	7.1 Program Approval	Text was revised to read: Applications for ~~enrollment~~ certification must identify home-based providers, either internal or contractual, who will serve children under 21 years of age. Home-based services can be provided by one or more providers who serve one or more age groups. Once ~~enrolled~~ certified, a program must ~~re-enroll~~ certify every three years. (Refer to the Directory Appendix for contact information.) MDHHS approval will be based on adherence to the requirements outlined below. Applications for ~~enrollment~~ certification must identify the target population to be served by the program. Providers must assure that staff providing home-based services meet the required qualifications. Information submitted to MDHHS must include basic program information submitted in a format prescribed by MDHHS. If necessary during an initial period, the provider may receive provisional approval that will allow them to provide services. However, any necessary additional actions must be completed within the timeframe specified by MDHHS or provisional approval will be withdrawn	Updated to transition from "enrollment" to "certification" language.
Behavioral Health and Intellectual and Developmental Disability Supports and Services	9.2 Children's Services; 9.2.A. Approval	Text was revised to read: The PIHP must seek and receive MDHHS approval through ~~an enrollment~~ a certification process, initially and every three years thereafter, for the intensive crisis stabilization services in order to use Medicaid funds for program services.	Updated to transition from "enrollment" to "certification" language.

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

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Behavioral Health and Intellectual and Developmental Disability Supports and Services; Children's Serious Emotional Disturbance Home and Community-Based Services Waiver Appendix	2.6 Child Therapeutic Foster Care	The last paragraph was revised to read: In addition to being licensed, all CTFC programs under this waiver are to be ~~pre-enrolled~~ certified by MDHHS to ensure they meet the requirements set forth in this policy. Separate payment will not be made for homemaker or chore services, for community living services provided by the foster parents, or for respite care furnished for the foster care parents to a child receiving CTFC services since these services are integral to, and inherent in, the provision of CTFC.	Updated to transition from "enrollment" to "certification" language.
Dental	6.6 Prosthodontics (Removable); 6.6.A. General Instructions	The last paragraph was revised to read: Complete or partial dentures are not authorized when: ▪ Medicaid or Medicaid Managed Care has ~~provided~~ reimbursed a denture in the same arch within five years. ▪ An adjustment, reline, repair, or rebase will make the current denture serviceable. ▪ A complete or partial denture obtained through Medicaid within five years has been lost or broken.	Language updated for clarification.

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

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Pharmacy	14.12 Over the Counter Drugs	Text was revised to read: Covered OTC drugs are listed in the MPPL. A prescription is required. The refill policy is the same as for legend drugs. OTC supply or test kit items that remain in their original packaging should not have a professional dispensing fee requested in the provider's usual and customary charge.	Language added for clarification.
Glossary Appendix	Acquisition Cost	The definition was revised to read: The manufacturer's invoice price, minus primary discount, plus a percentage over cost, plus actual shipping costs. Acquisition cost does not include handling fees. (For the specific percentage over cost, refer to the archived ~~MDHHS Medical Supplier/DME/Prosthetics and Orthotics Database Instructions~~ policy bulletin MSA 09-62 posted on the MDHHS website.)	General update.

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

Medicaid Provider Manual
October 2022 Updates

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
HASA 22-14	6/1/2022	Beneficiary Eligibility	2.1 Benefit Plans	In the table, the "Benefit Plan Description" for Children's Special Health Care Services was revised to read: This benefit plan is designed to find, diagnose, and treat children under age 21 with chronic illness or disabling conditions. Persons over age 21 with chronic cystic fibrosis, ~~or~~ certain blood coagulation blood disorders, or hereditary blood cell disorders commonly known as sickle cell disease may also qualify. Covers services related to the client's CSHCS-qualifying diagnoses. Certain providers must be authorized on a client file.
			Section 10 - Children's Special Health Care Services	In the 1st paragraph, the 2nd bullet point was revised to read: • Persons age 21 and older with cystic fibrosis, ~~or~~ hereditary coagulation defects commonly known as hemophilia, or hereditary red blood cell disorders commonly known as sickle cell disease.
		Children's Special Health Care Services	Section 3 - Medical Eligibility	In the 1st paragraph, the 2nd bullet point was revised to read: • Be within the age limits of the program: ➢ Under the age of 21; or ➢ Age 21 and above with cystic fibrosis, ~~or~~ hereditary coagulation defects commonly known as hemophilia, or hereditary red blood cell disorders commonly known as sickle cell disease.
			9.1.A. CSHCS General Dental Services	In the 1st paragraph, the following bullet point was added: • Sickle Cell Disease

*Bulletin inclusion updates are color-coded to the quarter in which the update was made (April 1 = Blue; July 1 = Pink; October 1 = Green; January 1 = Orange)

Medicaid Provider Manual
October 2022 Updates

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
HASA 22-15	6/1/2022	Children's Special Health Care Services	11.2 NEMT Reimbursement Process	The 1st paragraph was revised to read: In-state NEMT assistance ~~is prior authorized by the LHD using the process designated by CSHCS~~ for beneficiaries who do not have Medicaid, or who are receiving non-Medicaid eligible services, does not require prior authorization. Out-of-state NEMT assistance requests may be initiated by the LHD and must be authorized by the CSHCS state office. Prior authorization may be issued up to one calendar month for recurring visits.
HASA 22-16	6/1/2022	Medical Supplier	2.3 Blood Pressure Monitoring	"Definition" was revised to read: Blood pressure monitoring includes manual (sphygmomanometer/blood pressure apparatus with cuff and stethoscope) and automatic blood pressure ~~units~~ devices.

*Bulletin inclusion updates are color-coded to the quarter in which the update was made (April 1 = Blue; July 1 = Pink; October 1 = Green; January 1 = Orange)

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
				"Standards of Coverage" was revised in its entirety. New text reads: Manual or automatic blood pressure monitors are covered for beneficiaries of any age with uncontrolled blood pressure when all the following are met: • The treatment plan requires the beneficiary to self-monitor and record blood pressure readings at a minimum of once daily; • The beneficiary has any of the following conditions: ➢ History of heart disease, congenital heart defects, or stroke. ➢ A neurological condition that affects blood pressure. ➢ A medication regimen is present that affects blood pressure. ➢ Blood pressure fluctuations due to renal disease. ➢ Medications are titrated based on daily blood pressure readings. ➢ Hypertensive disorders in pregnancy, childbirth, or the puerperium period (e.g., pre-eclampsia); or ➢ Hypertension, despite beneficiary compliance with the treatment plan (i.e., adherence to medication regimen, dietary changes, smoking cessation, etc.).

*Bulletin inclusion updates are color-coded to the quarter in which the update was made (April 1 = Blue; July 1 = Pink; October 1 = Green; January 1 = Orange)

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
				• The ordering practitioner or practitioner's nursing staff have educated the beneficiary on self-measurement of blood pressure, recording blood pressure readings, have fit the beneficiary with the appropriate cuff size, and have provided or referred the beneficiary for follow-up education as necessary; and • The medical supplier has provided further education regarding use of the monitor/cuff, cleaning/maintenance, warranty information, troubleshooting errors, and the medical supplier's contact information for repairs/replacement or assistance for equipment malfunction. An automatic blood pressure monitor is recommended rather than a manual blood pressure monitor unless the beneficiary has an adult family member/caregiver available to assist the beneficiary in taking blood pressure using a manual blood pressure monitor. The family member/caregiver must be instructed by the beneficiary's practitioner or practitioner's staff regarding proper use of the blood pressure monitor. The blood pressure monitor must be registered with the U.S. Food & Drug Administration. Reference the American Medical Association (AMA), U.S. Blood Pressure Validated Device Listing of blood pressure monitors that meet the AMA's criteria for clinical accuracy. The list is available on the AMA website; refer to the Directory Appendix for website information. Provision of the link to the AMA validated device list is for provider informational purposes only. Medicaid blood pressure monitor coverage is not contingent upon the requested device being validated by the AMA.

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
				The following category/text was added: **Non-Covered Items**: • Finger and wrist monitors Under "Documentation", text was revised to read: The documentation must be less than 30 days old and include: • Diagnosis/medical condition pertaining to the need for the blood pressure monitor. • Complete ~~physician's~~ practitioner's treatment plan, including current blood pressure medications, frequency of checks, lifestyle changes (i.e., diet, exercise, etc.), and specific patient protocol in case of an abnormal reading. • ~~The medical reason a manual blood pressure unit cannot be used (for beneficiaries over the age of ten years).~~ • Prescription from a pediatric nephrologist when daily titration of medications is required for renal disease (**required for coverage under CSHCS**).

*Bulletin inclusion updates are color-coded to the quarter in which the update was made (April 1 = Blue; July 1 = Pink; October 1 = Green; January 1 = Orange)

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
				The following category/text was added: **Frequency**: One blood pressure monitor (manual or automatic) may be purchased within a five-year period. The blood pressure cuff may be replaced once every two years. Under "PA Requirements", text was revised to read: ~~PA is required for all blood pressure units.~~ Prior authorization is not required for the following when Standards of Coverage are met, and the beneficiary has one of the following diagnoses/conditions: • renal disease; or • hypertensive disorders in pregnancy, childbirth, or the puerperium period (e.g., pre-eclampsia). Prior authorization is required for the following: • Medical need beyond the standards of coverage. • Diagnoses/conditions other than those listed above. • Replacement of the monitor and/or accessories prior to frequency limitations.

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
				The following category/text was added: **Warranty** — Manual and automatic blood pressure monitors must have a minimum of a one-year warranty. Under "Payment Rules", text was revised to read: A blood pressure monitor is considered a **purchase only** item and includes all accessories necessary for operation of the monitor. Any warranties must be expired prior to requesting replacement of the monitor or accessories. Refer to the Medicaid Code and Rate Reference tool for HCPCS code coverage parameters. (Refer to the Directory Appendix for website information.)
		Directory Appendix	Provider Resources	Addition of: **Contact/Topic:** American Medical Association (AMA) **Mailing/Email/Web Address:** https://www.validatebp.org/ **Information Available/Purpose:** U.S. Blood Pressure Validated Device Listing of blood pressure monitors that meet the AMA's criteria for clinical accuracy.

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
HASA 22-17	6/1/2022	Hospital Reimbursement Appendix	7.3.A. Government Provider DSH Pool	The 3rd, 4th, and 5th paragraphs were deleted. ~~Medicare 2552 cost reports, supplemented by the Medicaid Cost Reports, will be used to determine each hospital's allowable DSH costs eligible for federal financial participation.~~ ~~An interim payment and reconciliation process will be employed when making allocations from this pool. Allowable DSH costs will be determined based on information obtained from the cost report periods ending during the second previous state fiscal year. Costs will be obtained from the most recently filed Medicare 2552 cost report and Medicaid Cost Report for that period. These costs will be trended to the current state fiscal year using an inflation factor taken from Health Care Cost Review published quarterly by Global Insight. Interim payments will then be made.~~ ~~Interim payments will be reconciled twice. First, an interim reconciliation of the original payments will be conducted based on updated allowable DSH costs. Information needed to reconcile initial payments will be obtained from hospital Medicare 2552 cost reports filed with the fiscal intermediary and Medicaid Cost Report for the applicable reporting period. Second, payments will be adjusted for a final time based on Medicare 2552 cost reports finalized with the fiscal intermediary and Medicaid Cost Report for the applicable reporting period.~~

*Bulletin inclusion updates are color-coded to the quarter in which the update was made (April 1 = Blue; July 1 = Pink; October 1 = Green; January 1 = Orange)

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			7.4 Calculation of DSH Ceiling	The 3rd paragraph was revised to read: The following trend factors will be applied to the financial elements used to calculate hospital DSH ceilings only during the Initial DSH Calculation for each year. These trend factors will not be applied during the ~~Interim~~ DSH Settlement calculations. The last paragraph was deleted. ~~During the Interim DSH Settlement calculation, an upward historical adjustment to the calculated DSH ceiling will be applied to those hospitals that meet certain requirements. To qualify, a hospital would need to be DSH eligible and have a higher audited ceiling calculation compared to the Interim ceiling calculation for each of the last three years of available DSH audits. An increase based on the difference between the audited ceiling and Interim ceiling from the most recent available year will then be applied to the current Interim DSH ceiling calculation. Hospitals may decline this upward adjustment by reducing their ceiling during the Interim DSH Settlement review period.~~
			7.5 Disproportionate Share Hospital (DSH) Process	The 1st paragraph was revised to read: The DSH process is designed to mitigate DSH audit-related recoveries. It is a ~~multiple~~ two-step process that allows hospitals to provide input into the DSH calculations, decline DSH funds, and reduce their DSH ceiling. The ~~multiple~~ two-step DSH process is as follows.

*Bulletin inclusion updates are color-coded to the quarter in which the update was made (April 1 = Blue; July 1 = Pink; October 1 = Green; January 1 = Orange)

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
				Under "***Step 1: Initial DSH Calculation***", the last paragraph was revised to read: DSH payments will be applied against a hospital's DSH ceiling in the following order: ~~1. $45 Million Pool~~ ~~2. Outpatient Uncompensated Care DSH Pool~~ ~~3. University with Both a College of Allopathic Medicine and a College of Osteopathic Medicine Pool (University Pool)~~ ~~4. Indigent Care Agreements Pool (ICA Pool)~~ ~~5. Government Provider DSH Pool (GP DSH Pool)~~ 1. Institutions for Mental Diseases Pool 2. $45 Million Pool 3. Outpatient Uncompensated Care DSH Pool 4. University with Both a College of Allopathic Medicine and a College of Osteopathic Medicine Pool (University Pool) 5. Government Provider DSH Pool (GP DSH Pool)

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
				Under "*Step 2: Interim DSH Settlement*", text was revised to read: **Step 2: ~~Interim~~ Final DSH Settlement Step** DSH ceilings, DSH payments and Medicaid utilization rates are recalculated during the final DSH settlement step. ~~using new Medicaid Cost Report data during the Interim DSH Settlement step to mitigate final DSH audit-related DSH recoveries. This may result in DSH recoveries for some hospitals during this step.~~ DSH funds will be reallocated in the following manner: ~~a manner that maintains the pool order outlined in the Initial DSH Calculation step.~~ 1. Institutions for Mental Diseases Pool 2. $45 Million Pool 3. Outpatient Uncompensated Care DSH Pool 4. University with Both a College of Allopathic Medicine and a College of Osteopathic Medicine Pool (University Pool) 5. Government Provider DSH Pool (GP DSH Pool) 6. Unspent funds not applicable to Step 1

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
				~~As part of the Interim DSH Settlement,~~ MDHHS will recalculate hospital-specific DSH ~~ceilings~~ limits, DSH payment allocations and Medicaid utilization rates ~~during the year following~~ upon completion of the DSH audit for the applicable DSH year. Inpatient and outpatient cost and payment data utilized from Step 1 will be refreshed to account for any cost report changes that occurred between steps during the cost report acceptance process. DSH limits and Medicaid utilization rates will be calculated using the final DSH audit. No hospital will receive a DSH payment in excess of its audited DSH Settlement limit. ~~data from Medicaid Cost Reports with hospital FYs ending during the previous calendar year will be utilized for ceiling, payment, and Medicaid utilization rate recalculations. The data will not be trended. For example, during 2013, data from hospital cost reports with FYs ending between January 1, 2012 and December 31, 2012 will be used to complete the FY 2012 Interim DSH Settlement calculations.~~ ~~MDHHS will share Interim DSH Settlement results with hospitals. Hospitals are able to decline DSH funds following the Interim DSH Settlement. If a hospital declines DSH funds during the Interim DSH Settlement step, the decision is irrevocable and the hospital is not eligible for any DSH funds for that state FY. Hospitals may also request a downward adjustment to their DSH ceiling during the Interim DSH Settlement step. Upon receipt of this feedback from hospitals, each hospital's calculated DSH ceiling will be reduced to the requested amount and Interim DSH Settlement payments will be issued.~~

*Bulletin inclusion updates are color-coded to the quarter in which the update was made (April 1 = Blue; July 1 = Pink; October 1 = Green; January 1 = Orange)

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
				~~Funds recovered from the $45 Million Pool and Outpatient Uncompensated Care DSH Pool are reallocated to other qualifying hospitals within that pool based on the original formula used to allocate funding from the pool. Funds recovered from the ICA Pool will be reallocated to other qualifying hospitals within that pool.~~ ~~No hospital will receive a DSH payment in excess of its Interim DSH Settlement ceiling.~~ Upon completion of the calculations for the first five pools outlined in the order above, any remaining unspent federal DSH allotment will be distributed through a new pool. The remaining allotment will be distributed to all remaining eligible hospitals proportionately based on their share of remaining audited hospital-specific DSH limit capacity adjusted to exclude the DSH payment amounts hospitals received from the university and GP DSH pools. No hospital will receive an allocation in excess of its remaining audited hospital-specific DSH limit capacity or other federal limits. The formulas to distribute these funds are as follows 1. (Eligible Hospital's Remaining Audited DSH Limit Capacity + University DSH Payment Amount + GP DSH Payment Amount) / (∑ of All Eligible Hospitals' Audited Remaining DSH Limit Capacity + University DSH Payment Amount + GP DSH Payment Amount) = (Hospital Pool Factor) 2. (Hospital Pool Factor) X (Pool Amount) = Pool Payment Text for "***Step 3: Final DSH Audit-Related DSH Redistribution***" was deleted.

*Bulletin inclusion updates are color-coded to the quarter in which the update was made (April 1 = Blue; July 1 = Pink; October 1 = Green; January 1 = Orange)

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
HASA 22-21	7/1/2022	Billing & Reimbursement for Institutional Providers	6.2.C. Special Circumstances for Hospital Readmissions and Transfers	A new section and text was added to the chart: **Neonatal Intensive Care Unit (NICU) Return Transfers** Stabilized infants from NICUs may transfer back to the hospital from which the infant was originally transferred. Transfers may be authorized, with parental consent, to another community hospital when the original facility is at capacity or not closely located to the patient's home. A Prior Authorization Certification Evaluation Review (PACER) must be authorized through the ACRC for elective transfers between hospitals. NICU return transfer requests for continued medical care at a lower acuity hospital will be authorized if a neonatologist provides a written order to transfer to the originating or community hospital for bonding, teaching, and growth. Existing hospital and ambulance transfer reimbursement methodology will be utilized when prior authorization is granted.
		Hospital	2.1.A.2. Admissions/ Readmissions/Transfers that Do Not Require a PACER Number	The 4th bullet point was revised to read: • Newborns admitted following delivery and newborns delivered within an emergency department and subsequently admitted to another facility.

*Bulletin inclusion updates are color-coded to the quarter in which the update was made (April 1 = Blue; July 1 = Pink; October 1 = Green; January 1 = Orange)