Michigan Medicaid Policy | MMP

BULLETIN

BEHAVIORAL AND PHYSICAL HEALTH AND AGING SERVICES ADMINISTRATION

MDHHS

Bulletin Number: MMP 24-57

Distribution: All Providers

Issued: November 27, 2024

Subject: Updates to the Medicaid Provider Manual

Effective: January 1, 2025

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 January 2025 quarterly update of the MDHHS Medicaid Provider Manual. The Manual is maintained on the MDHHS website at www.michigan.gov/medicaidproviders >> Policy, Letters & Forms >> Medicaid Provider Manual. A compact disc (CD) version of the manual is available to enrolled providers upon request.

The January 2025 version of the manual does not highlight changes made in 2024. 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. Subsequent changes made for the April, July, and October 2025 versions of the manual will be highlighted within the text of the on-line manual.

Manual Maintenance

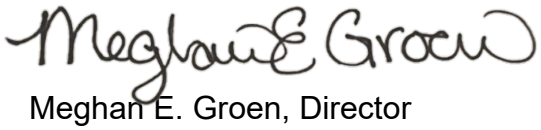
If utilizing the online version of the manual at www.michigan.gov/medicaidproviders >> Policy, Letters & Forms, this bulletin and those referenced in this bulletin may be discarded. If using a CD version of the manual, providers should retain all bulletins issued since the version date of the CD. Providers 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-mailed to ProviderSupport@michigan.gov. When you submit a question, 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



Meghan E. Groen, Director
Behavioral and Physical Health and Aging Services Administration

Medicaid Provider Manual
January 2025 Updates

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Billing & Reimbursement for Dental Providers	Section 9 – Julian Calendar	The first paragraph after the table was revised to read: For leap year, one day must be added to the number of days after February 28. The next three leap years are ~~2024~~, 2028, ~~and~~ 2032 and 2036.	General update.
Billing & Reimbursement for Institutional Providers	Section 13 – Julian Calendar	The first paragraph after the table was revised to read: For leap year, one day must be added to the number of days after February 28. The next three leap years are ~~2024~~, 2028, ~~and~~ 2032 and 2036.	General update.
Billing & Reimbursement for Professionals	Section 9 – Julian Calendar	The first paragraph after the table was revised to read: For leap year, one day must be added to the number of days after February 28. The next three leap years are ~~2024~~, 2028, ~~and~~ 2032 and 2036.	General update.
Behavioral Health and Intellectual and Developmental Disability Supports and Services	3.30 Treatment Planning	The 1st paragraph was revised to read: Activities associated with the development and periodic review of the plan of service, including all aspects of the person-centered planning process, such as pre-meeting activities, and external facilitation of person-centered planning. Individuals who receive specialty behavioral health supports and services have the right to choose an independent facilitator (IF) to facilitate the person-centered planning (PCP) process that is used to develop the Individual Plan of Service (IPOS). This includes writing goals, objectives, and outcomes; designing strategies to achieve outcomes (identifying amount, scope, and duration) and ways to measure achievement relative to the outcome methodologies; attending person-centered planning meetings per invitation; and documentation. Monitoring of the ~~individual plan of service~~ IPOS, including specific services when not performed by the case manager or supports coordinator, is included in this coverage. For children and youth, a family-driven, youth-guided planning process should be utilized.	

* 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	13.3 Core Requirements	The 2nd bullet point was revised to read: • Independent facilitation of the person-centered plan is made available. Individuals who receive specialty behavioral health supports and services have the right to choose an IF to facilitate the PCP process that is used to develop the IPOS.	
Dental	9.2.C. Implant Services	The 1st paragraph was revised to read: Dental implants, surgical guides and occlusal guards are covered for CSHCS beneficiaries who have a qualifying diagnosis, including but not limited to ~~of~~ anodontia or traumatic injury to the dental arches, and standard restorative treatment is contraindicated.	Clarify language is not limited to anodontia or traumatic injury to the dental arches, but other qualifying diagnosis as well. This aligns with 9.1.B. CSHCS Enhanced Dental Services in the Children's Special Health Care Services chapter.
Doula Services	Section 2 – Covered Services	The 5th paragraph was revised to read: A qualifying visit for attendance at labor and delivery requires the doula to be physically present during labor, delivery, and the immediate postpartum period. Physical presence at birth includes doulas who remain on-site at the facility ~~during the cesarean procedure~~.	Clarification.

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CHAPTER	SECTION	CHANGE	COMMENT
Home Help	4.1.B. CMHSP-Supervised Setting	Text was revised to read: Residents of a CMHSP-supervised setting who receive community mental health (CMH) services may also qualify for Home Help services if the setting does not meet the definition of an AFC or HFA. Home Help services cannot be provided by the person or agency provider that ~~who~~ owns, rents, or leases the home. A client's assessed hours for IADLs other than taking medication must be reduced by 50 percent unless it can be clearly documented that IADLs for the client are completed separately from other adults in the home. The client's ASW will make this determination in consultation with the client and their representative as part of the person-centered planning process.	Clarifies that no provider type that owns, rents or leases a CMHSP-supervised setting can serve as a resident's Home Help provider.
Home Help	8.6.A. Home Help Services Agreement (MSA-4676)	The 3rd paragraph was revised to read: The client must receive~~s~~ the MSA-4676 from the ASW and manages the form completion and submission. Once the client and provider sign and date the MSA-4676, it must be returned to the client's ASW or local MDHHS office. The form may be delivered in person or by fax, U.S. mail, or email. The client has the authority to decide how to return the completed MSA-4676 and may delegate the task to the provider.	Clarifies that MDHHS is the sole allowable source of the MSA-4676 Home Help Services Agreement.
Hospital Reimbursement Appendix	2.3.A.3. 3M™ APR-DRG Relative Weights	Under "Relative Weight Trim Points", the 1st paragraph was revised to read: The following trim points are established for the relative weighting system. All relative weight trim points are subject to reasonableness testing.	Language added to maintain consistency with prior section on State-Specific Relative Weight Methodology.

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CHAPTER	SECTION	CHANGE	COMMENT
Nursing Facility – Cost Reporting & Reimbursement Appendix	4.8.A. New Facility/New Ownership Initial Cost Report	Text was revised to read: A new Medicaid provider (either a new owner or a new Medicaid participating provider) must notify RARSS of its fiscal year and cost reporting period, and other pertinent information regarding the nursing facility. The initial cost report and any related home office cost reports must cover a period of at least two months but may not exceed 13 months.	Updated to include home office cost reports.
Nursing Facility – Cost Reporting & Reimbursement Appendix	6.1 Audit Process	The 2nd paragraph was revised to read: ~~Onsite audits will be conducted no less than once every four years.~~ An audit of either limited or full scope will be performed on the records of each participating nursing facility provider to ensure that the expenses attributable to allowable cost items are accurately reported in accordance with established principles and guidelines.	Removal of obsolete information. (This requirement stopped per bulletin MSA 19-28.)
Pharmacy	Section 5 – Signature Log, Data Collection and Documentation	The text box was removed: ~~NOTE: The requirements in the following subsection are waived in accordance with Letter L 20-20 beginning March 26, 2020 and until MDHHS issues policy notifying providers of their termination.~~	Removal of obsolete information.
Pharmacy	14.15.A. Respiratory Syncytial Virus (RSV) Injectables	Text was revised to read: Enrolled pharmacy providers may bill for ~~the injectable drugs Synagis and Beyfortus~~ covered RSV injectable drugs. (Refer to the Michigan Pharmaceutical Product List subsection for additional information.)	As more RSV injectables enter the market, we need to remove references to name brands.
Practitioner	7.9.B. Covered Supports and Services	In the 1st paragraph, the 1st bullet point was revised to read: • A face-to-face encounter, provided in-person or via simultaneous audio-visual technology, with the beneficiary lasting a minimum of 30 minutes.	Clarification regarding telemedicine delivery option.

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CHAPTER	SECTION	CHANGE	COMMENT
Therapy Services	1.7 Therapy for Beneficiaries with Autism Spectrum Disorder (new subsection)	New subsection text reads: Beneficiaries diagnosed with autism spectrum disorder (ASD) who have been determined eligible by the Prepaid Inpatient Health Plan (PIHP) for specialty Behavioral Health Treatment (BHT) services may also have any related OT, PT, and ST services covered through the PIHP when the therapy will result in a functional improvement that is significant to the beneficiary's ability to perform daily living tasks appropriate to their chronological, developmental or functional status. These functional improvements should be able to be achieved in a reasonable amount of time and should be durable (i.e., maintainable). Therapy services covered by the PIHP must meet the criteria outlined within the Program Requirements section (Medical Necessity Criteria subsection) of the Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter. Providers should also refer to the Covered Services section in the Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter for additional information. Medicaid does not require beneficiaries to be referred to or access therapy services through the Medicaid Health Plan (MHP) or Medicaid Fee-for-Service (FFS) program prior to, or in lieu of, accessing therapy through the PIHP when the therapy is related to the beneficiary's ASD diagnosis.	Clarification per letter L 24-23.
Directory Appendix	Mental Health/ Substance Abuse Resources	The section title was revised to read: ~~Mental Health/Substance Abuse~~ Behavioral Health/SUD Resources The section was relocated for alphabetical order purposes.	Update.

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Directory Appendix		Throughout the Directory Appendix, updates were made relative to Magellan Medicaid Administration, Inc. being changed to Prime Therapeutics State Government Solutions, LLC. The name change resulted in revisions to: • Mailing addresses • Website addresses • Email addresses	**NOTE:** The changes were included in the October 1, 2024 update of the MDHHS Medicaid Provider Manual; however, the changes were not reported in bulletin MMP 24-30. Providers are being informed of the revisions through this notification.

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Medicaid Provider Manual
January 2025 Updates

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HASA 22-10 **Note:** This bulletin was incorporated previously; however, additional information was identified to be added to the Manual.	4/1/2022	Billing & Reimbursement for Professionals	6.8 Clinical Trials	Text was revised to read: All claims for routine patient costs associated with participation in a clinical trial must include the National Clinical Trial (NCT) number and an ICD-10 diagnosis code indicating the services are associated with a clinical trial. Claims must also include a completed and signed Attestation to the Appropriateness of the Qualified Clinical Trial form (BPHASA-2210). (Refer to the Forms Appendix to review the form and to the Directory Appendix for form access on the MDHHS website.) In addition, professional claims must include: • ICD-10-CM Z00.6 (encounter for examination for normal comparison and control in clinical research program) in the primary or secondary position. • Clinical trial and non-clinical trial services on separate line items when claims are submitted for both types of services on the same claim. • Identify each line with the appropriate Healthcare Common Procedure Coding System (HCPCS) Modifier. ➢ HCPCS Modifier Q1 – routine clinical service provided in a clinical research study that is in an approved clinical research study.

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				Generally, services, investigational drugs, or items that are part of the clinical trial and considered experimental or investigational are not program covered services and should not be reported on a claim. In instances when claims processing edits require non-covered services be billed with their associated procedures, or when it is necessary for a provider to show the items and services provided free-of-charge to receive payment for the covered routine costs, providers are instructed to report non-covered services/charges on a separate claim line with the appropriate modifier and a charge of $0. • HCPCS Modifier Q0 - investigational clinical service provided in a clinical research study that is in an approved clinical research study. Refer to the Billing & Reimbursement for Institutional Providers and the Practitioner chapters for additional information.
MMP 24-22	7/1/2024	Hospital Reimbursement Appendix	8.7.C. GME Innovations Michigan Doctors (MIDocs) Program	The 2nd paragraph was revised to read: The single state agency will approve four (4) agreements with MIDocs participating medical schools statewide each state fiscal year (SFY), covering residencies for the academic year (July-June (AY)) beginning within the SFY. The agreements will total $1.52 million in fiscal year 2019, $10.73 million in fiscal year 2020, $19.98 million in fiscal year 2021, $27.75 million in fiscal year 2022, ~~and~~ $28.5 million in fiscal year 2023, and $22.8 million in fiscal year 2024.

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MMP 24-24	7/1/2024	Behavioral Health and Intellectual and Developmental Disability Supports and Services	20.5.D. Provider Infrastructure Requirements	In the table following the 1st paragraph, information for 'Health Home Partners (per 100 beneficiaries)' was revised to read: • Behavioral Health Specialist (0.25 FTE) • Nurse Care Manager (1.00 FTE) • ~~Peer Support Specialist, Peer Recovery Coach~~ • Peer Support Specialist, Peer Recovery Coach, Youth Peer Support Specialist, Community Health Worker, Medical Assistant (3.00-4.00 FTE) • Medical Consultant (.10 FTE) • Psychiatric Consultant (.10 FTE) In the table following the 1st paragraph, information for 'Regional PIHP (per 100 beneficiaries)' was revised to read: • Health Home Director (~~.50~~ .25 FTE) In the table following the 2nd paragraph, category information in the 1st column was revised to read: **Peer Support Specialist, Peer Recovery Coach, Youth Peer Support Specialist**

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		Directory Appendix	Behavioral Health (title reflects Technical Change update)	Under 'Behavioral Health Home', 'Information Available/Purpose' was revised to read: Provider Resources: Behavioral Health Home Handbook; Policy Bulletins MSA 20-48, ~~; Policy Bulletin~~ HASA 22-09,~~; Policy Bulletin~~ MMP 23-16, and MMP 24-24; State Plan Amendment Approval Letter; Health Home Provider Application; Behavioral Health Home Brochure and Poster; Behavioral Health Home Directory; Behavioral Health Home Encounter Codes and Rates; Care Plan Example.
MMP 24-25	7/17/2024	Billing & Reimbursement for Institutional Providers	6.2.E. Gender/Diagnosis Conflict (new subsection; the following subsections were re-numbered)	New subsection text reads: Medical services are available to beneficiaries based on medical need regardless of how the beneficiary identifies or expresses for gender. Claims and encounters for some services may be inadvertently denied or rejected due to sex-specific editing unless billed properly. Report institutional claims and encounters for services that may pose a gender/diagnosis/procedure conflict or may be subject to related mismatch edits with claim level condition code 45 Ambiguous gender category. Fee-for-Service claims may also be reported with a diagnosis code from the gender identity category (F64), and these will suspend for review and payment.

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Billing & Reimbursement for Professionals	6.15 Gender/Diagnosis Conflict (new subsection; the following subsections were re-numbered)	New subsection text reads: Medical services are available to beneficiaries based on medical need regardless of how the beneficiary identifies or expresses for gender. Claims and encounters for some services may be inadvertently denied or rejected due to sex-specific editing unless billed properly. Append modifier KX to professional claims and encounters for services that may pose a gender/diagnosis/procedure conflict or may be subject to related mismatch edits. Fee-for-Service claims may also be reported with a diagnosis code from the gender identity category (F64), and these will suspend for review and payment.
MMP 24-26	9/10/2024	Behavioral Health and Intellectual and Developmental Disability Supports and Services	3.21.C. Peer Recovery Coach Services	Under 'Peer Recovery Coach Services', the 5th paragraph was revised to read: Peer recovery coaches work in a variety of settings providing successful engagement in treatment and transitions across all levels of care for beneficiaries with high-risk and complex care needs. Some of the settings where peer recovery coaches may provide services include residential treatment facilities, Medication Assisted Treatment (MAT) programs, Recovery Community Organizations (RCO), hospital emergency rooms, ~~Opioid~~ Substance Use Disorder Health Homes ~~(OHH)~~ (SUDHH), housing programs, outpatient treatment and prevention, drug courts and other justice involved settings.
			Section 19 – Opioid Health Home	The section title was revised to read: ~~Opioid~~ Substance Use Disorder Health Home

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				Text was revised to read: Pursuant to the requirements of Section 2703 of the Patient Protection and Affordable Care Act and the State Plan and Alternative Benefit Plan Amendments, the purpose of this policy is to provide for the coverage and reimbursement of ~~Opioid~~ Substance Use Disorder Health Home ~~(OHH)~~ (SUDHH) services. This policy is effective for dates of service on and after October 1, ~~2020~~ 2024. The policy applies to Fee-for-Service (FFS) and managed care beneficiaries enrolled in Medicaid, the Healthy Michigan Plan, or MIChild who meet ~~OHH~~ SUDHH eligibility criteria. In addition to this policy, an operations guide for providers called the ~~Opioid~~ Substance Use Disorder Health Home ~~(OHH)~~ (SUDHH) Handbook is posted on the MDHHS website. (Refer to the Directory Appendix for website information.) NOTE: Continuation of the ~~OHH~~ SUDHH policy/benefit after ten (10) quarters of the effective date is subject to Michigan Department of Health and Human Services (MDHHS) review and approval. NOTE: Prepaid Inpatient Health Plan (PIHP) serves as the Lead Entity (LE) for the ~~OHH~~ SUDHH.

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			19.1 General Information	Text was revised to read: Effective October 1, ~~2020~~ 2024, MDHHS implemented a care management and care coordination primary care Health Home benefit called the ~~Opioid~~ Substance Use Disorder Health Home ~~(OHH)~~ (SUDHH) (previously referred to as the Opioid Health Home [OHH]). The goals of the program are to ensure seamless transition of care and to connect eligible beneficiaries with needed clinical and social services. MDHHS expects the benefit will enhance patient outcomes and quality of care, while simultaneously shifting people from emergency departments and hospitals to a primary care setting.
			19.2 Beneficiary Eligibility	Text was revised to read: Eligible beneficiaries ~~meeting geographic area requirements~~ cited in the Provider Eligibility Requirements subsection of this policy include those enrolled in Medicaid, the Healthy Michigan Plan, or MIChild who have a diagnosis of alcohol, stimulant, and opioid use disorder. Beneficiaries must also be at risk of developing mental health conditions, asthma, diabetes, heart disease, body mass index (BMI) over 25, or chronic obstructive pulmonary disease (COPD).

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			19.3.A. Enrollment Processes	The 1st paragraph was revised to read: Potential ~~Opioid~~ Substantial Use Disorder Health Home ~~(OHH)~~ (SUDHH) enrollees will be identified using a multifaceted approach. The Michigan Department of Health and Human Services (MDHHS) will provide a generated list that will pull potential enrollees from MDHHS administrative claims data into the Waiver Support Application (WSA) monthly. The PIHP will identify potential enrollees from the WSA and coordinate with a health home partner (HHP) to fully enroll the Medicaid beneficiary into the ~~OHH~~ SUDHH benefit. The selection of a ~~health home provider~~ HHP is optional, the beneficiary may have other choices of ~~health home providers~~ HHPs, and the beneficiary may disenroll from the benefit at any time. Enrolling into the health home benefit does not restrict access to other providers nor does it limit access to other Medicaid benefits. Enrollment into health home is voluntary and the potential enrollee must agree to receive health home services and provide consent that is maintained in the enrollee's health record.

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				PIHPs will provide information about the ~~OHH~~ SUDHH to all potential enrollees through community referrals, peer support specialist networks, other providers, courts, health departments, law enforcement, and other community-based settings. PIHPs will strategically provide these settings with informational brochures, posters, and other outreach materials to facilitate awareness and engagement of the ~~OHH~~ SUDHH. • **PIHP Identification of Potential Enrollees** The PIHP will be responsible for identifying potential enrollees that have a qualifying ~~OHH~~ SUD diagnosis in the WSA to a HHP and provide information regarding ~~OHH~~ SUDHH services to the Medicaid beneficiary in coordination with the HHP. • **Provider Recommended Identification of Potential Enrollees** ~~Health home partners~~ HHPs are permitted to recommend potential enrollees for the ~~OHH~~ SUDHH benefit via the WSA. ~~OHH providers~~ HHPs must provide documentation that indicates whether a potential ~~OHH~~ SUDHH enrollee meets all eligibility for the health home benefit, including diagnostic verification, obtaining consent, and establishment of an individualized care plan. The PIHP must review and process all recommended enrollments in the WSA. MDHHS reserves the right to review and verify all enrollments.
			19.3.B. Beneficiary Consent	References to 'Opioid Health Home/OHH' were revised to read 'Substance Use Disorder Health Home/SUDHH'.

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			19.3.C. OHH Benefit Plan Assignment	The subsection title was revised to read: ~~OHH~~ SUDHH Benefit Plan Assignment Additionally, references to 'Opioid Health Home/OHH' were revised to read 'Substance Use Disorder Health Home/SUDHH'.
			19.3.D. Beneficiary Disenrollment	The bullet points were revised to read: • Beneficiaries who moved out of ~~an eligible geographic area~~ the state of Michigan, are deceased, or are otherwise no longer eligible for the Medicaid program. These beneficiaries will have their eligibility files updated per the standard MI Bridges protocol. ~~Providers~~ HHPs will receive updated files accordingly. • Beneficiaries who are unresponsive for reasons other than moving or death. The PIHP must make at least three unsuccessful beneficiary contact attempts within six consecutive months for MDHHS to deem a beneficiary as unresponsive. For provider-recommended enrolled beneficiaries, if the beneficiary is unresponsive for ~~six~~ three months, the PIHP must mark the beneficiary as disenrolled via the WSA via the last date of service. The PIHP and MDHHS must maintain a list of disenrolled beneficiaries in the WSA. The PIHP must attempt to re-establish contact with these beneficiaries at least every six months after disenrollment, as applicable. Additionally, references to 'Opioid Health Home/OHH' were revised to read 'Substance Use Disorder Health Home/SUDHH'.

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			19.3.E. Beneficiary Changing OHH Providers	The subsection title was revised to read: Beneficiary Changing ~~OHH~~ SUDHH Providers Text was revised to read: While the beneficiary's stage in recovery and individualized care plan is utilized to determine the appropriate setting and ~~OHH provider~~ HHP of care (i.e., providers within Opioid Treatment Program versus Office-Based ~~Opioid~~ Substance Use Disorder Treatment), beneficiaries have the option to change ~~OHH providers~~ HHPs to the extent feasible within the regional PIHP's designated ~~OHH~~ HHP network. To maximize continuity of care and the patient-provider relationship, MDHHS expects beneficiaries to establish a lasting relationship with their chosen ~~OHH provider~~ HHP. However, beneficiaries may change ~~OHH providers~~ HHPs, and should notify their current ~~OHH provider~~ HHP immediately if they intend to do so. Current and future ~~OHH providers~~ HHPs must discuss the timing of the transfer and communicate transition options to the beneficiary. The change should occur on the first day of the next month with respect to the new ~~OHH provider's~~ HHP's appointment availability. Only one ~~OHH~~ SUDHH provider may be paid per beneficiary per month for ~~OHH~~ SUDHH services. ~~The new OHH provider is not eligible for the initial Recovery Action Plan payment if that one-time payment was already made to another OHH provider.~~

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			19.4 Covered Services	The 1st paragraph was revised to read: ~~OHH~~ SUDHH services provide integrated, person-centered, and comprehensive care to eligible beneficiaries to successfully address the complexity of ~~an opioid~~ substance use disorder and comorbid physical and behavioral health conditions. These services include the following:
			19.5 Provider Eligibility Requirements	Text was revised to read: Eligible ~~OHH~~ SUDHH providers must meet all applicable state and federal licensing requirements, including specifications set forth in this policy. Additionally, eligible providers must complete the MDHHS Health Home Provider (HHP) Application (form MDHHS-5745) which requires attestation to the requirements cited in this policy, the State Plan Amendment, and other applicable MDHHS policies and procedures. ~~Designated OHH providers must also be formally part of the regional PIHP's provider panel.~~ (The MDHHS-5745 and the State Plan are available on the MDHHS website. Refer to the Directory Appendix for website information.)
			19.5.A. Geographic Area	Text was revised to read: ~~OHH~~ SUDHH services are available to Medicaid beneficiaries ~~who reside in select counties and who meet all other eligibility criteria~~ pending availability of SUDHH providers. A listing/map of ~~counties~~ HHPs is posted on the MDHHS website. (Refer to the Directory Appendix for website information.)

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			19.5.B. Provider Types	Text was revised to read: Eligible provider types for the ~~OHH~~ SUDHH include Opioid Treatment Programs (OTPs) and Office-Based ~~Opioid~~ Substance Use Disorder Treatment ~~(OBOT)~~ (OBSUT) providers. ~~All OTPs and OBOT providers must provide MAT.~~ OTPs must meet all state and federal licensing requirements. ~~OBOT~~ OBSUT providers must attain the proper federal credentials from the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Drug Enforcement Agency (DEA) to provide MAT. ~~OBOT~~ OBSUT providers may include Community Mental Health Services Programs (CMHSPs), Federally Qualified Health Centers (FQHCs), including Section 330 grantees and FQHC Look-Alikes, Tribal Health Centers (THCs), and individual provider practices.

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			19.5.C. Provider Requirements	The 1st paragraph was revised to read: ~~PIHPs must adhere to the OHH contractual requirements with MDHHS. Designated OHH providers must meet the requirements indicated in the MDHHS-5745.~~ PIHPs and providers must adhere to the requirements of the State Plan Amendment, all Medicaid statutes, policies, procedures, rules, and regulations, and the ~~OHH~~ SUDHH Handbook. In the table after the 1st paragraph, under 'Health Home Partners', the 3rd bullet point was revised to read: • Peer Recovery Coach, Community Health Worker~~, Medical Assistant~~ (2.00-4.00 FTE) In the table after the 2nd paragraph, under 'Nurse Care Manager', text was revised to read: • licensed registered nurse, licensed practical nurse

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			19.6 Provider Enrollment and OHH Designation	The subsection title was revised to read: Provider Enrollment and ~~OHH~~ SUDHH Designation Text was revised to read: All HHPs must be properly paneled with the PIHP through contract, memorandum of understanding, or a similar mechanism conveying mutual partnership to execute ~~BHH~~ SUDHH services. Moreover, all HHPs must sign and attest to the requirements set forth in the provider application (MDHHS-5745).
			19.6.B. Use of Applicable Health Information Technology (HIT)	Text was revised to read: MDHHS requires ~~OHH providers~~ HHPs to utilize appropriate HIT for enrollment, health service documentation, and care coordination purposes. Training on specific HIT resources is provided by MDHHS.
			19.7 Provider Disenrollment	References to 'OHH' were revised to read 'SUDHH'.

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			19.8 OHH Payment	The subsection title was revised to read: ~~OHH~~ SUDHH Payment Text was revised to read: Payment for ~~OHH~~ SUDHH services is contingent on designated ~~OHH providers~~ HHPs meeting the requirements laid out in the State Plan Amendment, this policy, the provider application (MDHHS-5745), the ~~OHH~~ SUDHH Handbook, and as determined by MDHHS. Failure to meet these requirements may result in loss of ~~OHH provider~~ HHP designation.
			19.8.A. General Provisions for OHH Payment	The subsection title was revised to read: General Provisions for ~~OHH~~ SUDHH Payment
			19.8.A.1. MDHHS to Regional PIHP	References to 'OHH' were revised to read 'SUDHH'.
			19.8.A.2. Regional PIHP to OHH Providers	The subsection title was revised to read: Regional PIHP to ~~OHH Providers~~ Health Home Partners Text was revised to read: Designated ~~OHH providers~~ HHPs must bill through their regional PIHP to receive ~~OHH~~ SUDHH payment. Designated ~~OHH providers~~ HHPs are paid one monthly case rate per beneficiary.

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			19.8.A.3. Pay for Performance	Text was revised to read: MDHHS will afford P4P via a 5% performance incentive to the additional per member per month case rate. The PIHP must distribute P4P monies to HHPs that meet the quality improvement benchmarks in accordance with the timelines and processes. The State will only claim federal match once it determines quality improvement benchmarks have been met and providers have been paid. If quality improvement benchmarks are not met by any of the HHPs within a given performance year, the State ~~share of the withhold will be reserved by MDHHS and reinvested for OHH monthly case rate payments.~~ will distribute funds based on HHPs. The funding will be distributed equally among regions that maintain a recoupment rate less than 45% during the performance year. Subsequent performance years will operate in accordance with this structure. Details and guidance regarding applicable service encounter and diagnosis codes can be found in the ~~OHH~~ SUDHH Handbook. NOTE: Payment for ~~OHH~~ SUDHH services is in addition to the existing FFS payments, encounters, or daily rate payments for direct clinical services. The MDHHS payment methodology is designed to only reimburse for the cost of the ~~OHH provider~~ HHP staff for the delivery of ~~OHH~~ SUDHH services that are not covered by any other currently available Medicaid reimbursement mechanism.

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			19.8.B. Recoupment of Payment	Text was revised to read: The monthly payment is contingent upon an ~~OHH~~ SUDHH beneficiary receiving an ~~OHH~~ SUDHH service during the month at issue. The payment is subject to recoupment if the beneficiary does not receive an ~~OHH~~ SUDHH service during the calendar month. The recoupment lookback will occur six months after the monthly payment is made. Thus, six months after the month a payment is made (for example: in January, MDHHS would look back at the payment made in July), CHAMPS will conduct an automatic recoupment process that will look for an approved encounter code (refer to the ~~OHH~~ SUDHH Handbook) which documents that the ~~OHH~~ SUDHH provided at least one of the ~~five~~ six core ~~OHH~~ SUDHH services (refer to the Covered Services subsection) during the calendar month in question. If a core ~~OHH~~ SUDHH service is not provided during a month, that month's payment will be subject to recoupment by MDHHS. Once a recoupment has occurred, there shall be no further opportunity to submit a valid ~~OHH~~ SUDHH encounter code and/or claim for the month that has a payment recouped. Additional details regarding payment recoupment, including the recoupment schedule and other reasons for recoupment, can be found in the ~~OHH~~ SUDHH Handbook.

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Practitioner	14.3.H. Reimbursement	The 3rd paragraph was revised to read: To avoid duplication of services, CoCM services should not be provided to beneficiaries receiving the following Medicaid program services: • MI Care Team benefit, • Behavioral Health Home benefit, • ~~Opioid~~ Substance Use Disorder Health Home benefit, or • Other care management services that include mental health treatment.

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Special Programs	10.8 Covered Supports and Services	The 3rd paragraph was revised to read: Reimbursement for assessment, monitoring, and follow-up visits is inclusive of all related care coordination and monitoring activities. MDHHS does not reimburse for missed appointments/visits. A beneficiary may not be billed for a missed appointment/visit. Medicaid reimbursement for TCM services may not duplicate payments made to public agencies or private entities under other program authorities for the same purpose. To avoid duplication of services, TCM services should not be provided to beneficiaries receiving the following Medicaid program services: • MI Care Team Health Home benefit; • Behavioral Health Home benefit; • ~~Opioid~~ Substance Use Disorder Health Home benefit; • Collaborative Care Management services; or • Other case management benefit programs that provide similar services
		Acronym Appendix		Removal of: ~~OHH – Opioid Health Home~~ Addition of: SUDHH – Substance Use Disorder Health Home

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Directory Appendix	Behavioral Health (title reflects Technical Change update)	The section for 'Opioid Health Homes' was re-titled 'Substance Use Disorder Health Homes' and information was updated as applicable.
MMP 24-27	7/31/2024	Special Programs	Section 11 – Targeted Case Management – Recuperative Care (new section)	A new section was added for subject policy.
		Acronym Appendix		Addition of: NIMRC – National Institute for Medical Respite Care RC – Recuperative Care
		Directory Appendix	Prior Authorization	Addition of: **Contact/Topic:** Prior Authorization - Recuperative Care **Phone # Fax #:** 844-RECUP-MI (844-732-8764) **Mailing/Email/Web Address:** MDHHS Program Review Division PO Box 30170 Lansing, MI 48909 **Information Available/Purpose:** Telephonic prior authorization for Targeted Case Management - Recuperative Care

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			Provider Resources	Addition of: **Contact/Topic:** National Institute for Medical Respite Care **Mailing/Email/Web Address:** https://nimrc.org/standards-for-medical-respite-programs/ **Information Available/Purpose:** Information for Targeted Case Management - Recuperative Care: the National Institute for Medical Respite Care (NIMRC) standards for medical respite care.
		Forms Appendix		Addition of: BPHASA-2427; Recuperative Care (RC) Prior Authorization (PA) Request Data BPHASA-2428; Michigan Recuperative Care Provider Attestation

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MMP 24-28	8/30/2024	Program of All-Inclusive Care for the Elderly	4.2 Expansion Applications	Text was revised to read: An expansion application is for existing PACE organizations ~~who~~ that are seeking to expand. Types of expansions include: • A PACE organization requests to expand its geographic service area without building additional sites. • A PACE organization requests to open another physical site in the existing geographic service area. • A PACE organization requests to expand its geographic service area and open another physical site in the expanded area. • A PACE organization requests to expand its current ~~building~~ capacity. • A PACE organization requests to expand its current building or change to a new address (does not require a Letter of Intent 14 months before fiscal year). Expansion applications will not be accepted by MDHHS until the first CMS trial period audit has been completed with good standing and the organization is fiscally sound. A PACE organization will not be considered if the PACE organization has active sanctions, as defined in the Code of Federal regulations (42 CFR Part 460 Subpart D).

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			4.2.B. Feasibility Study	The 1st paragraph was revised in its entirety to read: PACE organizations requesting an expansion must submit a feasibility study that includes: • A PACE organization requests to expand its geographic service area without building additional sites. ➢ Identifies the proposed service area ➢ Shows evidence of demand for PACE services in the proposed service area ➢ Documents the organization's timeline ➢ Identifies the anticipated source of referrals for potential participants ➢ Includes assurance of adequate financial capacity to fund program development and start-up costs, including identification of participant capacity and break-even consideration ➢ Shows evidence of the proposed provider network and assurance that the organization will have staff and professionals experienced in providing care to the participants ➢ Shows evidence of experience in providing primary, acute and/or long-term care services to the target population and evidence of positive community support

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				➢ Demonstrates the ability to meet state and federal PACE requirements ➢ Demonstrates organizational commitment to principles consistent with the PACE model ➢ Shows evidence that the key positions of Executive Director, Medical Director, Center Manager, Financial Manager, and Quality Improvement Manager are sufficiently staffed ➢ Shows evidence that the Executive (Program) Director position will be staffed with a full-time employee ➢ Shows evidence that the organization has the depth in leadership and experience required to develop and implement PACE successfully • A PACE organization requests to open another physical site in the existing geographic service area. ➢ Identifies the proposed service area ➢ Shows evidence of demand for PACE services in the proposed service area ➢ Documents the organization's timeline for development and anticipated costs ➢ Includes assurance of adequate financial capacity to fund program development and start-up costs, including identification of participant capacity and break-even consideration ➢ Shows evidence that the key positions will be staffed on-site

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				➢ Shows evidence that the key positions of Executive Director, Medical Director, Center Manager, Financial Manager, and Quality Improvement Manager are sufficiently staffed ➢ Shows evidence that the Executive (Program) Director position will be staffed with a full-time employee ➢ Demonstrates the ability to meet state and federal PACE requirements ➢ Demonstrates organizational commitment to principles consistent with the PACE model ➢ Demonstrates that the organization has the depth in leadership and experience required to develop and implement PACE successfully ➢ Shows evidence of experience in providing primary, acute and/or long-term care services to the target population and evidence of positive community support • A PACE organization requests to expand its geographic service area and open another physical site in the expanded area. ➢ Identifies the proposed service area ➢ Shows evidence of demand for PACE services in the proposed service area ➢ Documents the organization's timeline for development and anticipated costs ➢ Identifies the anticipated source of referrals for potential participants

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				➢ Includes assurance of adequate financial capacity to fund program development and start-up costs, including identification of participant capacity and break-even consideration ➢ Shows evidence of the proposed provider network and assurance that the organization will have staff and professionals experienced in providing care to the participants ➢ Shows evidence of experience in providing primary, acute and/or long-term care services to the target population and evidence of positive community support ➢ Demonstrates the ability to meet state and federal PACE requirements ➢ Demonstrates organizational commitment to principles consistent with the PACE model ➢ Shows evidence that the key positions of Executive Director, Medical Director, Center Manager, Financial Manager, and Quality Improvement Manager are sufficiently staffed ➢ Shows evidence that the Executive (Program) Director position will be staffed with a full-time employee ➢ Shows evidence that the key positions will be staffed on-site ➢ Shows evidence that the organization has the depth in leadership and experience required to develop and implement PACE successfully

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				• A PACE organization requests to increase its current capacity. ➢ Identifies current capacity ➢ Identifies current enrollment ➢ Includes proposal for why increase is needed ➢ Documents physical capacity determined by fire marshal for ○ Building ○ Day Center ○ Clinic ➢ Identifies current average daily attendance for participants and staff ○ Building ○ Day Center ○ Clinic ➢ Documents projected daily attendance for participants and staff ○ Building ○ Day Center ○ Clinic • A PACE organization requests to expand its current building or change of address. ➢ Identifies information that will be available to organizations that file a letter of intent with MDHHS.

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MMP 24-29	9/26/2024	Community Health Worker Services	Section 7 – Specialty Behavioral Health Providers (new section)	New section text reads: CHW covered services (outlined in the Covered Services section of this chapter) are included in the Behavioral Health Code Charts and reimbursable through Prepaid Inpatient Health Plans (PIHPs) effective for dates of service on or after October 1, 2024.
			7.1 General Information (new subsection)	New subsection text reads: CHWs have an important role promoting health outcomes related to both physical and behavioral health. CHWs can be utilized by specialty behavioral health providers to facilitate access to needed health and social services.
			7.2 Covered Services (new subsection)	New subsection text reads: Covered services are the same as outlined in the Covered Services section of this chapter. Peer Support Specialist (PSS) and Peer Recovery Coach (PRC) services are separately covered. Refer to the Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter for additional information. To seek Medicaid reimbursement for the delivery of CHW services, an individual must meet the requirements outlined in the CHW Qualifications Criteria section of this chapter.

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		Medicaid Health Plans	1.1 Services Covered by Medicaid Health Plans (MHPs)	In the 1st paragraph, the following bullet point was added: • Community Health Worker (CHW)/Community Health Representative (CHR) services
MMP 24-33	8/30/2024	Ambulance	1.1 General Information	In the 3rd paragraph, the 5th bullet point was revised to read: Services that have been excluded from direct reimbursement to ambulance providers are: • Services to Medicaid Health Plan (MHP) enrollees~~, except for medically necessary ambulance transports related to Healthy Kids Dental, substance abuse, and community mental health services~~.
		Behavioral Health and Intellectual and Developmental Disability Supports and Services	12.6 Excluded Services	The last bullet point was revised to read: Some Medicaid-covered services are available to substance abuse beneficiaries but are provided outside of the PIHP ~~Plan~~. ~~The~~ PIHPs are not responsible to pay for the following: • Routine transportation to substance abuse treatment services which is the responsibility of the local MDHHS office or beneficiary's MHP.

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		Behavioral Health and Intellectual and Developmental Disability Supports and Services - Children with Serious Emotional Disturbances Home and Community-Based Services Waiver Appendix	Section 3 - Medicaid State Plan Services	The 3rd paragraph was revised to read: PIHPs are responsible for transportation to and from the beneficiary's place of residence when provided so that a beneficiary may participate in a state plan, HSW, or additional/1915(i) State Plan Amendment (SPA) service at an approved day program site or in a clubhouse psychosocial rehabilitation program. Medicaid Health Plans (MHPs) are responsible for assuring enrollee transportation to ~~the primary health care services provided by the MHPs, and to non-mental health specialists and out-of-state medical providers~~ Medicaid covered medical appointments. MDHHS is responsible for assuring transportation to medical appointments for Medicaid beneficiaries not enrolled in MHPs~~; and to dental, substance abuse, and mental health services~~ (except those noted above and in the HSW program – described in the Habilitation Supports Waiver for Persons with Developmental Disabilities Section of this chapter) ~~for all Medicaid beneficiaries~~.
		Medicaid Health Plans	1.1 Services Covered by Medicaid Health Plans (MHPs)	In the 1st paragraph, the 37th bullet point was revised to read: • Transportation for all medically necessary Medicaid covered services
			1.2 Services Excluded from MHP Coverage but Covered by Medicaid	The 12th bullet point was removed: • ~~Transportation for services not covered by the MHP~~

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		Non-Emergency Medical Transportation	Section 7 – Managed Care Programs	The 1st and 2nd paragraphs were revised to read: The Medicaid program contracts with Medicaid Health Plans (MHPs) and Integrated Care Organizations (ICOs), selected through a competitive bid process, to provide services to beneficiaries. These entities are responsible for providing NEMT services to their enrollees for all Medicaid covered services ~~covered under their contract~~. (For additional information, refer to the Medicaid Health Plans and the MI Health Link chapters of this manual.) For services provided to managed care enrollees in an FQHC, the MHP covers NEMT when: • the service is Medicaid covered ~~under the MHP contract~~ and the FQHC is in the MHP's provider network; or • the MHP has prior authorized the FQHC for the service. The last paragraph was revised to read: MDHHS contracts with dental health plans (DHPs) for the administration of dental services for Healthy Kids Dental (HKD) beneficiaries. The DHP is responsible for providing, arranging, and reimbursing covered dental services to enrolled Medicaid

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				beneficiaries. Providers must contact the DHP for specific information about covered HKD benefits. (For additional information about HKD, refer to the Dental chapter of this manual.) ~~Local MDHHS offices, except in Wayne, Oakland, and Macomb counties, are responsible for providing NEMT services to and from HKD covered dental services. A contracted transportation broker is responsible for providing NEMT services to and from HKD covered dental services in Wayne, Oakland, and Macomb counties.~~ The MHP is responsible for NEMT to HKD covered dental appointments for their enrollees.
MMP 24-34	9/4/2024	Electronic Visit Verification	3.1 PCS Service Codes	In the table, for 'Home Help', the Procedure Code was revised to read: ~~N/A~~ T1019: CG
			3.2 EVV PCS Exclusions	Text was revised to read: The following sections contain information on congregate living settings, live-in caregivers, and beneficiaries who receive PCS through Home Help and ~~CLS~~ Behavioral Health services during the same visit. PCS provided to beneficiaries who live in these settings, live with their caregiver(s), or receive Home Help and ~~CLS~~ Behavioral Health services, as described below, are exempt from EVV for their PCS. NOTE: Home Help providers who are eligible for these exemptions must document Home Help services using an alternate service verification designated by MDHHS. Additional information will be provided prior to Home Help payments being tied to EVV data.

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			3.2.A. Beneficiaries with Home Help and CLS Services	The subsection title was revised to read: Beneficiaries ~~With~~ Receiving Home Help and ~~CLS~~ Behavioral Health Services Text was revised to read: Beneficiaries who receive PCS ~~from~~ through both Home Help and Behavioral Health ~~(in the form of CLS)~~ in the same visit rendered by the same caregiver are excluded from EVV. When only one of these program's (Home Help OR Behavioral Health) services is rendered during a visit, EVV must be used.
			3.2.B. Congregate Living	In the 2nd paragraph, the last bullet point was revised to read: Congregate residential settings that provide PCS that do not require EVV include: • ~~Living facilities or private homes where PCS are provided 24 hours a day and a caregiver furnishes services to three or more individuals throughout a shift. NOTE: Home Help services provided in these settings require EVV.~~ Residential settings (including unlicensed provider-owned and/or -operated and privately-owned/-leased settings) with 24 hours per day/7 days per week service availability to two or more unrelated individuals throughout a shift. ➢ Home Help services provided in room and board settings do not qualify for the congregate living exemption.

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<table>
<tr><th>BULLETIN NUMBER</th><th>DATE ISSUED</th><th>CHAPTER</th><th>SECTION</th><th>CHANGE</th></tr>
<tr><td></td><td></td><td></td><td>3.2.C. Live-In Caregiver</td><td>Text after the 3rd paragraph was revised to read:

Approving entities are defined as follows:

<table>
<tr><th>Program</th><th>Approving Entity</th></tr>
<tr><td>Behavioral Health</td><td>Prepaid Inpatient Health Plan (PIHP) or Community Mental Health Services Program (CMHSP) designee</td></tr>
<tr><td>Home Help</td><td>MDHHS Adult Services Worker</td></tr>
<tr><td>MI Choice Waiver</td><td>MI Choice Waiver Agencies</td></tr>
<tr><td>MI Health Link</td><td>Integrated Care Organization (ICO) or designee</td></tr>
</table>

Live-in caregivers who do not complete all requirements for the exemption process must use EVV. Those caregivers with a pending exemption request must use EVV until their exemption request has been approved. Live-in caregivers must adhere to outlined policy to continue to be exempt from reporting EVV.

Live-in caregivers paid through a provider agency (i.e., home care agency, fiscal intermediary, etc.) may be required to use an EVV system for business purposes, such as service verification and payroll. The live-in caregiver exemption does not prevent an agency from requiring their caregivers to use EVV for business purposes.</td></tr>
</table>

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			3.2.C.1. Exemption Process for Live-In Caregivers	The following text was added after the 1st paragraph: BPHASA-2421 includes space for the caregiver to enter their CHAMPS Provider ID Number. For programs other than Home Help, caregivers may not have a CHAMPS Provider ID. Caregivers without a CHAMPS Provider ID may leave this field blank or write "N/A" in the field. The live-in caregiver must submit BPHASA-2421 to the correct Approving Entity. A completed BPHASA-2421 should be submitted directly to the Approving Entity; however, it may be submitted to the provider agency employer or fiscal intermediary (FI) who will forward it to the Approving Entity according to their records. The last four paragraphs were removed. Text is now located in a new subsection: 3.2.C.2. Responsibilities of Approving Entities and Other Parties Related to Live-In Caregiver Exemption Process

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			3.2.C.2. Responsibilities of Approving Entities and Other Parties Related to Live-In Caregiver Exemption Process (new subsection)	New subsection text reads: The MDHHS representative and Approving Entity are responsible for: • Approval or denial of the individual as a live-in caregiver; • Providing to the caregiver a reason for denial, if applicable; • Signing the BPHASA-2421, Live-In Caregiver Attestation; • Retaining the signed BPHASA-2421 in the beneficiary's case record; • Sending a copy of the approved BPHASA-2421 to the beneficiary, the live-in caregiver, and the fiscal intermediary or home care agency; • Updating live-in caregiver information in the EVV system; and • Monitoring live-in caregiver compliance to live-in caregiver policy. The MDHHS representative or Approving Entity must review the BPHASA-2421 and documents and provide to the caregiver a reviewed, signed BPHASA-2421 within ten business days of the approver's receipt. Caregivers with a denied request may resubmit a corrected form, as applicable. Each program's Approving Entity must establish a standard process for submission and review of the BPHASA-2421 and documentation. This process must include a secure process for receiving the documentation if email is used so that personal identifying/health information is not shared publicly.

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				The Approving Entity is required to have at least two designated approvers (a primary approver and a backup approver) so that review of the form is not delayed if an approver is unavailable. The Approving Entity must review BPHASA-2421 and attached documents and make the decision to approve or deny the exemption request within ten (10) calendar days of receipt of the documentation. If the request is denied, the Approving Entity must indicate a Reason for Denial on BPHASA-2421. The reason for denial must be detailed so the caregiver understands why it is denied. The Approving Entity must share the approved or denied BPHASA-2421 with the provider agency or FI, live-in caregiver, and the beneficiary. Caregivers must use EVV until an approval is received. NOTE: Home Help caregivers who have submitted the BPHASA-2421 to their Home Help client's MDHHS adult services worker (ASW) are exempt from using EVV until a determination is made. ~~The fiscal intermediary, home care agency, or Approving Entity must enter the approved information for the live-in caregiver into the beneficiary's EVV record in the EVV system as "Residing Caregiver." This serves as a flag that the caregiver has been approved as live-in and is exempt from EVV.~~ Provider agencies are required to complete initial set-up within the HHAeXchange system that reflects the beneficiary has an approved live-in caregiver exemption. This requires the provider agency or FI (depending on system access allowed) to enter the live-in caregiver as a "Residing Caregiver" in the appropriate field in the HHAeXchange system. This step will support pre- and post-payment reconciliation needs.

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				The Approving Entity is required to ensure that documentation is maintained in accordance with their program's document retention policies and must be shared with MDHHS upon request for audit or monitoring purposes. If the beneficiary transfers to a different Approving Entity, the receiving Approving Entity must maintain the BPHASA-2421 and documentation and may choose to adopt the current BPHASA-2421 or obtain a new one.

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			3.2.C.3. Renewal of Live-in Caregiver Status for Managed Care Programs (new subsection)	New subsection text reads: Renewal of live-in status must be done annually. Using the Notification of Upcoming End Date for Electronic Visit Verification Live-In Caregiver Attestation Documentation letter template, the Approving Entity must notify the caregiver of the upcoming end date (one year after the signed BPHASA-2421) of their approved BPHASA-2421 so the caregiver can timely submit the annual renewal documentation. This notifying letter should be sent to the caregiver, provider agency or FI, and beneficiary. The Approving Entity may send BPHASA-2421 with this letter for the caregiver to use for their renewal. The Managed Care Program Approving Entity must send notification at least 30 calendar days prior to the end date of the existing Attestation. (Refer to the Forms Appendix of this manual for the Notification of Upcoming End Date for Electronic Visit Verification Live-In Caregiver Attestation Documentation letter.) If the caregiver fails to submit renewal documentation, this must not delay services. The caregiver would no longer be exempt from using EVV and would have 30 days to get set-up with EVV. If EVV is not used after the 30-day grace period, the Approving Entity is held responsible for non-compliance and potential recoupment of funds.

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				If a beneficiary moves with a caregiver, and the caregiver does not notify the Approving Entity within ten (10) calendar days, the Approving Entity must provide notice that the current BPHASA-2421 will end and on what date. The caregiver will have 30 calendar days from this notice to submit a new BPHASA-2421 and documentation to maintain the live-in caregiver exemption. If documentation is not provided, the caregiver must begin using EVV. The EVV set-up will occur within that 30-day period after the Approving Entity is notified of the move. During the transition/move, a United States Postal Service (USPS)-issued Change of Address form or Michigan Secretary of State issued temporary State ID are acceptable forms of documentation. If a provider has recurring issues with non-compliance, the Approving Entity must address the issues with the provider. The Approving Entity must allow time for the provider to make corrections.
			3.2.C.4. Renewal of Live-in Caregiver Status for the Home Help Program (new subsection)	New subsection text reads: Renewal of live-in status must be done every six months to remain exempt from EVV. ASWs will work with caregivers to complete a renewal of BPHASA-2421 during each six-month review.
		Forms Appendix		Addition of: Sample: Notification of Upcoming End Date for Electronic Visit Verification Live-In Caregiver Attestation Documentation Letter

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MMP 24-35	8/30/2024	Nursing Facility Cost Reporting & Reimbursement Appendix	4.6.A. Corrected Cost Report Due Date	Text was revised to read: If a cost report is returned to the provider as unaccepted by the LTC Reimbursement and Rate Setting Section (RARSS), the provider is given five business days from the date of the RARSS cost report return letter to submit a corrected cost report via File Transfer. A written request for an extension may be made to RARSS for additional days (not to exceed 30 calendar days from the return date). The RARSS will notify the provider in writing of the extension decision. If a corrected cost report is not received by the correction due date, the nursing facility is subject to cost report delinquency and payment termination notification and a cost report late file penalty may be applied. Refer to the Cost Report Delinquency subsection of this appendix for additional information.
			4.9 Cost Report Delinquency	Text after the 1st paragraph was revised to read: If the nursing facility cost report is delinquent, RARSS will share a delinquency and Medicaid payment termination notice with the nursing facility or the provider's designated business office through File Transfer. The notice will indicate the date (not less than ten business days from the notice date) on which Medicaid payment will be terminated unless a cost report is received by the RARSS. If the cost report is not received after ten calendar days, a notice will be sent that the Medicaid payment will be terminated, and the following penalty will be assessed.

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				Upon delinquency, the provider's interim payments will be reduced by 100 percent and the provider may be assessed a late-file penalty of ten percent of any claims for dates of service beginning on the 15th of the month after the cost report was due until a complete and acceptable cost report is received. If an acceptable cost report is received after payment termination, payments will be reinstated through the normal pay cycle(s) process. Medicaid will remove the payment termination entry pertaining to the cost report delinquency action allowing the release of all payments withheld for the cost report delinquency action. However, the ten percent late-file penalty will apply to these claims. Even when a complete and acceptable cost report is received, the late-file penalties will be applied through the gross adjustment process. No repayment schedules will be allowed for any penalty assessments. This penalty does not apply to Class VII facilities. For providers with licensed-only beds and Medicare-only facilities, a penalty of $20 per bed, per day, will be assessed beginning on the 15th of the month after the census data is due until the data is received. This penalty may be assessed even if MDHHS has provided a written notice of termination to a facility. For providers who still do not submit a complete and acceptable cost report or the appropriate census data 60 days after delinquency, the total number of licensed beds, multiplied by 365 days, will be used as the number of taxable days for the calculation of the Quality Assurance Assessment Program. This will apply to both Medicaid and non-Medicaid providers.

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MMP 24-36	9/9/2024	Maternal Infant Health Program	2.7 Professional Visits	The 2nd paragraph was revised to read: The professional visit, additional home visit, and discharge visit are ~~is~~ ~~a~~ one-on-one visits that must be scheduled to accommodate the beneficiary's situation and be appropriate to the beneficiary's level of understanding. Visits lasting less than 30 minutes or provided in a group setting are not billable.
			2.8 Enhanced Care Coordination Time (new subsection; the following subsections were re-numbered)	New subsection text reads: This time must only be reported by the care coordinator. Enhanced care coordination time includes all hours spent on provider office-based phone calls, referrals, and non-face-to-face interactions concerning beneficiary services and support. This time must be reported when at least 30 minutes of MIHP home visitor time is dedicated to care management activities within a single calendar month.
			2.9 Drug-Exposed Infant (reflects new numbering)	The following text was added at the end of current text: In instances where a request is made for additional visits for a drug-exposed infant, the MIHP provider may, when deemed necessary and substantiated by appropriate documentation, substitute the drug-exposed procedure code with the complex home visit code. This substitution will still be considered one of the 18 allowable additional visits for the beneficiary and must be drug exposure related. Furthermore, the total number of professional visits, in addition to the initial assessment visit, shall not exceed the maximum limit of 36 visits.

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			2.10.C. Telehealth Services (reflects new numbering)	The following text was added after the 4th paragraph: All audio-visual and audio-only MIHP telehealth services must be reported with: • Modifier 93 for audio–only services • Modifier 95 for audio-visual services • Report the place of service (POS) code that would be reported as if the beneficiary were in-person for the visit (e.g., home or office)
			Section 3 - Reimbursement	The 1st paragraph was revised to read: To receive reimbursement for services, the MIHP billing National Provider Identifier (NPI) must be a facility, agency, or organization. A MIHP specialty must be indicated when enrolling as a MIHP provider through CHAMPS. Claims should include a primary diagnosis code for an infant-related or pregnancy-related condition. Providers are encouraged to report a secondary diagnosis reflecting a social determinant of health (SDOH) utilizing the ICD-10 codes in the category range Z55-X65. The MIHP provider must bill only the procedure codes listed in the MDHHS Maternal Infant Health Program Database located on the MDHHS website. (Refer to the Directory Appendix for website information.)

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MMP 24-38	8/30/2024	Behavioral Health and Intellectual and Developmental Disability Supports and Services	3.3 Assessments	Under "All Other Assessments and Testing", the 2nd paragraph was revised to read: ~~The Child and Adolescent Functional Assessment Scale (CAFAS) must be used for the assessment of children 7 to 18 years of age with suspected serious emotional disturbance, and must be performed by staff who have been trained in the implementation of CAFAS. The Preschool and Early Childhood Functional Assessment Scale (PECFAS) must be used for the assessment of young children, 4 to 7 years of age, with suspected serious emotional disturbance, and must be performed by staff who have been trained in the implementation of the PECFAS. The Devereux Early Childhood Assessment (DECA) must be used for the assessment of infants and young children, 1 month to 47 months, with suspected serious emotional disturbance, and must be performed by staff who have been trained in the implementation of the DECA.~~ The MichiCANS Screener is the tool required at the point of access for infants, toddlers, children, youth and young adults ages birth through 20 years of age (day prior to 21). Depending on the results of the MichiCANS Screener, the MichiCANS Comprehensive will be used at initial intake, annually thereafter, and at time of exit for infants, toddlers, young children, youth, and young adults ages birth through 20 to guide treatment service planning. The MichiCANS must be administered by staff who have been trained and certified in the use of the MichiCANS. The Devereux Early Childhood Assessment (DECA) must be used at intake and during treatment planning, based on the results of the MichiCANS Screener for infants, toddlers, and children

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				ages one month and through age 5 (day prior to 6) who have a Serious Emotional Disturbance (SED) or have SED and Intellectual/Developmental Disabilities (IDD). The assessment must be performed by staff who have been trained in the implementation of the DECA. Refer to the MichiCANS section of this chapter for additional information.
			7.2.A. Prenatal/Birth Through Age Three	The 1st paragraph was revised to read: Unique criteria must be applied to define serious emotional disturbance for the prenatal/birth ~~to~~ through age three population, given: The 3rd paragraph and the table after the 3rd paragraph were removed and replaced with the following text: Refer to the MichiCANS section, Respite Care subsection, for additional information.

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			7.2.B. Age Four Through Six	The subsection title was revised to read: Age Four Through ~~Six~~ Five Text was revised to read: Decisions regarding whether a child age four through ~~six~~ five ~~is seriously emotionally disturbed~~ has a serious emotional disturbance and in need of home-based services and supports utilize similar dimensions to older children. The dimensions include a diagnosable behavioral or emotional disorder, substantial functional impairment/limitation of major life activities, and duration of condition. However, as with younger children birth through age three, assessment must be sensitive to the critical indicators of development and functional impairment for the age group. Significant impairments in functioning are revealed across life domains in the child's expression of affect/self-regulation, social development (generalization of attachment beyond parents, capacity for peer relationships and play, etc.), physical and cognitive development, and the emergence of a sense of self. All of the dimensions must be considered when determining if a child is eligible for home-based services. The table was removed and replaced with the following text: Refer to the MichiCANS section, Home Based Services subsection, for additional information.

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			7.2.C. Age Seven Through Seventeen	The subsection title was revised to read: Age ~~Seven~~ 6 Through ~~Seventeen~~ 20 Text was revised to read: ~~**NOTE:** For EPSDT, this same criteria should be utilized to determine eligibility for home-based services for young adults ages 18-21.~~ Decisions regarding whether a child or adolescent has a serious emotional disturbance and is in need of home-based services is determined by using the following dimensions: the child has a diagnosable behavioral or emotional disorder, substantial functional impairment/limitation of major life activities, and duration of the condition. For children age ~~seven~~ 6 through ~~seventeen~~ 20 (day prior to 21), the ~~Child and Adolescent Functional Assessment Scale (CAFAS)~~ MichiCANS is used to make ~~discriminations~~ determinations within the functional impairment dimension. All of the dimensions, as well as family voice and choice, must be considered when determining if a child is eligible for home-based services. The table was removed and replaced with the following text: Refer to the MichiCANS section, Home Based Services subsection, for additional information.
			Section 22 – MichiCANS (new section)	A new section was added for MichiCANS policy.

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Acronym Appendix		Addition of: ICCW – Intensive Care Coordination with Wraparound ICSS – Intensive Crisis Stabilization Services IDD – Intellectual/Developmental Disabilities MICAS – Michigan Intensive Child and Adolescent Services MichiCANS – Michigan Child and Adolescent Needs and Strengths
MMP 24-39	8/29/2024	Federally Qualified Health Centers	2.4 Advisory Committee on Immunization Practices (ACIP) Vaccines (new subsection; the following subsection was re-numbered)	New subsection text reads: FQHCs providing Advisory Committee on Immunization Practices (ACIP) recommended vaccines for beneficiaries 19 years of age and older in FQHC settings will be reimbursed outside of the Prospective Payment System (PPS) methodology. Reimbursement for ACIP recommended vaccines will be made up to the applicable Medicaid fee screen rates. Refer to the Medical Clinics and/or Federally Qualified Health Centers databases on the MDHHS website or the Medicaid Code and Rate Reference tool for additional information. (Refer to the Directory Appendix for website information.)
MMP 24-40	9/26/2024	Billing & Reimbursement for Professionals	6.10 Doula Services	In the table, under 'Prenatal Visits and Postpartum Visits', text for 'Limit per Pregnancy' was revised to read: ~~6~~ 12 total visits

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		Doula Services	Section 2 – Covered Services	The 4th paragraph was revised to read: Doula services may include a maximum of ~~six~~ 12 total visits during the prenatal and postpartum periods and one visit for attendance at labor and delivery. All prenatal and postpartum visits must be at least a minimum of 20 minutes in duration with a beneficiary to be considered eligible for reimbursement. Additional visits~~,~~ beyond the limits in policy~~,~~ may be requested through the prior authorization (PA) process. PA requirements for MHP enrollees may differ from those required for Fee-for-Service (FFS) beneficiaries. Providers should contact the individual MHPs regarding their authorization requirements.
			4.1 Reimbursement Considerations	The 2nd bullet point was revised to read: • Medicaid will provide reimbursement for the first eligible claims submitted for these services up to the limit of ~~six~~ 12 total prenatal and postpartum visits and one visit for attendance at labor and delivery.

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			4.2 Prior Authorization (PA) Criteria (new subsection; the following subsections were re-numbered)	New subsection text reads: There may be occasions when a beneficiary requires services beyond those ordinarily covered by Medicaid, such as additional visits. PA requests should be related to physical, emotional, and educational support services to pregnant individuals during the prenatal and postpartum periods. Approval for a maximum of six additional visits is dependent on person-centered needs. Requests should include at least one of the following criteria: • Promoting health literacy and knowledge • Assisting with the development of a birth plan • Supporting personal and cultural preferences around childbirth • Providing emotional support • Encouraging self-advocacy • Reinforcing practices known to promote positive outcomes, such as breastfeeding • Identifying and addressing social determinants of health • Educating regarding newborn care, nutrition, and safety • Supporting breastfeeding • Encouraging self-care measures • Supporting beneficiary in attending recommended medical appointments • Identifying and addressing social determinants of health

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				• Grief support services • Coordinating referrals to community-based support services (e.g., Women, Infants and Children [WIC] program, behavioral health services, transportation, home visiting services) PA requests for Fee-For-Service may be submitted by the following methods: • In writing, via Direct Data Entry (DDE) in the Community Health Automated Medicaid Processing System (CHAMPS). No PA form is required if the request is submitted this way, but the provider will need to include a statement in the procedure comments explaining the need for extra visits. • By faxing form MSA-1653-B and including a statement on the form or on the fax cover sheet explaining the need for extra visits. Providers will receive a hard copy of the PA determination letter to the address selected in CHAMPS (located in the pull-down list when a DDE request is entered). If the form is faxed, the address indicated on the form should ideally match the communication address used to enroll in CHAMPS. Refer to the General Information for Providers chapter for additional information regarding prior authorization of services.

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MMP 24-42	10/1/2024	Hearing Services and Devices	1.1.K. Speech-Language Pathologists	Text was revised to read: Speech-Language Pathologists (SLPs) may enroll with Medicaid for reimbursement of audiological rehabilitation and speech-language therapy services. SLPs must possess a current license ~~and be authorized by ASHA to use Certificate of Clinical Competence in Speech-Language Pathology (CCC-SLP) credentials~~ and/or be certified by the appropriate standard-setting authority in the state in which they are practicing. Refer to the Therapy Services chapter for information and requirements related to SLPs.
		Therapy Services	1.6 Reimbursement	A second paragraph was added and reads: Students, graduates, educational limited temporary licensed therapists, and assistants are not eligible to enroll or be directly reimbursed by Medicaid. Services performed by these individuals are required to be reported under the National Provider Identifier (NPI) of the supervising therapist.

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			4.3 Speech-Language Therapy	In the 1st paragraph, the 1st and 2nd bullet points were revised to read: • A speech-language pathologist with a current license ~~and who is authorized by ASHA to use Certificate of Clinical Competence in Speech-Language Pathology (CCC-SLP) credentials~~. Out-of-state therapists must be licensed and/or be certified by the appropriate standard-setting authority in the state in which they are practicing. (Refer to the Out of State/Beyond Borderland Providers subsection of the General Information for Providers chapter for more information.) • An appropriately supervised speech-language pathologist ~~candidate (i.e., in their clinical fellowship year)~~ Educational Limited Temporary licensee completing their postgraduate clinical experience or having completed all requirements but has not yet obtained a full license. All documentation must be reviewed and co-signed by the appropriately credentialed supervising speech-language pathologist.

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MMP 24-44	10/1/2024	Nursing Facility Cost Reporting & Reimbursement Appendix	8.8 Interest	The last bullet point was revised to read: • ~~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.~~ • For loans issued on or after October 1, 2019, the minimum payment amount on the principal balance or a payment amount totaling at least 0.1 percent of the total outstanding loan balance, whichever is greater, must be made at least annually for any loan that has a loan period of greater than four years in order for interest to be considered an allowable expense. 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. This includes when a short-term loan balance is paid off with borrowed funds, including bridge and balloon type loans. ➢ For loans issued on or after October 1, 2019, if a provider is prohibited from making principal payments or is unable to restructure/negotiate the payment of principal, the Department will calculate allowable interest expense based on an audited amortization schedule with monthly principal payments of 0.1 percent of the declining loan balance amount.

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				➢ Any loan costs related to obtaining or negotiating principal payment compliant loans will be deemed allowable and amortized for the life of the loan. Pre-payment penalties will also be allowable for the initial conversion to a loan with compliant principal payments and amortized for the life of the loan. ➢ Loans that are refinanced into Federal Housing and Urban Development (HUD) loans are exempt from the principal payment requirement. If the loan is denied or the provider chose to withdraw from the Federal HUD financing process, all interest expense reported in the preceding years will be removed in the current audit year. ➢ All related party loan costs, including interest expense, are unallowable regardless of any principal payment requirements.
		Acronym Appendix		Addition of: HUD – Housing and Urban Development

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MMP 24-45	9/27/2024	Billing & Reimbursement for Professionals	6.10.A Reimbursement Considerations and Billing Guidelines (new subsection)	New subsection text reads: Medicaid may reimburse a maximum of 12 total in-person group sessions per pregnant beneficiary in addition to the required individual professional maternity visit when all the following criteria are met: • The group visit is in addition to, and does not replace, the individual prenatal physical assessment visit; • Group sessions are 90 to 120 minutes; and • Documentation must support the actual time the pregnant individual spent in the group session. One of the 12 group visits may be provided in relation to the postpartum professional visit. Report group prenatal services as follows: **Visit Type**: Group Prenatal Visits **Procedure Code**: CPT 99078 Physician or other qualified health care professional qualified by education, training, licensure/regulation (when applicable), educational services rendered to patients in a group setting (e.g., prenatal, obesity, or diabetic instructions) **Modifier**: TH - Obstetrical treatment/services, prenatal or postpartum

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		Federally Qualified Health Centers	4.2.A. Billing Requirements for Group Prenatal Care Services (new subsection)	New subsection text reads: Centering Pregnancy™ group services will be reimbursed outside of the Prospective Payment System (PPS) or All-Inclusive Rate (AIR) methodology at the Medicaid fee screen reimbursement rates for these services. FQHCs should use appropriate Healthcare Common Procedure Coding System (HCPCS) codes as identified in the Billing & Reimbursement for Professionals chapter of this manual.
		Practitioner	7.12 Centering Pregnancy™ (new subsection)	New subsection text reads: Group prenatal care is a service delivery model provided to pregnant individuals. Groups are facilitated by a trained healthcare provider and include individuals in similar stages of pregnancy. Group prenatal care models improve patient education and skill building and include opportunities for peer social support while maintaining the risk screening and physical assessment included in the individual prenatal maternity professional visit.
			7.12.A. Covered Services (new subsection)	New subsection text reads: The Medicaid program will cover professional services associated with in-person, group prenatal care when delivered by accredited Centering Pregnancy™ providers. Centering Pregnancy™ is an evidence-based group prenatal care model that typically includes cohorts of 10 to 12 pregnant individuals within the same gestational period. Individuals are educated in health topics such as childbirth preparation, nutrition and exercise, stress management, breastfeeding, parenting, and contraception.

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			7.12.B. Provider Criteria (new subsection)	New subsection text reads: Collaborative group sessions are led by a Medicaid-enrolled physician, physician assistant, or advanced practice registered nurse. This practitioner is generally the same practitioner who performs the in-person individual prenatal physical assessment. Sites must be accredited with the Centering Healthcare Institute (CHI). Services must be provided in accordance with the most current Centering Pregnancy™ model of care. Refer to the Billing & Reimbursement for Professionals chapter of this manual for additional billing information. Refer to the Federally Qualified Health Centers chapter of this manual for additional billing guidance for services provided within the FQHC.
		Rural Health Clinics	6.2.A. Billing Requirements for Group Prenatal Care Services (new subsection)	New subsection text reads: Centering Pregnancy™ group services will be reimbursed outside of the Prospective Payment System (PPS) methodology at the Medicaid fee screen reimbursement rates for these services. RHCs should use appropriate Healthcare Common Procedure Coding System (HCPCS) coded as identified in the Billing & Reimbursement for Professionals chapter of this manual.

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Tribal Health Centers	7.8 Billing for Maternity Care (new subsection)	New subsection text reads: Global codes for maternity care are used to reimburse a package of services (prenatal visits and delivery) at different places of services (THC and hospital). In order for the THC to be reimbursed for prenatal visits under the PPS methodology, the THC should not bill for global maternity care. The claims for delivery and prenatal care should be billed separately. The claim for delivery should show a hospital place of service and will be paid under the FFS methodology. The claim for prenatal care will be reimbursed under the PPS methodology. If the THC elects to bill for global maternity care, all services will be reimbursed under the FFS rules.
			7.8.A. Billing Requirements for Group Prenatal Care Services (new subsection)	New subsection text reads: Centering Pregnancy™ group services will be reimbursed outside of the Prospective Payment System (PPS) or All-Inclusive Rate (AIR) methodology at the Medicaid fee screen reimbursement rates for these services. THCs should use appropriate Healthcare Common Procedure Coding System (HCPCS) codes as identified in the Billing & Reimbursement for Professionals chapter of this manual.
		Acronym Appendix		Addition of: CHI – Centering Healthcare Institute
MMP 24-46	10/1/2024	Billing & Reimbursement for Institutional Providers	8.9 Cost Settled Provider Detail Report (FD-622)	In the 3rd paragraph, the 4th bullet point was removed: • ~~an indicator if the facility is on Medicaid Interim Payments~~

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		Nursing Facility Cost Reporting & Reimbursement Appendix	Section 11 – Appeal Process	In the 3rd paragraph, the 3rd bullet point was removed: • ~~Medicaid Interim Payment (MIP) Program normal payment amount or reconciliation of payments and approved service billings.~~
			Section 12 – Medicaid Interim Payment Program	The section was removed in its entirety. This includes subsections: • 12.1 Enrollment in MIP • 12.2 Disenrollment in MIP • 12.3 Claims Submission • 12.4 Calculation of MIP Payment • 12.5 Frequency of MIP Payment • 12.6 Annual Reconciliation • 12.7 New Providers

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MMP 24-47	9/27/2024	Pharmacy	13.10.A. Secondary Payer Coverage of Select Continuous Glucose Monitoring Systems (CGMS), Disposable Insulin Pumps, and Related Supplies (new subsection)	New subsection text reads: MDHHS allows coordination of benefits for select CGMS and disposable insulin pumps and their respective supplies on the pharmacy claim format where primary insurance only covers these products as a pharmacy benefit and has already been billed. Refer to the Directory Appendix for a list of covered products. These select products are covered for eligible MDHHS program beneficiaries under the Durable Medical Equipment (DME) program medical benefit when no other insurance applies (or the other insurance covers under the DME benefit). Pharmacies must submit coordination of benefit claims utilizing one of the following National Council for Prescription Drug Program (NCPDP) Other Coverage Codes: 2 – Other coverage exists, payment collected (Coinsurance claim) 4 – Other coverage exists, payment not collected (Deductible claim) Refer to the PBM's Pharmacy Claims Processing Manual for billing procedures. (Refer to the Directory Appendix for website information.)

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		Directory Appendix	Pharmacy Resources	Addition of: **Contact/Topic:** Continuous Glucose Monitoring Systems, Secondary Payer Coverage **Mailing/Email/Web Address:** https://mi.primetherapeutics.com/ >> Provider Portal >> Documents >> Fee for Service Drug Coverage >> Continuous Glucose Monitoring Systems, Secondary Payer Coverage **Information Available/Purpose:** List of approved CGMS and accessories for secondary payer coverage.

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MMP 24-48	10/3/2024	Nursing Facility Cost Reporting & Reimbursement Appendix	Section 12 – Direct Care Worker Wage Increase for Personal Care Services (new section)	New section text reads: The direct care worker wage increase is consistent with the final State fiscal year budget and is available for eligible clinical and non-clinical direct care workers providing in-person direct care for Medicaid beneficiaries in Medicaid-certified nursing facilities. This payment applies to base hourly wages that were in effect on September 30 of the previous fiscal year and includes any associated share of employer Federal Insurance Contributions Act (FICA) payroll taxes. Any subsequent wage increases will be according to the applicable fee schedule found on the MDHHS website. (Refer to the Directory Appendix for website information.) • Eligible clinical direct care workers include registered nurses, licensed practical nurses, competency-evaluated nursing assistants, and respiratory therapists employed by Medicaid-certified nursing facilities. • Eligible non-clinical workers include Medicaid-certified nursing facility employees whose costs are reported in the following job classifications in nursing facility institutional cost reports: other housekeeping, other maintenance worker, other plant operations, other laundry, dining room assistants, other dietary worker, other medical records, other social services, other diversion therapy, beauty and barber, gift, flower, coffee and canteen worker.

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				➢ An employee in a non-direct care position (e.g., recreation coordinator, administrator) who also has a current license as a Registered Nurse, Licensed Practical Nurse or respiratory therapist, or current certification as a competency-evaluated nursing assistant is eligible for the wage increase only for hours worked providing direct care. ➢ A nursing assistant who has not completed the evaluation for certification is not eligible for the wage increase. ➢ An administrative or support employee providing direct care does not qualify if that person does not have the qualifying license or certification. ➢ Any qualifying administrative or support employee providing direct care is required to remain in compliance with all federal laws applied in CFR 483.35 (b)(1)-(3). (Refer to the Directory Appendix for website information.) ➢ State employees are not eligible for the wage increase.

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			12.1 Administration of Premium Pay (new subsection)	New subsection text reads: • For eligible clinical direct and indirect care staff, the hourly wage increase should be a base wage increase paid above the worker's regular wage paid or starting wage offered to eligible staff on September 30 of the previous fiscal year. • The wage increase payment cannot be used to supplant other wage increases. • The wage increase must be applied entirely to eligible employee wages. Any associated share of employer Federal Insurance Contributions Act (FICA) payroll taxes must also be paid. • The wage increase must be paid to employees prior to requesting reimbursement from MDHHS and on at least a monthly basis. Any nursing facility who holds employee owed wage increases in a bank account for any period of time shall be required to reimburse MDHHS for any accumulated interest associated with the payments. • The wage increase applies to overtime hours for non-exempt employees (including those employees covered by the "8 and 80" overtime system) at a time-and-a-half rate per hour for clinical workers and non-clinical workers providing direct care.

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				➢ For example, if the current wage increase amount was $3.40 for clinical and $0.85 for non-clinical and an employee works 43 hours in a week and is not covered by the "8 and 80" overtime system, they would be eligible for 3 hours of overtime and the wage increase would be $5.10 per hour for a clinical worker and $1.28 per hour for the non-clinical worker for the 3 overtime hours. ➢ If an eligible employee providing direct care is paid on a salary basis, the wage increase for a regular work week would be $136 (40 hours x $3.40) or $272 (80 hours x $3.40) in a two-week period for a clinical worker and $34 (40 hours x $0.85) for a regular work week or $68 (80 hours x $0.85) in a two-week period for a non-clinical worker. ➢ A nursing facility is eligible for reimbursement for employee payroll tax expenses directly related to the $3.40 and $0.85 per hour wage increase and $5.10 and $1.28 per hour overtime wage increase. • The wage increase does not apply to employer contributions to the employee's retirement plan. • Additional funding is not available to the nursing facility for Worker's Compensation, unemployment insurance costs or other additional administrative costs associated with the wage increase funding.

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				• The wage increase is a direct pass-through separate from the Medicaid nursing facility per diem. • An employee eligible for the wage increase may elect to not receive the payment. This decision must be documented in writing or electronically by the employee. • This funding is subject to audit and recoupment if these funds are not used for their intended purpose
			12.2 Reporting (new subsection)	New subsection text reads: Updated Wage Pass-Through forms, as well as more information regarding administration of the wage increase for skilled nursing facilities, can be found in a Frequently Asked Questions document found on the MDHHS website. (Refer to the Directory Appendix for website information.) • Nursing homes must complete the Nursing Home Direct Care Worker and Non-Clinical Staff Wage Pass-Through Reimbursement form (MDHHS-5919-A) and submit to MDHHS for reimbursement. (Refer to the Directory Appendix for website information.) Completed forms should be submitted on a monthly or bi-weekly basis. Nursing facilities must maintain payroll and personnel records to support wage increases to eligible employees for direct care hours worked, including overtime hours. As with all MDHHS payments to providers, wage increase funds are subject to audit and recovery of inappropriate payments.

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				• Nursing facilities should not send to MDHHS any information that is specific to an individual employee. Employee-specific information must be maintained by the nursing facility for audit purposes. If the documentation is required for an audit, it must be submitted using a secure method.
		Directory Appendix	Nursing Facility Resources	Under 'Nursing Facility Rate Setting' text under 'Information Available/Purpose' was revised to read: Nursing facility rate setting and cost reporting information;~~.~~ New Provider Information Packet;~~.~~ Nursing Facility reimbursement; Skilled Nursing Facility (SNF) DCW Wage Increase Medicaid Fee Schedule.
			Nursing Facility Resources	Addition of: **Contact/Topic:** Direct Care Worker (DCW) Forms **Web Address:** www.michigan.gov/medicaidproviders >> Policy, Letters & Forms >> Forms **Information Available/Purpose:** MDHHS-5919-A & MDHHS-5919-C; AFC/HFA; Skilled Nursing Facility DCW Wage Pass-Through forms; DCW Frequently Asked Questions

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