MDHHS Michigan Department of Health & Human Services

Medical Services Administration

BULLETIN MSA

Bulletin Number: MSA 21-45

Distribution: All Providers

Issued: December 1, 2021

Subject: Updates to the Medicaid Provider Manual; Change to Attending/Ordering/Referring Claim Editing; Changes to the MDHHS Medical Services Administration

Effective: January 1, 2022

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

Updates to the Medicaid Provider Manual

The Michigan Department of Health and Human Services (MDHHS) has completed the January 2022 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 2022 version of the manual does not highlight changes made in 2021. 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 2022 versions of the manual will be highlighted within the text of the on-line manual.

Change to Attending/Ordering/Referring Claim Editing

Effective for dates of service on and after 1/1/2022, MDHHS has updated claim editing for all claim types to ensure the provider reported in claim fields for attending, ordering, and/or referring provider are appropriate for the services reflected on the claim. The reported National Provider Identifier (NPI) must be of a provider type appropriate and consistent with current licensing, scope of practice, and Medicaid policy criteria. Claims reflecting inappropriate provider types for the claim type will be denied.

Changes to the MDHHS Medical Services Administration

On October 14, 2021, Governor Gretchen Whitmer signed EO 2021-14 to establish the Health and Aging Services Administration within the Michigan Department of Health and Human Services (MDHHS). The newly established agency will provide more coordinated services to Michigan's growing aging population by combining the former MDHHS Aging and Adult Services Agency and Medical Services Administration under one umbrella within MDHHS. Michigan's Medicaid Office is also part of the new Health and Aging Services Administration.

All references to the Medical Services Administration will be deemed references to the Health and Aging Services Administration. In the coming months, MDHHS will continue to work to update all references to the Medical Services Administration on department webpages, future policy bulletins, forms, brochures, letters, Medicaid Provider Manual, and other publications. Providers should continue to use existing MDHHS documents while the updates are being completed.

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-mail at 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.

Approved

Kate Massey, Director
Medical Services Administration

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January 2022 Updates

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Beneficiary Eligibility	2.1 Benefit Plans	Addition of benefit plan: **Benefit Plan ID:** BIS **Benefit Plan Name:** Brain Injury Services **Benefit Plan Description:** Brain Injury Services (BIS) are services and supports provided to persons aged 21 and older with a qualifying brain injury who, but for the provision of these services, would otherwise be served within an institutional setting. The program provides critical rehabilitation and support in the post-acute injury period with the goal of assisting the participant in becoming capable of living in the most independent setting. **Type:** Fee for Service **Funding Source:** XIX **Covered Services:** A9	

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CHAPTER	SECTION	CHANGE	COMMENT
Beneficiary Eligibility	2.1 Benefit Plans	Addition of benefit plan: **Benefit Plan ID:** CCBHC **Benefit Plan Name:** Certified Community Behavioral Health Clinic **Benefit Plan Description:** The CCBHC Demonstration benefit plan will reimburse state certified CCBHC sites for providing a comprehensive array of quality behavioral health services. CCBHCs will receive a fixed daily clinic-specific rate (known as a PPS-1 rate) for all CCBHC services provided on a given day, and individuals are eligible for the benefit if they have a mental health or substance use disorder diagnosis, regardless of Medicaid eligibility. CCBHCs are federally required to provide nine core behavioral health services and must meet stringent standards for care coordination, quality and financial reporting, staffing, and governance. **Type:** Managed Care Organization **Funding Source:** XIX-XXI **Covered Services:** AI, MH	
Beneficiary Eligibility	2.1 Benefit Plans	The following benefit plans were deleted. • Children's Home and Community Based Services Waiver (CWP) • Habilitation Supports Waiver Program (HSW) • Prepaid Inpatient Health Plan (PIHP) • PIHP Healthy Michigan Plan (PIHP-HMP) • Children's Serious Emotional Disturbance Waiver Program (SED) • Children's Serious Emotional Disturbance Waiver Program – DHS (SED-DHS)	These benefit plans are obsolete.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Billing & Reimbursement for Dental Providers	6.1 General Information	The 1st paragraph was revised to read: Replacement claims must be submitted when all or a portion of the claim was paid incorrectly or a third party payment was received after MDHHS has made payment. Both the provider NPI and beneficiary ID numbers on the replacement claim must be the same as on the original claim. ~~To replace a previously paid claim adjudicated with a Claim Reference Number (CRN) prior to October 1, 2007, both the Medicaid legacy provider ID number and the NPI must be reported on the replacement claim for successful adjudication.~~ Reasons claims may need to be replaced:	Removal of obsolete information.
Billing & Reimbursement for Dental Providers	6.2 Claim Replacement and Void/Cancel Claims	The 2nd paragraph was revised to read: A void/cancel claim must be submitted if the original claim was paid under the incorrect provider ID or beneficiary ID number. ~~To void/cancel an original claim adjudicated with a Claim Reference Number (CRN) prior to October 1, 2007, both the correct Medicaid legacy provider ID number and NPI must be reported along with the correct beneficiary ID number.~~	Removal of obsolete information.
Billing & Reimbursement for Institutional Providers	3.1 Replacement Claims (Adjustments)	The last paragraph was revised to read: To replace a previously paid claim, indicate 7 (xx7) as the third digit in the Type of Bill Form locator frequency. Providers must enter the 18-digit Transaction Control Number (TCN) of the last approved claim being replaced and the reason for the replacement in Remarks. The provider NPI number and beneficiary ID number on the replacement claim must be the same as on the original claim. Providers must enter in Remarks the reason for the replacement. Refer to the Void/Cancel subsection below for additional information. ~~To replace a previously paid claim adjudicated with a Claim Reference Number (CRN) prior to October 1, 2007, both the Medicaid legacy provider ID number and the NPI must be reported on the replacement claim for successful adjudication.~~	Removal of obsolete information.
Billing & Reimbursement for Institutional Providers	3.2 Void/Cancel a Prior Claim	The 2nd paragraph was revised to read: A void/cancel claim must be completed exactly as the original claim. ~~To void/cancel an original claim adjudicated with a Claim Reference Number (CRN) prior to October 1, 2007, both the correct Medicaid legacy provider ID number and NPI must be reported along with the correct beneficiary ID number.~~	Removal of obsolete information.

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CHAPTER	SECTION	CHANGE	COMMENT
Billing & Reimbursement for Professionals	4.1 Replacement Claims (Adjustments)	In the 3rd paragraph, the 2nd bullet point was revised to read: • Resubmission code 7 must be entered in the left side of Item 22 and the 18-digit Transaction Control Number (TCN) of the previously paid claim in the right side of Item 22. If either the resubmission code of 7 or the original ~~CRN~~ TCN is missing, the claim cannot be processed as a replacement claim. and the last bullet point was removed: • ~~To replace a previously paid claim adjudicated with a Claim Reference Number (CRN) prior to October 1, 2007, both the Medicaid legacy provider ID number and the NPI must be reported on the replacement claim for successful adjudication.~~	Removal of obsolete information.
Billing & Reimbursement for Professionals	4.2 Void/Cancel Claims (Adjustments)	In the 2nd paragraph, the 2nd bullet point was removed: • ~~To void/cancel an original claim adjudicated with a Claim Reference Number (CRN) prior to October 1, 2007, both the correct Medicaid legacy provider ID number and NPI must be reported along with the correct beneficiary ID number.~~	Removal of obsolete information.
Behavioral Health and Intellectual and Developmental Disability Supports and Services	17.3.G.4. Youth Peer Support Services	The 2nd paragraph was revised to read: Youth Peer Support Services are provided by trained youth peer support specialists, one-on-one ~~or in a group~~, for youth with SED and young adults with SMI.	Due to the highly individualized nature of this service, it is not able to be provided in a group setting and still meet with criteria listed in the Medicaid Provider Manual.

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CHAPTER	SECTION	CHANGE	COMMENT
Behavioral Health and Intellectual and Developmental Disability Supports and Services Children's Serious Emotional Disturbance Home and Community-Based Services Waiver Appendix	2.3 Family Support and Training	In the 2nd paragraph, the 1st sentence was revised to read: Coverage includes education and training, including instructions about treatment regimens, to safely maintain the child at home (as specified in the individual plan of service [POS]) and peer support provided by a trained peer-parent (one-on-one ~~or in a group~~) for assistance with identifying coping strategies for successfully caring for or living with a person with SED.	Due to the highly individualized nature of this service, it is not able to be provided in a group setting and still meet with criteria listed in the Medicaid Provider Manual.
Pharmacy	5.1.A. Signature Log	The 1st paragraph was revised to read: Pharmacy providers must maintain a log containing the following information: • Beneficiary's name; • The manual or electronic signature of the beneficiary or ~~that of his~~ their representative; and • The date of receipt of the prescription.	Rewording for gender neutrality.
Pharmacy	5.1.B. Proof of Delivery	The bullet points were revised to read: • the manual or electronic signature of the member or their representative at the time of delivery; or • the tracking detail from the carrier showing medication was delivered, including date and time of delivery.~~; or~~ • ~~the manual or electronic signature of the member or that of his representative at the time of delivery.~~	Rewording for gender neutrality. Transposing the two bullet points: placing the bullet point referencing the signature first, and then the second bullet point is the tracking delivery.

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CHAPTER	SECTION	CHANGE	COMMENT
Pharmacy	Section 13 – Reimbursement, Copayments, and Coordination of Benefits	The following text was added: Prescriptions dispensed by Tribal 638 facility pharmacies are reimbursed at the Indian Health Services per visit outpatient rate. Refer to the Tribal Health Centers chapter for additional information.	Necessary in order to identify the new Tribal 368 facility AIR payment.
Practitioner Reimbursement Appendix	1.3 Neonatal and Pediatric Critical Care Services (new subsection)	New subsection text reads: Effective for dates of service on and after February 1, 2020, practitioner rates for inpatient neonatal and pediatric critical and intensive care services will be reimbursed at 95% of the Medicare annual rate.	Clarification of information in bulletin MSA 20-07.
Practitioner Reimbursement Appendix	1.4 Obstetrical Services (new subsection)	New subsection text reads: Effective for dates of service on and after October 1, 2014, practitioner rates for obstetric care, including antepartum, delivery, and postpartum services, will be reimbursed at 95% of Medicare rates.	Clarification of information in bulletin MSA 14-32.
Practitioner Reimbursement Appendix	1.5 Psychiatric Services for Individuals <21 Years of Age	New subsection text reads: Effective for dates of service on and after February 1, 2020, practitioner rates for psychiatric diagnostic evaluation services provided to individuals less than 21 years of age will be reimbursed at 100% of the Medicare annual rate. Effective for dates of service on and after January 1, 2021, practitioner rates for psychotherapy and other psychiatric services provided to individuals less than 21 years of age will be reimbursed at 63% of Medicare.	Clarification of information in bulletins MSA 20-08 and MSA 21-15.
Acronym Appendix		Removal of: ~~CRN – Claim Reference Number~~	Removal of obsolete information.
Directory Appendix	Eligibility Verification	Information regarding **Web-DENIS** was removed.	Removal of obsolete information.

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BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MSA 19-35	12/2/2019	Healthy Michigan Plan	2.5 Healthy Behaviors Incentives Program (new subsection)	New subsection text reads: The Healthy Behaviors Incentives Program for Healthy Michigan Plan beneficiaries enrolled in a MHP is designed to encourage and support beneficiaries in maintaining and implementing healthy behaviors as identified in collaboration with their health care provider. Comprehensive information on the Healthy Behaviors Incentives Program and the administration of healthy behavior requirements can be found in the Policy and Operational Process Document: Healthy Behavior Requirements located at the end of this chapter.
			3.1 Managed Care Members – MI Health Accounts	Text was revised to read: Healthy Michigan Plan managed care members are required to satisfy cost-sharing contributions through a MI Health Account. Cost sharing requirements, which include copays and ~~additional contributions~~ fees based on a beneficiary's income level, will be monitored through the MI Health Account by the health plan. These requirements begin after the beneficiary has been enrolled in a health plan for six months. Beneficiaries enrolled in a health plan will have the opportunity for reductions and/or elimination of cost sharing responsibilities to promote access to care if certain healthy behaviors are attained. If the amount contributed by the beneficiary is less than the amount due for a service received, the provider will still be paid in full for the services provided. Comprehensive information on the administration of MI Health Account copays and fees can be found in the Policy and Operational Process Document: MI Health Account Co-Pays and Fees for HMP Beneficiaries located at the end of this chapter.

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			Policy and Operational Process Document: Healthy Behavior Requirements (new)	Addition of the Policy and Operational Process Document: Healthy Behavior Requirements.
			Policy and Operational Process Document: MI Health Account Co-Pays and Fees for HMP Beneficiaries (new)	Addition of the Policy and Operational Process Document: MI Health Account Co-Pays and Fees for HMP Beneficiaries.
MSA 20-10	4/28/2020	Healthy Michigan Plan	3.5 Cost Sharing Exemptions for Medically Frail Individuals (new subsection)	New subsection text reads: For all Healthy Michigan Plan beneficiaries, both Fee-For-Service and those enrolled in a health plan, there are no cost sharing requirements for those who are medically frail in accordance with 42 CFR 440.315(f). Comprehensive information on program designation and processes related to medical frailty can be found in the Policy and Operational Process Document: Identification of Medically Frail Beneficiaries located at the end of this chapter.
			Policy and Operational Process Document: Identification of Medically Frail Beneficiaries (new)	Addition of the Policy and Operational Process Document: Identification of Medically Frail Beneficiaries.

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MSA 20-20	5/1/2020	Rural Health Clinics	5.2 Alternate Payment Methodology	Text was revised to read: ~~The State and the RHC may agree to an alternative payment methodology that provides reimbursement at least equal to that which an RHC would receive under the PPS.~~ In accordance with State Plan authority, MDHHS may enter into an alternative payment methodology with an RHC, referred to as a Memorandum of Understanding (MOU). Reimbursement for Medicaid primary care services provided by an RHC to Medicaid beneficiaries is subject to the terms of the signed MOU. For an RHC paid under the MOU, the PPS base methodology described within this chapter will be maintained to ensure compliance with Section 1902(bb)(6)(B) of the Social Security Act. The MOU is effective when both MDHHS and an RHC are signatories to the document. CMS, rather than the State, is the final arbiter of the permissibility of this agreement. The MOU does not supersede any corresponding policy in the MDHHS Medicaid Provider Manual but documents the clinic's acceptance of the terms outlined in the Michigan Medicaid State Plan. If an RHC does not sign the MOU, reimbursement and corresponding policy defaults to that which is described under the PPS methodology and outlined in this manual.

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MSA 20-67	10/12/2020	Maternity Outpatient Medical Services	2.1 Covered Services	The following text was added: • Behavioral health and substance use disorder (SUD) services and supports are covered during the prenatal period and through 60 days postpartum. Covered services include, but are not limited to: ➢ Appropriate screenings and preventive services ➢ Behavioral health treatment services and validated clinical assessment tools ➢ Perinatal depression screening, counseling, and intervention ➢ Medication-Assisted Treatment (MAT) for SUD ➢ Tobacco use interventions for smoking cessation ➢ Inpatient, outpatient, and residential treatment ➢ Emergency services, crisis intervention and stabilization; and ➢ Behavioral health and SUD-related case management services. • Refer to the Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter for information on coverage details of the specialty supports and services provided through the local Prepaid Inpatient Health Plans (PIHPs). For services not included in the capitation payments to the PIHPs, services are covered through Medicaid Fee For Service.
		Acronym Appendix		Addition of: MAT – Medication-Assisted Treatment

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MSA 21-28	9/30/2021	Practitioner	3.12 Gender Affirmation Services (new subsection; the following subsections were re-numbered and alphabetized)	New subsection text reads: The Medicaid program covers medically necessary gender affirmation/ confirming medical, surgical, and pharmacologic treatments and procedures for beneficiaries clinically diagnosed with gender dysphoria. Treatment and procedures for the health management of individuals with gender dysphoria are not considered to be elective or cosmetic when determined to be medically necessary. Medical and mental health services, determination of medical necessity, as well as the relevant qualifications and clinical experience requirements of treating providers, must adhere to the most current clinical practice guidelines, including those established by the World Professional Association for Transgender Health (WPATH) and the Endocrine Society, as applicable. For coverage of gender affirmation surgical procedures, the medical necessity determination must include a mental health evaluation indicating the individual meets diagnostic and readiness criteria in accordance with current WPATH standards of care. The mental health evaluation must be conducted by a fully licensed mental health professional who possesses, at a minimum, a master's degree or equivalent in a clinical behavioral science field and has experience in the treatment and assessment of gender dysphoria. The evaluation must be documented in the beneficiary's medical record and included in requests for coverage of surgical interventions that require prior authorization.
		Acronym Appendix		Addition of: WPATH - World Professional Association for Transgender Health

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MSA 21-29	7/30/2021	Billing & Reimbursement for Professionals	6.8.E. Place of Service Codes	Under "Nursing Facility Residents", the following text was added: DMEPOS items for beneficiary use in the home and community may be delivered on the skilled nursing facility or nursing facility date of discharge. (Refer to the Medical Supplier Chapter for additional information.) The medical supplier must report the facility date of discharge in the relevant dates section of the electronic ASC X12N 837 5010 professional claim (loop 2300 DTP segment) or the Community Health Automated Medicaid Processing System (CHAMPS) direct data entry claim.
		Medical Supplier	1.4 Place of Service	The following text was added after the 2nd paragraph: The medical supplier may deliver durable medical equipment, prosthetics, orthotics and medical supplies (DMEPOS) for beneficiary use in the beneficiary's home and community on the date of discharge from the skilled nursing facility (SNF) or nursing facility (NF). The SNF/NF is required to report the beneficiary date of discharge in the CHAMPS admission record. (Refer to the Beneficiary Eligibility Chapter for additional information.) To ensure DMEPOS items are not delivered prior to the facility discharge date and prevent beneficiary access to care issues, it is recommended that the SNF/NF and medical supplier coordinate the facility discharge date and DMEPOS delivery date.

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MSA 21-30	7/30/2021	Pharmacy	Section 2 – Prescriber Requirements	The 2nd paragraph was revised to read: Coverage of pharmaceutical products is based on limitations stated in this chapter, the MPPL, and medical necessity. Determination of medical necessity and appropriateness of service is the responsibility of the prescribing physician/provider (prescriber) within the scope of currently accepted medical practice and MDHHS limitations. Participating providers must observe applicable State and Federal laws, rules, regulations, and policies. Providers or designees of such providers who prescribe a controlled substance are required to check the Michigan Automated Prescription System (MAPS) for the beneficiary's 12-month prescription drug history before prescribing controlled substances. Documentation of the required MAPS check should be retained in accordance with the Medicaid record retention policy. Exemptions to this requirement include: • Beneficiaries who are receiving cancer treatment or hospice/ palliative care in long-term care facilities described in 1396d of Title XIX or other facilities with a single pharmacy contract, and • Prescriptions provided during declared natural disasters or emergency services. (Refer to the Directory Appendix for MAPS information.) MDHHS may impose additional constraints to reduce misuse.
		Acronym Appendix		Addition of: MAPS - Michigan Automated Prescription System
		Directory Appendix	Pharmacy Resources	Addition of: **Contact/Topic:** Michigan Automated Prescription System (MAPS) **Mailing/Email/Web Address:** www.michigan.gov/mimapsinfo

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
				Information Available/Purpose: Michigan's prescription drug monitoring program. MAPS is used to identify and prevent drug diversion at the prescriber, pharmacy, and patient level.
MSA 21-31	8/2/2021	Vision	3.4.B. Ophthalmic Frames	The 2nd and 3rd paragraphs were revised to read: Ophthalmic frame styles that are a Medicaid benefit are available from the contractor. Vision providers may order sample frames directly from the contractor, and a list of available frames is available from the contractor. (Refer to the Directory Appendix for contact information.) The vision provider is charged for sample frames at the same price stated in the current contract. Neither the provider nor the contractor may charge Medicaid for sample frames. Vision providers must offer a beneficiary the opportunity to select a frame from ~~at least 80 percent of the total authorized frame styles~~ a minimum of 100 authorized frame samples. Additionally, a vision provider must offer beneficiaries the contractor's brochure of frames which includes all available styles so beneficiaries can select from more than the vision provider's inventory of sample frames. A vision provider who fails to comply with ~~this~~ these requirements is subject to termination of enrollment in Medicaid.
MSA 21-32	8/25/2021	Tribal Health Centers	Section 1 – General Information	The following text was added after the 3rd paragraph: In addition, eligible prescriptions dispensed by THC and Tribal FQHC pharmacies constitute a separate encounter per prescription and are reimbursed the IHS outpatient AIR. The AIR applies to prescriptions for both native and non-native Medicaid beneficiaries.

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			Section 9 – Alternative Payment Methodology for Prescriptions (new section)	New section text reads: All prescriptions will be reimbursed at the IHS per visit outpatient AIR determined annually by CMS and published in the Federal Register. Reimbursement at the AIR will be allowed for each prescription provided to Medicaid and Healthy Michigan Plan beneficiaries served at a THC or Tribal FQHC pharmacy. The AIR applies to encounters for both native and non-native beneficiaries.
			9.1 Encounters (new subsection)	New subsection text reads: There is no limit on the number of prescription encounters that may be reimbursed in a single day, and each prescription constitutes a separate encounter. The encounter rate includes dispensing services and drug costs. All THC and Tribal FQHC pharmacies are paid the encounter rate by Michigan Medicaid regardless of their method of purchasing. All drugs on the Michigan Pharmaceutical Product List (MPPL) and drugs with Medicaid prior authorization will be reimbursed the AIR. No drugs will be excluded from the AIR except for drugs on the Children's Special Health Care Services (CSHCS) drug list. All THCs and Tribal FQHC pharmacies must have a mechanism to dispense all necessary medications and, if a medication is not available, pharmacies must coordinate and transfer the prescription to a local pharmacy that carries the drug to minimize any disruption to the beneficiary. All other existing Medicaid policies and coverage limitations apply.

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			9.2 Quarterly Payments (new subsection)	New subsection text reads: MDHHS will adjudicate and reimburse the AIR for Medicaid FFS claims and cost-settle Medicaid Health Plan (MHP) and Integrated Care Organization (ICO) prescription encounters at an agreed upon frequency. A cost settlement payment is based on an estimate of the difference between (1) the AIR and (2) the amount the Tribal 638 facility receives for managed care encounters and third-party payments (including Medicare Part B covered drugs). Medicare Part D covered drugs will be excluded from AIR reimbursement. (Refer to the Coordination of Benefits Chapter for information on Medicare Part D coverage.) When payment determination is made, correspondence will be sent to the THC or Tribal FQHC with overall reimbursement and the non-federal match due. If the THC or Tribal FQHC disagrees with the amount, the facility may request reconsideration within 14 calendar days of the date of the correspondence. Requests must be supported with sufficient details and examples for MDHHS to render a determination. (Refer to the Appeals subsection of this chapter for information on appealing an adverse action.)
MSA 21-34	9/1/2021	Behavioral Health and Intellectual and Developmental Disability Supports and Services	Section 21 – Certified Community Behavioral Health Clinic Demonstration (new section)	Bulletin was incorporated into the MDHHS Medicaid Provider Manual through the addition of a new section to the chapter.

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Acronym Appendix		Addition of: CARES – Coronavirus Aid, Relief, and Economic Security Act of 2020 CCBHC – Certified Community Behavioral Health Clinic CC PPS-1 – certified clinic prospective payment system DCO – designated collaborating organization HIE - Health Information Exchange MEI – Medicare Economic Index MiCal – Michigan Crisis and Access Line MMIS – Medicaid Management Information System PAMA – Protecting Access to Medicare Act of 2014 PMPM – per member per month PPS-1 – Prospective Payment System 1 QBP – Quality Bonus Payment SAMHSA – Substance Abuse and Mental Health Services Administration SUD – substance use disorder WSA – Waiver Support Application
		Directory Appendix	Mental Health/Substance Abuse Resources	Addition of: **Contact/Topic:** Certified Community Behavioral Health Clinic Demonstration
MSA 21-36	10/1/2021	Program of All Inclusive Care for the Elderly	5.4 Unmet Need (new subsection)	Bulletin was incorporated into the MDHHS Medicaid Provider Manual through the addition of a new subsection to the chapter.

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		Acronym Appendix		Addition of: MPR – market penetration rate NPA – National PACE Association PPB – potential PACE beneficiaries TPPB - true potential PACE beneficiaries

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