MDHHS
Michigan Department of Health & Human Services

BULLETIN

Michigan Medicaid Policy (MMP) | Health Services

Bulletin Number: MMP 26-08

Distribution: All Providers

Issued: February 27, 2026

Subject: Updates to the MDHHS Medicaid Provider Manual

Effective: April 1, 2026

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 April 2026 update of the online version of the MDHHS Medicaid Provider Manual. The manual will be available April 1, 2026, at www.michigan.gov/medicaidproviders >> Policy, Letters & Forms >> Medicaid Provider Manual.

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

The attachments describe the changes made, the location of the changes within the manual and, when appropriate, the reason for the change.

Manual Maintenance

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

Questions

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

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

Approved

Meghan E. Groen, Chief Deputy Director
Health Services

Michigan Department of Health and Human Services

Medicaid Provider Manual
April 2026 Updates

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Throughout the Manual		References to "Pharmacy Benefits Manager" and "PBM" were revised to read "Pharmacy Benefits Administrator	Update.
Billing & Reimbursement for Institutional Providers	6.2.C. Special Circumstances for Hospital Readmissions and Transfers	The category title "**Neonatal Intensive Care Unit (NICU) Return Transfers"** was revised to read **"Neonatal Intensive Care Unit (NICU) ~~Return~~ Transfers"**. Text was revised to read: ~~Stabilized infants from NICUs may transfer back to the hospital from which the infant was originally transferred. Transfers may be authorized, with parental consent, to another community hospital when the original facility is at capacity or not closely located to the patient's home.~~ ~~A Prior Authorization Certification Evaluation Review (PACER) must be authorized through the MDHHS PRD for elective transfers between hospitals. NICU return transfer requests for continued medical care at a lower acuity hospital will be authorized if a neonatologist provides a written order to transfer to the originating or community hospital for bonding, teaching, and growth. Existing hospital and ambulance transfer reimbursement methodology will be utilized when prior authorization is granted.~~ MDHHS PRD may authorize the transfer of stabilized infants from the originating NICU to a different hospital as follows: • When the original hospital is at capacity or not close in proximity to the infant's home. • NICU transfer requests for continued medical care at a lower acuity hospital may be authorized by the MDHHS PRD when a neonatologist provides a written order to transfer to another hospital for bonding, teaching, and growth. • Medically necessary initial transfers will be authorized when the specialty care and treatment are not available at the transferring hospital. Repeated transfers of NICU patients for the sole purpose of specialty care will not be authorized. All elective transfers must be authorized by MDHHS. Existing hospital and ambulance transfer reimbursement methodology will be utilized when prior authorization is granted.	Clarification.

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Medicaid Provider Manual
April 2026 Updates

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Behavioral Health and Intellectual and Developmental Disability Supports and Services	3.31.B. Qualified Staff	In the 1st paragraph, the 3rd bullet point was revised to read: • Maintain certification in ICCW: ➢ Complete one annual ICCW booster. ➢ Complete at least two MDHHS-provided trainings related to ICCW. ➢ Complete ~~an additional 16 hours of training~~ the required 24 training hours of Children's Diagnostic and Treatment Service per the Michigan Administrative Code (annually) related to provision of support to children, youth, or young adults and their families when providing ICCW ~~to those served under the SEDW~~.	
Behavioral Health and Intellectual and Developmental Disability Supports and Services	3.31.E. Child and Family Team Plan and Wraparound Planning Process	In the table, under "Wraparound Plan", the last bullet point was revised to read: • Wraparound Plan elements must be developed with fidelity to the MDHHS Wraparound model ~~to ensure fidelity~~ and must include the identification of functional strengths and needs assessment for each member of the family.	
Behavioral Health and Intellectual and Developmental Disability Supports and Services Children With Serious Emotional Disturbances Home and Community-Based Services Waiver Appendix	1.4 Enrollment and Disenrollment	The 1st paragraph was revised to read: Eligibility for SEDW includes the requirement for the child/youth to reside in a home or community-based setting at the time of enrollment into the waiver. It is also the requirement that the family agrees to receive intensive home and community-based waiver services. Children and youth will undergo an annual assessment to confirm continued eligibility for the waiver as part of the redetermination process.	

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Behavioral Health and Intellectual and Developmental Disability Supports and Services Children With Serious Emotional Disturbances Home and Community-Based Services Waiver Appendix	2.11.C. Provider Qualifications	Text was revised to read: Due to the intense needs and level of risk for children/youth and their families served in the SEDW, all SEDW ICCW care coordinators and targeted case managers and those who provide supervision to coordinators/case managers must ~~attend 16 hours of training related to provision of support to children/youth and their families served in the waiver annually as required by MDHHS~~ complete the required 24 training hours of Children's Diagnostic and Treatment Service per the Michigan Administrative Code (annually) related to provision of support to children, youth, or young adults and their families when providing ICCW or TCM.	
Early and Periodic Screening, Diagnosis and Treatment	9.4 Immunizations	The 2nd and 3rd paragraphs were revised to read: Immunizations are covered when administered according to ACIP recommendations. MDHHS encourages providers to immunize all Medicaid beneficiaries. • For Medicaid eligible children 18 years of age and younger, the Vaccines for Children (VFC) Program provides covered immunizations at no cost to the provider. • Medicaid covers immunizations for beneficiaries 19 years of age and older. • Any LHD in the state can be contacted for specifics about the VFC program such as what immunizations are available, instructions on enrolling and obtaining immunizations. For immunizations available free of charge under the VFC program, the amount a provider may charge for vaccine administration may be limited. Providers cannot charge more for services provided to Medicaid beneficiaries than for services provided to their general patient population. For example, if the charge for administering a vaccine to a private-pay patient is $5.00, then the charge for immunization administration to the Medicaid beneficiary cannot exceed $5.00. Refer to the Practitioner Chapter for more information about coverage of immunizations that are available free of charge.	Updated to align with information provided in Practitioner Chapter. Added to clarify reimbursement policy in Practitioner Chapter applies to immunizations provided under the EPSDT benefit. Reimbursement to providers is not available for immunizations the provider receives free of charge, including through the VFC program.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Hearing Services and Devices	4.7 Measurable Benefits/Conformity Evaluations	The 3rd paragraph was revised to read: ~~Hearing aid dealers must instruct beneficiaries to return to the evaluating audiologist for~~ The conformity evaluation should be conducted within 90 days of the hearing aid dispensing date to allow for the return of the device, if necessary~~, within 90 days of the hearing aid dispensing date~~. When a delivered hearing aid does not provide benefit, as defined above, providers are expected to return it to the manufacturer within 90 days for modifications, remake, exchange, or credit as recommended by the evaluating ~~audiologist~~ hearing aid provider. ~~The hearing aid dealer must notify the beneficiary of this when the hearing aid is dispensed.~~	Clarification/correction.
Home Help	Section 6 – Home Help Program Enrollment	The last paragraph was revised to read: (Refer to the Directory Appendix for local MDHHS office contact information and ~~the Forms Appendix for copies of the DHS-54A and DHS-390~~ for webpage information to obtain copies of Home Help Program application forms.)	Update.
Hospital	2.1.A.4. PACER Transfers	The 1st paragraph was revised to read: If a beneficiary needs to be transferred, authorization for the transfer must be obtained through MDHHS PRD. Authorization for a transfer is granted only if the transfer is medically necessary and the care or treatment is not available at the transferring hospital. For additional information, including NICU transfers, refer to the Billing & Reimbursement for Institutional Providers chapter of this manual. Additionally, authorization may be granted if the beneficiary is a newborn returning to the originating hospital. Transfers for convenience are not considered. Transfers include the following situations:	Clarification.

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CHAPTER	SECTION	CHANGE	COMMENT
Hospital	4.2 Inpatient and Outpatient Post-Payment Reviews	The 2nd paragraph was revised to read: The objective of the MDHHS post-payment review process is to ensure that MDHHS reimbursement is for medically necessary care provided in the appropriate setting, that diagnostic and procedural information is valid, and that the care rendered meets current clinical and quality standards of practice. ~~Cases are reviewed using Medicaid-approved Severity of Illness/Intensity of Services (SI/IS) criteria, clinical judgment and generic quality screens.~~ For cases reviewed on or after October 1, 2023, MCG (Millman Care Guidelines) criteria, along with clinical judgement, is used. For review dates prior to October 1, 2023, InterQual criteria, along with clinical judgement, was used.	Clarification.
Maternity Outpatient Medical Services	2.1 Covered Services	Under the 1st bullet point, the last sub-bullet point was revised to read: • Prenatal period services, including: ➢ ~~ACIP recommended vaccines~~ Immunizations provided in accordance with currently accepted standards of medical or professional practice and their administration	Clarify coverage of immunizations is not limited to what is recommended by ACIP.
Medical Supplier	2.3 Blood Pressure Monitoring	Under "Standards of Coverage", 2nd bullet point, the 6th sub-bullet point was revised to read: • The beneficiary has any of the following conditions: ➢ Beneficiary who is pregnant or who is within the 12-month postpartum period (with or without uncontrolled blood pressure).	Correction to January 2026 Provider Manual incorporation of policy bulletin MMP 25-48.
MI Coordinated Health	1.2.A.10. Personal Care Supplement for Enrollees in Adult Foster Care (AFC) Facilities, Home for the Aged (HFA) and Unlicensed Congregate Residential Settings	In the last paragraph, the bullet point was revised to read: • Supported Independent Setting ~~(SIP)~~: Homes supervised by Community Mental Health (CMH) with three or four residents all receiving CMH services. ~~SIP homes~~ Supported Independent Settings do not need to be licensed unless one of the residents is not receiving CMH services. Residents of a ~~SIP home~~ Supported Independent Setting could qualify for PCS. The person who owns, rents, or leases the ~~SIP~~ Supported Independent Setting cannot be the individual caregiver or agency provider of the Home Help client.	

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CHAPTER	SECTION	CHANGE	COMMENT
MI Coordinated Health	1.3 Coordination of Services Covered Outside of the SMAC	The 1st through 4th bullet points were revised to read: • Inpatient hospital psychiatric services. (Refer to ~~the Directory Appendix for the Medicaid Behavioral Health and Substance Use Disorder Authorization and Payment Responsibility Grid and~~ the Inpatient Hospital Psychiatric Services subsection of this chapter.) • Outpatient partial hospitalization psychiatric care. (Refer to ~~the Directory Appendix for the Medicaid Behavioral Health and Substance Use Disorder Authorization and Payment Responsibility Grid and~~ the Behavioral Health subsection of this chapter.) • Behavioral health assessment and services for enrollees meeting the guidelines under Medicaid policy for serious mental illness or severe emotional disturbance. (Refer to the ~~Directory Appendix for the Medicaid Behavioral Health and Substance Use Disorder Authorization and Payment Responsibility Grid and the~~ Behavioral Health subsection of this chapter.) • Certain substance use disorder (SUD) services (refer to the ~~Directory Appendix for the Medicaid Behavioral Health and Substance Use Disorder Authorization and Payment Responsibility Grid and the~~ Substance Abuse, Inpatient and Outpatient subsection of this chapter), including: ➢ Assessment (per MDHHS policy, the HIDE SNP must reimburse SUD services provided in the office setting by a practitioner not enrolled with or associated to a PIHP) ➢ Detoxification ~~(see the Medicaid Behavioral Health and Substance Use Disorder Authorization and Payment Responsibility Grid)~~ ➢ Intensive outpatient counseling and other outpatient services ➢ Methadone treatment and other SUD treatment	Updating by removing reference to specific grid.

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CHAPTER	SECTION	CHANGE	COMMENT
MI Coordinated Health	2.1 Communicable Disease Services	Text was revised to read: HIDE SNP must cover or pay applicable Medicare cost sharing for enrollees to receive treatment services for communicable diseases from local health departments ~~(LCDs)~~ (LHDs) without prior authorization, including Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS), Sexually Transmitted Infections (STI), tuberculosis, and vaccine-preventable communicable diseases.	Correction.
MI Coordinated Health	2.7.B.2. Behavioral Healthcare	Text was revised to read: The HIDE SNP must ensure access to all behavioral health services covered under the SMAC to all enrollees with behavioral health needs~~, in accordance with the Medicaid Behavioral Health and Substance Use Disorder Authorization and Payment Responsibility Grid~~. ~~MDHHS reserves the right to modify the Medicaid Behavioral Health and Substance Use Disorder Authorization and Payment Responsibility Grid including, but not limited to, changing coverage responsibility for mental health services so that responsibility will be determined by the level of the enrollee's needs rather than by the setting in which a service is provided.~~	Updating by removing reference to specific grid.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
MI Coordinated Health	2.11 Substance Abuse, Inpatient and Outpatient	Text was revised to read: The HIDE SNP must provide all substance abuse services not provided by the PIHPs consistent with ~~the Medicaid Behavioral Health and Substance Use Disorder Authorization and Payment Responsibility Grid (refer to the Directory Appendix) and~~ MDHHS Medicaid policy. The HIDE SNP may provide services through contracts with PIHPs, CMHSP providers, or contracts with other appropriate Medicaid network providers. Medicaid specialty services, including behavioral health, intellectual/developmental disabilities services and supports, and substance use services, must be provided by the PIHP ~~in accordance with the Medicaid Behavioral Health and Substance Use Disorder Authorization and Payment Responsibility Grid (refer to the Directory Appendix)~~. The HIDE SNP must provide information to the enrollee regarding the availability of certain SUD services, including: • Assessment (per MDHHS policy, the HIDE SNP must reimburse SUD services provided in the office setting by a practitioner not enrolled with or associated to a PIHP) • Detoxification ~~(see the Medicaid Behavioral Health and Substance Use Disorder Authorization and Payment Responsibility Grid)~~ • Intensive outpatient counseling and other outpatient services • Methadone treatment and other SUD treatment	Updating by removing reference to specific grid.
MI Coordinated Health	6.3 Data Methodology	The last bullet point was revised to read: • Any ~~or~~ criteria indicated in rate certification materials	Correction.

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CHAPTER	SECTION	CHANGE	COMMENT
MI Coordinated Health	10.8 Door 0 Process	The 2nd paragraph was revised to read: The HIDE SNP must ~~continue to~~ upload all supporting documentation in CHAMPS at the time of submission of a Door 0 LOCD. MDHHS will review every Door 0 and make the determination of eligibility. MDHHS will enter a new LOCD after each review whether they find the enrollee to be eligible or ineligible. If MDHHS determines the enrollee is ineligible based on the information submitted, MDHHS will enter a new Door 0 into CHAMPS which will inactivate the HIDE SNP entered Door 0. MDHHS will provide Notice and Hearing Request to the enrollee~~,~~ and the HIDE SNP ~~and MDHHS will be copied~~. All ~~three~~ parties ~~would~~ will be notified and required to participate in any Administrative Hearing as witnesses. If MDHHS determines that the enrollee is eligible based on the information submitted, MDHHS will complete and enter a new LOCD into CHAMPS which will inactivate the HIDE SNP Door 0 LOCD. ~~Michigan Peer Review Organization (MPRO)~~ MDHHS will mail a letter to the HIDE SNP ~~and copy MDHHS~~ indicating that the enrollee was found eligible. The HIDE SNP will be able to check the status of any Door 0 they have submitted in CHAMPS (keeping in mind the two-business day turnaround time). The HIDE SNP must adopt the eligible LOCD by conducting the FOC form with the enrollee. The HIDE SNP should refer to the Freedom of Choice Form subsection of the Nursing Facility Level of Care Determination chapter for additional instructions on completion of the FOC.	Update.
Non-Emergency Medical Transportation	Section 4 – Transportation Provider Qualifications	In the 3rd paragraph, the 1st bullet point was revised to read: • Seatbelts and child safety seat requirements~~, if appropriate~~ in accordance with associated state law, when applicable; and	Adding additional clarification that state laws apply to seatbelt and child safety seat usage.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Nursing Facility Coverages	Section 8 – PASARR Process	The following text was added to the table in the last paragraph: **Hospital Exempted Discharge (HED)** — Individuals being admitted from an inpatient medical hospitalization may be eligible to admit to a nursing facility without a level II evaluation if they meet Hospital Exempted Discharge (HED) criteria. If the individual needs nursing care beyond the 30 days permitted by a HED, the Nursing Facility must notify the local CMHSP that the Level II evaluation is needed on the 25th day following admission by providing the CMHSP with the admitting DCH-3877 and DCH-3878 which invoked the exemption. The CMHSP will determine the need for a level II evaluation.	Hospital Exempted Discharges (HEDs) are a federal exemption to the OBRA PASARR process and a type of level II assessment. This section addresses when a HED exemption would turn into a level II evaluation.
Nursing Facility Coverages	8.3 Level II Evaluation Exemption	In the 2nd paragraph, the 3rd bullet point was revised to read: • The individual is convalescing after hospitalization for an acute illness and meets all of the following Hospital Exempted Discharge (HED) conditions:	Hospital Exempted Discharges (HEDs) are a federal exemption to the OBRA PASARR process and this section describes the criteria of the exemption; however, it does not call them 'HED', which is a common term in the OBRA PARARR process. This is not a change, it is adding the name of the exemption as it was not properly named within the Medicaid Provider Manual.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Nursing Facility Coverages	10.30 Private Room	The 3rd paragraph was revised to read: In cases where a current Medicaid resident needs to be in a private room because they require isolation due to an infection or illness, but no Medicaid-certified private rooms are available, the MDHHS Long-Term Care Operations section may provide a written exception to this policy. This exception is provided to allow the residents to reside in a non-Medicaid-certified bed within their facility on a short-term, temporary basis. Form ~~MSA-0823~~ MSA-0832 (Nursing Facility Isolation Bed Request) may be completed by the NF in need of isolating a Medicaid resident in a private room using a non-Medicaid-certified bed. Only forms approved by MDHHS may result in Medicaid reimbursement for Medicaid beneficiaries residing in a non-Medicaid-certified bed on a temporary basis. (Refer to the Forms Appendix for a sample form, along with instructions on form completion.)	Correction; clarification.
Nursing Facility Cost Reporting & Reimbursement Appendix	10.13.F.1. Change of Ownership	Text was revised to read: A new owner may receive reimbursement for the balance of the facility's eligible years of participation in the FIDS program. The new owner must notify RARSS via File Transfer within 45 calendar days of the change of ownership if the facility is going to continue participation in the FIDS program, or RARSS will assume participation has been discontinued and end FIDS reimbursement supplemental payments. In order to receive the supplemental Medicaid payment, the new owner must continue the FIDS facility standards and culture change. If the new owner initially decides to discontinue participation as a FIDS facility and subsequently decides to participate as a FIDS facility, the provider must notify ~~the LARA, Bureau of Community and Health Systems (BCHS) team manager and~~ MDHHS Health Services. MDHHS will notify the provider of the supplemental payment amount upon reinstatement of participation in FIDS. MDHHS will notify the provider of the terminated supplemental payment if the facility is determined ineligible for the supplemental payment because the new owner has discontinued or plans to discontinue the FIDS facility standards or culture change.	Update.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Nursing Facility Level of Care Determination	2.3 Program Specified Eligibility Requirements	The subsection title was revised to read: Program ~~Specified~~ -Specific Eligibility Requirements Text was revised to read: In addition to meeting Medicaid financial and functional eligibility requirements, individuals must also meet all program-specific requirements before they can be determined eligible for that program. (Refer to the Nursing Facility Coverages, the MI Choice Waiver, the Program of All-Inclusive Care for the Elderly, and the MI Health Link chapters or to provider contracts for ~~specific~~ program-specific requirements.) This chapter applies only to the LOCD process and is not intended to replace program-specific requirements.	Clarification.
Pharmacy	1.1 MDHHS Pharmacy Benefits Manager and Other Vendor Contractors	The subsection title was revised to read: MDHHS Pharmacy Benefits ~~Manager~~ Administrator and Other Vendor Contractors	Update.
Pharmacy	13.11 Electronic Funds Transfer (new subsection)	New subsection text reads: Electronic Funds Transfer (EFT) is the method of direct deposit of payments into a provider's bank account. All Fee for Service payments due to pharmacy providers enrolled with MDHHS are issued via EFT. Refer to the Pharmacy Resources section of the Directory Appendix for EFT PBA website information.	Letter L 25-50 clarified that paper check payments to FFS pharmacies would be discontinued and only EFT payments would be made. Other providers in the MPM specify how payments are made, so we wanted to make it clear in the Pharmacy Chapter as well.

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CHAPTER	SECTION	CHANGE	COMMENT
Practitioner	3.15 Immunizations (Vaccines and Toxoids)	The 1st and 2nd paragraphs were revised to read: Immunizations are covered when medically necessary and provided in accordance with currently accepted standards of medical or professional practice. Medical necessity may be established with an evidence-based recommendation developed or endorsed by the Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP) or medical professional societies such as the American Academy of Pediatrics, the American Academy of Family Physicians, the American College of Physicians, and the American College of Obstetricians and Gynecologists. This includes recommendations that are routine, based on health condition, occupation, shared clinical decision making, and travel. • For Medicaid children 18 years and younger, the Vaccine for Children (VFC) Program provides covered immunizations at no cost to the provider. • Medicaid covers immunizations for beneficiaries 19 years of age or older. • Any ~~Local Health Department (~~LHD~~)~~ in the state can be contacted for specifics about the VFC program, such as what immunizations are available, and instructions on enrolling and obtaining immunizations. Medicaid does not ~~pay immunization costs~~ reimburse for any immunization product that is available free of charge, ~~for Medicaid beneficiaries~~ including those provided under the VFC Program. An administration fee is covered separately for immunizations ~~given~~ administered to Medicaid beneficiaries whether the immunization is free or not, and without regard to other services provided on the same day. The administration fee is set for each immunization.	Clarification.

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CHAPTER	SECTION	CHANGE	COMMENT
Acronym Appendix		Removal of: ~~PBM – Pharmacy Benefits Manager~~ Addition of: FTS – File Transfer Service HED - Hospital Exempted Discharge PBA – Pharmacy Benefits Administrator	Update.
Directory Appendix	Prior Authorization	Under "Prior Authorization - Dental (FFS Medicaid & CSHCS)", mailing address information was revised to read: MDHHS Dental Prior Authorization PO Box ~~30154~~ 30170 Lansing, MI 48909	Update.
Directory Appendix	Home Help	Addition of: **Contact/Topic:** Adult Services Forms and Publications **Phone #/Fax #:** **Mailing/Email/Web Address:** https://www.michigan.gov/mdhhs/adult-child-serv/adults-and-seniors/forms-pubs **Information Available/Purpose:** Includes hyperlinks to Home Help application forms.	

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CHAPTER	SECTION	CHANGE	COMMENT
Forms Appendix	MSA-0832; Nursing Facility Isolation Bed Request Form	Form version dated 2/2026 contains the following notable changes: • A paragraph was added above the Instructions section to describe when it is appropriate to request an exception to the policy -- specifically in cases where a Medicaid resident requires a private room due to isolation needs related to an infection or illness. • Several rows requesting additional facility information were removed as this information is no longer required to complete the form. • A table requesting census data was added, along with a brief description clarifying what census data should be provided. • Subheadings were added in parentheses within the beneficiary information table to help clarify common errors made by providers.	Update.

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BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MMP 25-20	5/30/2025	Billing & Reimbursement for Institutional Providers	7.3.G. Emergency Transports to Crisis Stabilization Units (new subsection)	New subsection text reads: When billing emergency ambulance transportation to Crisis Stabilization Units (CSUs) for dually eligible FFS Medicaid and Medicare beneficiaries, providers must include a claim note that states "Crisis Stabilization Unit". If CSU is not reported on the claim, services may not be reimbursed by Medicaid. Diagnostic or therapeutic sites are recognized by the origin and destination code of "D" when reporting transportation modifiers.
		Billing & Reimbursement for Professionals	7.2.A. Origin and Destination Modifiers	Addition of the following text: Claims for emergency ambulance transports to Crisis Stabilization Units (CSUs) provided to dually eligible FFS Medicaid and Medicare beneficiaries must include a claim note that states "Crisis Stabilization Unit". If CSU is not reported on the claim, services may not be reimbursed by Medicaid. Diagnostic or therapeutic sites are recognized by the origin and destination code of "D" when reporting transportation modifiers.

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BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Ambulance	2.6 Emergency	Text was revised to read: Claims may be made to MDHHS for emergency transports that meet the criteria specified in the definitions of BLS Emergency, ALS 1 Emergency and ALS 2 transports in this section. Claims for emergency ambulance transports must be coded with both an emergency procedure code and an appropriate ICD diagnosis code whenever the service results in transport to a hospital, Crisis Stabilization Unit (CSU), or other approved alternate destination as allowed by state law or assessment and treatment/stabilization determines that no further transport is necessary. Claims for emergency transports without this information will be rejected. Documentation supporting the emergency diagnosis code must be retained in the ambulance provider's records for audit purposes. Claims for emergency ambulance transports to a CSU provided to dually eligible FFS Medicaid and Medicare beneficiaries must include a claim note that states "Crisis Stabilization Unit". If CSU is not reported on the claim, services may not be reimbursed by Medicaid. Diagnostic or therapeutic sites are recognized by the origin and destination code of "D" when reporting transportation modifiers. To assure appropriate coverage and reimbursement for emergency ambulance services, MDHHS maintains a list of diagnosis codes for emergency ambulance transport. For allowable diagnosis codes, refer to the Medicaid Code and Rate Reference tool. (Refer to the Directory Appendix for website information.)
		Behavioral Health and Intellectual and Developmental Disability Supports and Services	Section 9 – Intensive Crisis Stabilization Services	Section was re-written in its entirety.

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BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Acronym Appendix		Addition of: BHCRM - Behavioral Health Customer Relationship Management CSU – Crisis Stabilization Unit
		Directory Appendix	Behavioral Health/SUD Resources	The following topics were added: • Intensive Crisis Stabilization Services • Access Standards • Behavioral Health Customer Relationship Management
MMP 25-44	9/30/2025	Pharmacy	13.6.A. Medicaid Copayments	In the "Copayment Exemptions" table, under "Other Exclusions", addition of bullet point: • Medicaid beneficiaries who are under the age of 21 are excluded from the copay requirement. • American Indians/Alaska Natives consistent with federal regulations at 42 CFR §447.56(a)(1)(x). • All CSHCS, MOMS, and Plan First Family Planning program beneficiaries are excluded, including those over age 21. • Medicare/Medicaid dual eligibles. • Claims for drugs used to prevent Human Immunodeficiency Virus (HIV) (Pre-Exposure Prophylaxis [PrEP] & Post-Exposure Prophylaxis [PEP]).

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BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MMP 25-45	9/30/2025	Private Duty Nursing (NOTE: These changes are in addition to those reported in the January 2026 update of the Manual.)	2.4 Determining the Amount of Authorized PDN Hours	The table following the 2nd paragraph was removed: **High Category**: Beneficiaries requiring nursing assessments, judgments and interventions by a licensed nurse (RN/LPN) at least one time each hour throughout a 24-hour period, when delayed nursing interventions could result in further deterioration of health status, in loss of function or death, or in acceleration of the chronic condition. **Medium Category**: Beneficiaries requiring nursing assessments, judgments and interventions by a licensed nurse (RN/LPN) at least one time every three hours throughout a 24-hour period, or at least 1 time each hour for at least 12 hours per day, when delayed nursing interventions could result in further deterioration of health status, in loss of function or death, or in acceleration of the chronic condition. This category also includes beneficiaries with a higher need for nursing assessments and judgments due to an inability to communicate and direct their own care. **Low Category**: Beneficiaries requiring nursing assessments, judgments and interventions by a licensed nurse (RN/LPN) at least one time every three hours for at least 12 hours per day, as well as those beneficiaries who can participate in and direct their own care.

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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></td><td>The table following the 4th paragraph was removed:

Decision Guide for Establishing Maximum Amount of Private Duty Nursing to be Authorized on a Daily Basis

<table>
<tr><th colspan="2" rowspan="2">FAMILY SITUATION/
RESOURCE CONSIDERATIONS</th><th colspan="3">INTENSITY OF CARE
Average Number of Hours Per Day</th></tr>
<tr><th>LOW</th><th>MEDIUM</th><th>HIGH</th></tr>
<tr><td rowspan="5">Factor I – Availability of Caregivers Living in the Home</td><td>2 or more caregivers; both work or are in school F/T or P/T</td><td>4-8</td><td>6-12</td><td>10-16</td></tr>
<tr><td>2 or more caregivers; 1 works or is in school F/T or P/T</td><td>4-6</td><td>4-10</td><td>10-14</td></tr>
<tr><td>2 or more caregivers; neither works or is in school at least P/T</td><td>1-4</td><td>4-8</td><td>6-12</td></tr>
<tr><td>1 caregiver; works or is in school F/T or P/T</td><td>4-8</td><td>6-12</td><td>10-16</td></tr>
<tr><td>1 caregiver; does not work or is not a student</td><td>1-4</td><td>6-10</td><td>8-14</td></tr>
<tr><td rowspan="2">Factor II – Health Status of Caregiver(s)</td><td>Significant health issues</td><td>Add 2 hours if Factor I <= 8</td><td>Add 2 hours if Factor I <= 12</td><td>Add 2 hours if Factor I <= 14</td></tr>
<tr><td>Some health issues</td><td>Add 1 hour if Factor I <= 7</td><td>Add 1 hour if Factor I <= 9</td><td>Add 1 hour if Factor I <= 13</td></tr>
<tr><td>Factor III – School *</td><td>Beneficiary attends school 25 or more hours per week, on average</td><td>Maximum of 6 hours per day</td><td>Maximum of 8 hours per day</td><td>Maximum of 12 hours per day</td></tr>
<tr><td colspan="5">* Factor III limits the maximum number of hours which can be authorized for a beneficiary:
▪ Of any age in a center-based school program for more than 25 hours per week; or
▪ Age six and older for whom there is no medical justification for a homebound school program.
In both cases, the lesser of the maximum "allowable" for Factors I and II, or the maximum specified for Factor III, applies.</td></tr>
</table>
</td></tr>
<tr><td>MMP 25-47</td><td>11/26/2025</td><td>Throughout the Manual</td><td></td><td>References to ‘MI Health Link” were revised to read:
• “MI Health Link/MI Coordinated Health”, as applicable
• “MI Health Link/MI Coordinated Health HCBS Waiver”, as applicable</td></tr>
</table>

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Medicaid Provider Manual Overview	1.1 Organization	The following text was added to "Chapter Content" for the MI Health Link chapter: The program ended December 31, 2025, and transitioned to the MI Coordinated Health program. Addition of information for new MICH chapter: **Chapter Title:** MI Coordinated Health (MICH) **Affected Providers:** Highly Integrated Dual Eligible Special Needs Plans (HIDE SNPs) and related providers **Chapter Content:** Coverage policy and procedures related to the MI Coordinated Health (MICH) program

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		Beneficiary Eligibility	2.1 Benefit Plans	Addition of: **Benefit Plan ID**: HDE-SNP-MC **Benefit Plan Name**: HIDE SNP - MI Coordinated Health **Benefit Plan Description**: MI Coordinated Health (MICH) is a capitated managed care program for Michigan adults, age 21 or older, who are dually eligible for Medicare and Medicaid. Members with chronic conditions will benefit from better care coordination, person-centered planning, and management of health and long term supports and services. In addition, benefits also include all Medicare and Medicaid physical health services and 1915b/c waiver services for qualifying individuals. MI Coordinated Health (MICH) offers a broad range of medical and behavioral health services, nursing home care, pharmacy and home and community based services through managed care entities called HDE-SNPs and Medicaid's existing Pre-paid Inpatient Health Plans (PIHP). **Type**: Managed Care Organization **Funding Source**: XIX **Covered Services**: 1, 33, 35, 42, 47, 48, 50, 54, 56, 71, 86, 88, 98, AL, CQ, UC
			2.1 Benefit Plans	For Benefit Plan ID 'ICO-MC', the following text was added: NOTE: The program ended December 31, 2025 and transitioned to the MI Coordinated Health program.
			2.2 Program Enrollment Type (PET) Codes	Codes were added applicable to the MI Coordinated Health (MICH) program. Refer to the chapter for full details.

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		Billing & Reimbursement for Institutional Providers	8.2.C.1. Claim Documentation Requirements When Offsetting the Patient-Pay Amount	In the table, under "MI Health Link", text was revised to read: For beneficiaries enrolled in the MI Health Link/MI Coordinated Health program, nursing facilities must still collect and maintain patient-pay amount offset information according to policy. Nursing facilities will not be required to submit this information to MDHHS for the months in which a beneficiary is enrolled in MI Health Link/MI Coordinated Health. Nursing facilities should continue to abide by their individual contracts with the Integrated Care Organizations (ICOs))/Highly Integrated Dual Eligible Special Needs Plans (HIDE-SNPs) as it relates to reporting patient-pay amount offsets when a beneficiary is enrolled in MI Health Link/MI Coordinated Health.
		Electronic Visit Verification	3.2.C. Live-In Caregivers	In the table in the 4th paragraph, text was revised as follows: **Program:** MI Health Link/MI Coordinated Health **Approving Entity:** Integrated Care Organization (ICO)/Highly Integrated Dual Eligible Special Needs Plan (HIDE-SNP) or designee

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		Community Transition Services	Section 9 – Enrollment in Other Programs	Text was revised to read: Some beneficiaries may choose to enroll in other Medicaid programs such as the MI Choice Waiver, MI Health Link/MI Coordinated Health, PACE, or Home Help after the discharge from the nursing facility. TNs may follow these beneficiaries for up to 30 days to ensure previously planned services are completed. Once the beneficiary is enrolled in these other programs, the transition agency must not bill for any new CTS for which there are similar services offered through the other program. If a beneficiary is enrolled in Medicaid managed care with a Medicaid Health Plan, the TN must keep the health plan informed that transition work is occurring and when the transition from the institution to a community setting occurs. ~~If the beneficiary is enrolled in the MI Health Link program when the CTS referral is made to the transition agency, the transition agency must refer that beneficiary back to the MI Health Link Integrated Care Organization with which the beneficiary is enrolled.~~
		Home and Community Based Services	1.2 Effective Date	The 1st paragraph was revised to read: The HCBS Final Rule was effective March 17, 2014. With the exception of the Home and Community Based (HCB) settings requirements, all topics covered by the HCBS Final Rule were effective on this date. The HCBS Final Rule requires programs approved by CMS after March 17, 2014, to be in immediate compliance with the entire HCBS Final Rule, including the settings requirements. The MI Health Link HCBS Waiver was initially approved by CMS for January 1, 2015, and must be in immediate compliance with the HCBS Final Rule. The MI Coordinated Health (MICH) HCBS Waiver was initially approved by CMS on January 1, 2026.

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		Hospice	6.9.D. MI Health Link	The last paragraph was revised to read: (Refer to the MI Health Link Chapter for additional details regarding hospice services under the MI Health Link program. Refer to the MI Coordinated Health Chapter for additional details regarding hospice services under the MI Coordinated Health program.)
		MI Choice Waiver	3.1.A.5. Enrollment in MI Health Link	Text was revised to read: Individuals enrolled in MI Health Link/MI Coordinated Health cannot also enroll in MI Choice. Individuals should be referred to a Medicare/Medicaid Assistance Program counselor for options counseling before deciding to opt-out or disenroll from MI Health Link or disenroll from MI Coordinated Health. Michigan ENROLLS handles all enrollments, disenrollments and opt-outs for MI Health Link. The Highly Integrated Dual Eligible Special Needs Plans (HIDE-SNPs) handle all enrollments, disenrollments, and opt-outs for MI Coordinated Health. All MI Health Link/MI Coordinated Health disenrollments are effective on the last day of a month. Normally, this is the last day of the month of the request. In MI Health Link, for requests made later in the month, the disenrollment may not take effect until the last day of the month following the month of the request. Eligible individuals may enroll in MI Choice after the effective date of the MI Health Link/MI Coordinated Health disenrollment. MI Health Link/MI Coordinated Health has nine PET codes depending upon the living arrangement of the individual. Waiver agencies will need to coordinate enrollments with the MI Health Link/MI Coordinated Health discharge to ensure the proper MI Choice PET sets on the day of MI Choice enrollment. MI Health Link/MI Coordinated Health discharges will be effective on the last day of the month. Therefore, MI Choice must not enroll until the first day of the following month.
		MI Coordinated Health (MICH)		Addition of new chapter.

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		Non-Emergency Medical Transportation	Section 3 – Transportation Authorization	The 2nd paragraph was revised to read: The Medicaid program contracts with Medicaid Health Plans (MHPs) and Integrated Care Organizations (ICOs)/Highly Integrated Dual Eligible Special Needs Plans (HIDE-SNPs), selected through a competitive bid process, to provide services to Medicaid beneficiaries. MHPs and ICOs/HIDE-SNPs are responsible for providing NEMT services to their enrollees for all Medicaid covered services. (For additional information, refer to the Medicaid Health Plans, ~~and~~ MI Health Link, and MI Coordinated Health chapters of this manual.)
			Section 7 – Managed Care Programs	The 1st paragraph was revised to read: The Medicaid program contracts with Medicaid Health Plans (MHPs) and Integrated Care Organizations (ICOs)/Highly Integrated Dual Eligible Special Needs Plans (HIDE-SNPs), 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 services. (For additional information, refer to the Medicaid Health Plans, the MI Coordinated Health, and the MI Health Link chapters of this manual.)
		Nursing Facility Level of Care Determination	2.3 Program Specific Eligibility Requirements	Text was revised to read: In addition to meeting Medicaid financial and functional eligibility requirements, individuals must also meet all program specific requirements before they can be determined eligible for that program. (Refer to the Nursing Facility Coverages, the MI Choice Waiver, the Program of All-Inclusive Care for the Elderly, the MI Coordinated Health, and the MI Health Link chapters or to provider contracts for specific program requirements.) This chapter applies only to the LOCD process and is not intended to replace program-specific requirements.

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			4.8 Door 8: Frailty	Text was revised to read: MDHHS or its designee determined that the beneficiary is eligible for Medicaid LTSS services based upon the Frailty Criteria. Individuals who exhibit certain behaviors and treatment characteristics that indicate frailty may be admitted or enrolled to LTSS programs requiring an LOCD. The individual needs to trigger one element of this criteria to be considered for Frailty. Refer to the Michigan Medicaid Nursing Facility Level of Care Determination Exception Process on the MDHHS website for more information. (Refer to the Directory Appendix for website information.) For the MI Health Link/MI Coordinated Health program, the Frailty Criteria are applied by the Integrated Care Organization/Highly Integrated Dual Eligible Special Needs Plan.
		Acronym Appendix		Addition of: Bi-PAP - Bilevel positive airway pressure CEAC - Counties with Extreme Access Considerations ECLS - Expanded Community Living Supports FCC – Federal Communications Commission FDR – First Tier, Downstream, and Related Entity FI – Fiscal Intermediary HEDIS - Healthcare Effectiveness Data and Information Set HIDE SNP – Highly Integrated Dual Eligible Special Needs Plan HIV/AIDS - Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome HRA – Health Risk Assessment HRAT – Health Risk Assessment Tool HRSN – Health-Related Social Needs

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				ICP – Individualized Care Plan ICT – Integrated Care Team LIS – Low Income Subsidy LOCD-VR – level of care determination verification review MHL – MI Health Link MICH – MI Coordinated Health MME – Medicare-Medicaid eligible mmHG – millimeters of mercury MOC – model of care MSSSP - Managed Specialty Services and Supports Program NMT – non-medical transportation PASRR - Preadmission Screening and Resident Review PCA – Personal Care Assessment P02 - partial pressure of oxygen PPA – Patient Pay Amount prn – pro re nata (as needed) QI - Qualified Individual RAI HC – Resident Assessment Instrument Home Care RAI HC/iHC - Resident Assessment Instrument Home Care/InterRAI Home Care Assessment RTS – Reasonable Time Schedule SMAC - State Medicaid Agency Contract STI - sexually transmitted infections TDD – Technology for the Deaf and Disabled UCC – urgent care center UL – Underwriters Laboratories

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		Directory Appendix		Addition of MI Coordinated Health (MICH) section.
		Forms Appendix		• BPHASA-2421; Live-In Caregiver Attestation Reflects removal of "MI Health Link" checkbox and addition of "MI Coordinated Health" checkbox in Section 2. • DHS-390; Adult Services Application Form was removed from the Forms Appendix.

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MMP 25-51	11/26/2025	Medical Supplier	2.19 Incontinent Supplies	Under "**Standards of Coverage**", text was revised to read: **Intermittent catheters** are covered when catheterization is required due to severe bladder dysfunction. ~~**Hydrophilic-coated intermittent catheters are considered for individuals that have Mitrofanoff stomas, partial stricture or small, tortuous urethras.**~~ **Intermittent catheters with insertion supplies** are covered for beneficiaries who have a chronic urinary dysfunction for which sterile technique is clinically required. Under "**Documentation**", the last paragraph was revised to read: In addition to the above documentation: ~~requirements,~~ Intermittent Catheters: The ordering practitioner is required to provide supporting documentation substantiating the medical/functional need when ordering the following: • Coude (curved) tip rather than a straight tip catheter. • Hydrophilic coated rather than uncoated or other coating type catheter. • Medical need for intermittent catheter with insertion supply sterile kit rather than clean catheterization. **Note**: Children's Special Health Care Services (CSHCS) beneficiaries require a prescription from a CSHCS-authorized physician subspecialist.

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				Pull-on briefs require the following: • An initial nursing assessment for all ages, regardless of whether the pull-on briefs will be used short or long term. • A six-month reassessment is required for under 21 years of age or a time determined by MDHHS. • If the beneficiary has a medical condition that results in permanent incontinence, reassessment is required annually or a time determined by MDHHS. • For under age 21 and attending school, a copy of the teacher's continence report or a letter from the school detailing the bowel/bladder plan. The reassessment must have a copy of the teacher's plan or school letter detailing any changes to the plan and progress made since the last assessment. Under "**PA Requirements**", text was revised to read: ~~PA is required for:~~ ~~• Hydrophilic type urinary catheters.~~ ~~• usage over the established quantities.~~ ~~PA is not required for all other incontinent items unless usage exceeds established quantity limitations.~~ PA is required for medical need beyond the standards of coverage and for usage over the established quantity limits.

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<tr><td></td><td></td><td></td><td></td><td>Under "Services Covered Through the Contract", the following codes were added:

<table>
<tr><th>HCPCS Code</th><th>Nomenclature</th><th>CSHCS Coverage</th><th>Mandatory for Medicaid/ Medicare</th></tr>
<tr><td>A4295</td><td>Straight tip hydrophilic cath</td><td>X</td><td></td></tr>
<tr><td>A4296</td><td>Coude tip hydrophilic cath</td><td>X</td><td></td></tr>
<tr><td>A4297</td><td>Hydrophilic coat insert sup</td><td>X</td><td></td></tr>
</table></td></tr>
<tr><td rowspan="2">MMP 25-53</td><td rowspan="2">11/26/2025</td><td>Behavioral Health and Intellectual and Developmental Disability Supports and Services</td><td>Section 22 – Home and Community-Based Services (HCBS) Final Rule – Behavioral Health</td><td>Addition of new section.</td></tr>
<tr><td>Acronym Appendix</td><td></td><td>Addition of:
CIE – Competitive Integrated Employment</td></tr>
</table>

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MMP 25-55	11/26/2025	Early and Periodic Screening, Diagnosis and Treatment	6.1 Maternal Depression Screening	Subsection text was replaced in its entirety. New text reads: Michigan Medicaid covers EPSDT services, including maternal depression screenings, in accordance with the AAP periodicity schedule, its components, and medical guidelines. The AAP periodicity schedule indicates a maternal depression screening is to be performed during each EPSDT well child visit beginning by one month of age and up to six months of age of the child. In accordance with Public Act 246 of 2024, Michigan Medicaid covers maternal depression and/or mental health screenings for individuals who have given birth which are conducted at follow-up appointments or well child visits up to 12 months postpartum. Mental health screenings are covered for follow-up appointments for individuals who have given birth and for well child visits during the postpartum period if the provider is seeing the individual in a pediatric or obstetric and gynecological setting and the provider determines at the follow-up appointment or well child visit that a mental health screening is appropriate for the individual. Providers in other settings (e.g., family practice or internal medicine) may also provide mental health screenings following the same process when appropriate. A maternal depression and/or mental health screening conducted by a provider using an evidence-based validated and standardized screening tool (such as the Edinburgh scale) assesses an individual's maternal mental health, depression, or other postpartum risk factors. When the maternal depression and/or mental health screening is conducted during the child's visit, the service should be reported under the child's Medicaid ID number as it is considered a service rendered for the benefit of the child. When the maternal depression and/or mental health screening is conducted by a provider during a visit for the postpartum individual such as, but not limited to, a follow-up visit in a primary care or obstetric and gynecological setting, the service should be reported under the postpartum individual's Medicaid ID number.

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				If the screening is positive, the primary care provider (PCP) should address the mother-child dyad relationship (attachment and bonding), follow-up, and refer as appropriate. If the child's PCP or other provider determines that a postpartum individual may be in need of mental health resources in addition to a mental health screening, the provider may furnish the individual with mental health resources including: • Information regarding postpartum mental health conditions and their symptoms; • Treatment options for postpartum mental health conditions; • Referrals considered appropriate by the provider for the individual; and • Any additional supports, services, or information considered appropriate by the provider to support the individual.

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