MDHHS
Michigan Department of Health & Human Services

BULLETIN

Michigan Medicaid Policy (MMP) | Health Services

Bulletin Number: MMP 26-22

Distribution: All Providers

Issued: June 1, 2026

Subject: Updates to the MDHHS Medicaid Provider Manual

Effective: July 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 July 2026 update of the online version of the MDHHS Medicaid Provider Manual. The manual will be available July 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
July 2026 Updates

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
General Information for Providers	11.1 Billing Provider	The last paragraph was revised to read: Providers rendering services to residents of the Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) may not bill Medicaid directly. All covered services (e.g., laboratory, x-rays, medical surgical supplies including ~~incontinent~~ incontinence supplies, hospital emergency rooms, clinics, optometrists, dentists, physicians, and pharmacy) are included in the per diem rate.	Clarification.
Beneficiary Eligibility	2.1 Benefit Plans	The benefit plan informational chart was removed. Individuals should refer to the Benefit Plan ID table posted on the MDHHS website at www.michigan.gov/mdhhs >> Resources >> Beneficiary Eligibility Verification >> Benefit Plans >> Benefit Plan ID table. NOTE: Website information is available in the Directory Appendix of the Manual.	Update.
Billing & Reimbursement for Institutional Providers	6.2.C Special Circumstances for Hospital Readmissions and Transfers	Under "Neonatal Intensive Care Unit (NICU) Transfers", the last paragraph was revised to read: All ~~elective~~ newborn transfers must be authorized by MDHHS. Authorization for emergent/urgent transfers must be requested by the next business day. Existing hospital and ambulance transfer reimbursement methodology will be utilized when prior authorization is granted. Under "Transfers", the following text was added: • Transfers from an off-campus outpatient hospital (OPH) (including Free Standing Emergency Departments) to an inpatient hospital (IPH) with the same tax ID as the originating OPH do not require prior authorization. All charges from the OPH and IPH must be submitted on one claim for the services provided. • Transfers from an OPH (including Free Standing Emergency Departments) to an IPH with a different tax ID than the originating OPH do not require prior authorization. The OPH and IPH must submit separate claims for the services provided.	Clarification

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Medicaid Provider Manual
July 2026 Updates

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CHAPTER	SECTION	CHANGE	COMMENT
Billing & Reimbursement for Institutional Providers	8.11 Ancillary Physical and Occupational Therapy, Speech Pathology	The textbox after the 2nd paragraph was revised to read: When billing, facilities must enter the PA number from the Medicaid authorization ~~form~~ letter on the claim. If a beneficiary is approved for both complex care and therapy services, one PA number is issued for both complex care and therapy.	Providers no longer receive the authorization form back -- they get an authorization letter (via mail and/or accessible to providers in CHAMPS).
Behavioral Health and Intellectual and Developmental Disability Supports and Services	2.1 Mental Health and Developmental Disabilities Services	The last bullet point was revised to read: • Discuss with the beneficiary during the person-centered planning process all components of services (i.e., for CLS, this includes components such as transportation, activities, staff wages, employer costs, training time) as well as the amount, scope, duration, and frequency of each such component that may be medically necessary for the participant. Components of services are defined in relevant service sections of the Medicaid Provider Manual. ~~and~~ Billing guidance, service requirements, and provider qualifications are defined in the Behavioral Health Code Charts and Provider Qualifications document available on the MDHHS website.	Clarification.
Behavioral Health and Intellectual and Developmental Disability Supports and Services	3.21.B. Peer Specialist Services	The subsection title was revised to read: Peer Support Specialist Services Extensive revisions were made to the subsection. Refer to the chapter for full content.	
Behavioral Health and Intellectual and Developmental Disability Supports and Services	3.21.C. Peer Recovery Coach Services	Extensive revisions were made to the subsection. Refer to the chapter for full content.	

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CHAPTER	SECTION	CHANGE	COMMENT
Behavioral Health and Intellectual and Developmental Disability Supports and Services	3.21.D. Youth Peer Support Services	The 1st paragraph was revised to read: Youth Peer Support is a peer-delivered service for youth and young adults. It is designed to support youth and young adults with a serious emotional disturbance/serious mental illness (SED/SMI) through shared activities and interventions in the form of non-judgmental support, connection through lived experience and supporting self-advocacy. A youth and/or young adult with an intellectual or developmental disability, including Autism, in addition to SED or SMI, may also qualify for Youth Peer Support. The decision to engage in the service must be directed by the youth or young adult and determined by their ability to participate in the service as intended.	Adding language to further clarify current eligibility requirements.
Behavioral Health and Intellectual and Developmental Disability Supports and Services	3.24 Prevention-Direct Service Models	Under "Infant Menal Health", the 1st paragraph was revised to read: Provides home-based parent-infant support and therapeutic intervention services, using ~~the~~ an evaluated ~~Infant Mental Health Home Visiting~~ model ~~(perinatal people, birth to 36 months)~~, to families where the parent's condition and life circumstances, or the characteristics of the infant, threaten the parent-infant attachment and the consequent social, emotional, behavioral and cognitive development of the infant. Services reduce the incidence and prevalence of abuse, neglect, developmental delay, behavioral and emotional disorder and promote healthy attachment, resilience and optimal mental health for both the infant and parent/primary caregiver. PIHPs or their provider networks may provide infant mental health services, in the home or community based setting, as a specific service when it is not part of a MDHHS-certified home-based program.	Removed specific reference to one evaluated model. There are other models (i.e., Child-Parent Psychotherapy) which would be appropriate for this relationship-based service.

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CHAPTER	SECTION	CHANGE	COMMENT
Behavioral Health and Intellectual and Developmental Disability Supports and Services	3.31.A. Organizational Structure	The 1st paragraph was revised to read: The required organizational structure of ~~Wraparound~~ ICCW must include a Child and Family Team, ICCW Care Coordinator, ICCW supervisor, and Community Team. Under the 1st bullet point, the last sub-bullet point was revised to read: ➢ If coordinators are assigned to other programs as well as ICCW, the number of child/youth and family teams they facilitate shall correlate to the percentage of their position dedicated to providing ~~Wraparound facilitation~~ ICCW.	
Behavioral Health and Intellectual and Developmental Disability Supports and Services	3.31.B. Qualified Staff	In the 1st paragraph, the last bullet point was revised to read: • If coordinators are assigned to other programs as well as ICCW, the number of child/youth and family teams they facilitate shall correlate to the percentage of their position dedicated to providing ~~Wraparound facilitation~~ ICCW. In the 2nd paragraph, 9th bullet point, the last sub-bullet point was removed: ➢ ~~Complete an additional 16 hours of annual training related to provision of support to children, youth, or young adults and their families when supervising the provision of ICCW to those served under the SEDW.~~ In the 3rd paragraph, the 5th bullet point was revised to read: • Align internal policies and procedures, contracts and/or memorandums of understanding with ~~Wraparound~~ ICCW philosophy and ~~ICCW~~ policy.	
Behavioral Health and Intellectual and Developmental Disability Supports and Services	3.31.C. Amount and Scope of Service	In the 1st paragraph, the last bullet point was revised to read: • Frequency and scope (face-to-face, in person and virtual ~~and telephone~~) of other ICCW monitoring activities must reflect the intensity of the child, youth or young adult's health and welfare needs	

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CHAPTER	SECTION	CHANGE	COMMENT
Behavioral Health and Intellectual and Developmental Disability Supports and Services	3.31.D.2. Child Caring Institutions (CCI) and State Hospitals	The 1st bullet point was revised to read: • ICCW is covered by Medicaid for up to 180 days while in placement for the purpose of transition back to the community; ~~Wraparound~~ ICCW must be suspended once the child/youth has been placed for more than 180 days. When ~~Wraparound~~ ICCW-enrolled children/youth are placed at a CCI, including a Qualified Residential Treatment Program (QRTP), or State Hospitals, transition planning should begin immediately in conjunction with the Wraparound Child and Family Team and facility staff.	
Behavioral Health and Intellectual and Developmental Disability Supports and Services	3.31.E. Child and Family Team Plan and Wraparound Planning Process	Under "Safety/Crisis Plan", the last bullet point was revised to read: • Safety/Crisis plans must be developed with fidelity to the MDHHS ~~Wrapround~~ ICCW model. Under "Wraparound Plan", the last bullet point was revised to read: • Wraparound Plan elements must be developed with fidelity to the MDHHS ~~Wraparound~~ ICCW model and must include the identification of functional strengths and needs assessment for each member of the family. Under "Wraparound Team Meeting Minutes", the last bullet point was revised to read: • Meeting minutes elements must comply with documentation requirements for MDHHS ~~Wraparound~~ ICCW model fidelity monitoring. Under "Graduation Summary", the last bullet point was revised to read: • The Graduation summary elements must be developed with fidelity to the MDHHS ~~Wraparound~~ ICCW model.	

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CHAPTER	SECTION	CHANGE	COMMENT
Behavioral Health and Intellectual and Developmental Disability Supports and Services	Section 14 – Children's Home and Community-Based Services Waiver (CWP)	The last paragraph was removed: ~~Services, equipment and Environmental Accessibility Adaptations (EAAs) that require prior authorization from MDHHS must be submitted to the CWP Clinical Review Team at MDHHS. The team is comprised of a physician, registered nurse, psychologist, and licensed master's social worker with consultation by a building specialist and an occupational therapist.~~	
Behavioral Health and Intellectual and Developmental Disability Supports and Services	20.3.F. Beneficiary Disenrollment	The last paragraph was revised to read: ~~Other than~~ Excluding beneficiary-initiated disenrollment, disengaged beneficiaries will be categorized into one of the following two groups, which have ~~unique~~ distinct disenrollment processes: • Beneficiaries who have ~~moved~~ relocated out of an eligible geographic area, are deceased, or are otherwise no longer eligible for the Medicaid program. These beneficiaries will have their eligibility files updated ~~per~~ in accordance with ~~the~~ standard MI Bridges protocol. Providers will receive updated files accordingly. • Beneficiaries who are unresponsive for reasons other than ~~moving~~ relocation or death. The PIHP or HHP must ~~make~~ document at least three unsuccessful ~~beneficiary~~ contact attempts within three consecutive months for MDHHS to deem a beneficiary as unresponsive. During this time, the beneficiary must remain enrolled in BHH. Once a beneficiary is deemed unresponsive, the PIHP can disenroll the beneficiary from the BHH. 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 for a year or until eligibility changes.	

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CHAPTER	SECTION	CHANGE	COMMENT
Behavioral Health and Intellectual and Developmental Disability Supports and Services	20.5.D. Provider Infrastructure Requirements	The 1st paragraph was revised to read: HHPs, through the PIHP, will ensure beneficiary access to an interdisciplinary care team that addresses the beneficiary's behavioral and physical health needs. ~~The requirements will span two settings – the PIHP and the HHP providers.~~ Each service setting, PIHP and HHP ~~will have~~ has its own unique set of requirements commensurate with the scope of ~~their~~ its operations to reflect beneficiary needs. The staffing structure below is based on 100 beneficiaries enrolled in the health home. The last paragraph was revised to read: In addition, ~~to the above Provider Infrastructure Requirements, eligible~~ BHH providers should coordinate care, as appropriate, with other health care and community-based partners. Examples include, but are not limited to: ~~with the following professions:~~	
Behavioral Health and Intellectual and Developmental Disability Supports and Services	20.7 Provider Disenrollment	Text was revised to read: To ~~maximize~~ promote continuity of care and the patient-provider relationship, MDHHS expects HHPs to establish and maintain ~~a~~ lasting relationships with enrolled beneficiaries. ~~However,~~ A HHP~~s~~ ~~wishing~~ that elects to discontinue participation in the BHH ~~services~~ program must ~~notify the regional~~ submit written notice to the PIHP and MDHHS at least six months ~~in advance of ceasing BHH operations~~ prior to the intended termination date. ~~BHH services may not be discontinued without MDHHS approval of a provider-created cessation plan and protocols for beneficiary transition.~~ MDHHS will review and approve cessation plans.	
Behavioral Health and Intellectual and Developmental Disability Supports and Services	20.8.A. BHH Case Rates to the PIHP	Text was revised to read: MDHHS will maintain ~~a fee schedule of the BHH case rate~~ detailed rate information on the MDHHS BHH website, in the BHH Handbook, and in the MDHHS Health Services Service Encounter Coding Chart. MDHHS will review ~~the case~~ rates ~~at least~~ annually and ~~make updates~~ adjust as appropriate, with a minimum rebasing every three years.	

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CHAPTER	SECTION	CHANGE	COMMENT
Behavioral Health and Intellectual and Developmental Disability Supports and Services	20.8.B. PIHP Payment to Health Home Partners	Text was revised to read: MDHHS will provide a monthly case rate to the PIHP based on the number of BHH beneficiaries with at least one BHH service during a calendar month. The PIHP will reimburse the HHP for delivering health home services. PIHPs must have a monitoring plan in place to review BHH services and ensure appropriate billing. Depending on the current services provided by the HHP, the PIHP may negotiate a rate with the HHP for value-based payment while following the guidelines below, requirements in the approved SPA, policy, and the BHH Handbook.	
Behavioral Health and Intellectual and Developmental Disability Supports and Services	20.8.C. Pay-For-Performance	The 1st paragraph was revised to read: MDHHS will ~~afford~~ offer P4P via a 5% performance withhold. The PIHP must distribute P4P ~~monies~~ funds to HHPs that meet ~~the~~ established quality improvement benchmarks in accordance with the approved SPA, policy, and BHH Handbook. HHPs that have been active participants in the BHH program for the entire performance year are eligible to receive P4P payments. MDHHS 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 withhold will be reserved by MDHHS and reinvested for BHH monthly case rate payments.~~ If performance benchmarks for a given performance year are not met by any region, the P4P funds will be distributed equally among providers with a recoupment rate below 30%. Subsequent performance years will operate in accordance with this structure. The methodology for metrics, specifications, and distribution will be maintained on the MDHHS BHH website and in the BHH Handbook.	

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Behavioral Health and Intellectual and Developmental Disability Supports and Services	21.4.A.1. Ages Prenatal/Birth Through 5	In the chart, under "Complexity", text for Criterion D was revised to read: A rating of '2' or '3' on any of the following Life Functioning~~,~~; and Developmental Module~~/, and~~ Autism Spectrum Module items: • Family Functioning • Social & Emotional Functioning • Early Care & Education Attendance • Early Care & Education Behavior • Early Care & Education Achievement • ~~Communication (Expressive/Receptive)+~~ • Sensory Responsiveness~~**~~ • Receptive Communication~~**~~ • Expressive Language~~**~~ • Restricted Interests~~**~~ Footnotes were removed: ~~+Developmental Module item~~ ~~**Autism Spectrum Module item~~	

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CHAPTER	SECTION	CHANGE	COMMENT
Behavioral Health and Intellectual and Developmental Disability Supports and Services	21.5.A.1. Ages Birth Through 5	In the chart, under "Complexity", text for Criterion C was revised to read: A rating of '1', '2' or '3' on any of the following Life Functioning~~,~~; and Developmental Module~~, and~~/Autism Spectrum Module items: • Family Functioning • Social & Emotional Functioning • Early Care & Education Attendance • Early Care & Education Behavior • Early Care & Education Achievement • Communication (Expressive/Receptive) + • Sensory Responsiveness** • Receptive Communication** • Expressive Language** • Restricted Interests** Footnotes were removed: ~~+ Developmental Module item~~ ~~**Autism Spectrum Module item~~	

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CHAPTER	SECTION	CHANGE	COMMENT
Behavioral Health and Intellectual and Developmental Disability Supports and Services	21.6.A.1 Ages Birth through 5	In the chart, under "Complexity", text for Criterion C was revised to read: At least one rating of '3' or two or more ratings of '2' on any of the following Life Functioning~~,~~; and Developmental Module~~, and~~/Autism Spectrum Module items or item groups*. • Family Functioning • Social & Emotional Functioning • Sensory Responsiveness~~**~~ • Restricted Interests~~**~~ • Communication* -- either ➢ ~~Communication (Expressive/Receptive)+,~~ ➢ Receptive Communication~~**~~, or ➢ Expressive Language~~**~~ • Early Care & Education* – either ➢ Attendance, or ➢ Behavior, or ➢ Achievement Footnotes were removed: ~~+Developmental Module item~~ ~~**Autism Spectrum Module item~~	

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Brain Injury Services	Section 6 – Reimbursement	Text was revised to read: Reimbursement for Transitional Residential BIS will be according to per diem rates, negotiated with the BIS providers, which reflect the service needs of the beneficiary and a reasonable cost basis for the services rendered. PA is required for the Transitional Residential BIS per diem reimbursement. Requests for PA are submitted for days of services, not for individual services (for example, PA request is for 60 days of BIS, regardless of services provided). Providers should contact the MDHHS HCBS Section regarding BIS authorization requirements. ~~(Refer to the Prior Authorization section of the General Information for Providers chapter of this manual for additional information.)~~ Reimbursement for Outpatient BIS will be according to a published fee schedule based upon the services received by the beneficiary. PA is required for Outpatient BIS reimbursement. Requests for PA are submitted for individual services for a specified duration (for example, PA request is for 30 days of physical therapy BIS for eight 15-minute units per day). Providers should contact the MDHHS HCBS Section regarding BIS authorization requirements. ~~(Refer to the Prior Authorization section of the General Information for Providers chapter of this manual for additional information.)~~	Removal of obsolete information.
Children's Special Health Care Services	Section 1 – General Information	The 2nd paragraph was revised to read: Medicaid beneficiaries with CSHCS coverage are assigned to a CSHCS benefit plan. ~~(Refer to the Benefit Plan table in the Beneficiary Eligibility Chapter of this manual.)~~ (Refer to the Benefit Plan ID table on the MDHHS website for additional information. Refer to the Directory Appendix for website information.) As a Medicaid benefit plan, the CSHCS program is fully integrated into Medicaid. CSHCS is a part of the Medicaid benefit package for clients enrolled in both Medicaid and CSHCS. Most Medicaid beneficiaries with CSHCS coverage are required to enroll in a Medicaid Health Plan. CSHCS strives to enroll CSHCS beneficiaries into Medicaid when they are eligible in order to access the broader range of medical services that are covered by Medicaid.	Update.

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CHAPTER	SECTION	CHANGE	COMMENT
Home Help	5.3.C. Requests for Service Changes	Text was revised to read: A client requesting an increase in Home Help services must participate in a new review and comprehensive assessment ~~update~~ with the ASW before the increase can be authorized. The ~~update~~ review and comprehensive assessment may take place in person or by phone. If the client is non-verbal or requests an in-person visit, the ~~update~~ review and comprehensive assessment must be conducted in person in the client's home.	Combines the policies in this section and Section 5.3.E. Requests for Service Changes.
Home Help	5.3.E. Requests for Service Changes	Subsection was deleted. ~~A client who requests a change in Home Help services must participate in a new review and comprehensive assessment with the ASW before payment can be authorized. The review and comprehensive assessment may take place in person or by phone. If the client is non-verbal or requests an in-person visit, the review and comprehensive assessment must be conducted in person in the client's home.~~	Incorporated into Section 5.3.C. Requests for Service Changes.
Home Help	8.5.B. New Agency Provider Compliance Review	In the 1st paragraph, the last bullet point was revised to read: • Three months of payroll records that must include agency caregiver names, pay period dates, payment amounts, Federal Insurance Contributions Act (FICA) withholdings, and proof of compliance with state unemployment insurance filings and payments. If payroll records do not verify tax payments, the agency provider may need to submit ~~State of Michigan Form UIA 1028~~ State of Michigan Employer's Quarterly Wage/Tax Reports and IRS Form 941.	

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CHAPTER	SECTION	CHANGE	COMMENT
Hospital	3.21 Laboratory	The 2nd paragraph was revised to read: Medicaid covers hospital laboratory services and pathology procedures reasonable and necessary to guide detection, diagnosis, management, and/or treatment of a specific medical condition, illness, or injury. ~~and~~ Medicaid also covers a limited number of screening laboratory tests ~~associated with preventive services assigned a grade A or B by the United States Preventive Services Task Force (USPSTF)~~ including, but not limited to, those specified for the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program, recommended as Grade A or B by the United States Preventive Services Taskforce, or identified in Medicaid policy. In the 3rd paragraph, the 1st bullet point was revised to read: • Recommended and ordered by the beneficiary's treating physician~~, podiatrist, physician assistant, nurse practitioner, clinical nurse specialist, dentist, or CNM according to their scope of practice~~ or other licensed practitioner working within their scope of practice as determined under State law.	Clarification.

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CHAPTER	SECTION	CHANGE	COMMENT
Medical Supplier	2.19 Incontinent Supplies	The subsection title was revised to read: ~~Incontinent~~ Incontinence Supplies Under "Definition", the 1st and 2nd paragraphs were revised to read: ~~Incontinent~~ Incontinence supplies are items used to assist individuals with the inability to control excretory functions. The type of coverage for ~~incontinent~~ incontinence supplies may be dependent on the success or failure of a bowel/bladder training program. A bowel/bladder training program is defined as instruction offered to the beneficiary to facilitate: Under "Payment Rules", the 1st paragraph was revised to read: **Volume Purchase Agreement** - Through a competitive bid process, the State of Michigan has contracted with a volume purchase contractor for selected ~~incontinent~~ incontinence supplies for beneficiaries enrolled in Medicaid FFS and CSHCS.	Clarification.
MI Choice Waiver	9.11 Additional General Requirement for Providers	The 2nd bullet point was revised to read: • Waiver agencies and service providers enter into contractual agreements that include required assurances for nondiscrimination, minimum provider service standards, and contract requirements included in 42 CFR §434, 42 CFR §438, and the MDHHS ~~Medical Services Administration (MSA)~~ Health Services provider enrollment agreement.	Update.

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CHAPTER	SECTION	CHANGE	COMMENT
MI Choice Waiver	10.4.C. Critical Incident Reporting	The 1st paragraph was revised to read: Waiver agencies are responsible for tracking and responding to individual critical incidents using the Critical Incident Reporting web-based system. The online system allows MDHHS to review the reports in real time and ask questions or address concerns with the waiver agencies. MDHHS must receive notification from waiver agencies of suspicious deaths within two business days. Waiver agencies submit critical incident reports to ~~the~~ MDHHS~~, MSA~~ Health Services, Home and Community Based Services Section as they occur using the Critical Incident Management System.	Update.
MI Coordinated Health	1.2.A.4. Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL)	The table after the 1st paragraph was revised to read: 1 | **Independent** | The enrollee performs the activity with no human assistance. 2 | **Verbal assistance** | The enrollee performs the activity with verbal assistance such as reminding, guiding or encouraging. 3 | **Minimal assistance** | The enrollee performs the activity with some direct physical assistance and/or assistance technology. 4 | **Moderate assistance** | The enrollee performs the activity with a great deal of human assistance and/or assistive technology. 5 | **Dependent** | The enrollee does not perform the activity even with human assistance and/or assistance technology.	

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CHAPTER	SECTION	CHANGE	COMMENT
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 Settings: Homes supervised by Community Mental Health (CMH) with three or four residents all receiving CMH services. Supported Independent Settings do not need to be licensed unless one of the residents is not receiving CMH services. Residents of a Supported Independent Setting could qualify for PCS. The person who owns, rents, or leases the Supported Independent Setting cannot be the individual caregiver or agency provider of the ~~Home Help client~~ enrollee.	
MI Coordinated Health	1.2.A.11. Resident Care Agreements in AFC Licensed Settings	The 1st paragraph was revised to read: Licensed AFC settings require Resident Care Agreements to indicate care needs, payment for room and board and services, among other things. These agreements must be signed by the ~~resident~~ enrollee or their authorized/legal representative or guardian and the HIDE SNP as soon as possible since the HIDE SNP is responsible for paying the personal care supplement payment.	
MI Coordinated Health	1.2.A.14. Continuity of Care for Personal Care Services	In the 1st paragraph, the bullet points were revised to read: • 180 calendar days for enrollees receiving services through the PIHP under the Managed Specialty Services and Supports Program (MSSSP) or Habilitation Supports Waiver • 90 calendar days for all other enrollees	
MI Coordinated Health	1.2.B. Home and Community Based Services (HCBS) Waiver Services	The last paragraph was revised to read: Enrollees must receive at least one waiver service each month to remain on the waiver. The HIDE SNP and ~~direct service~~ HCBS waiver providers must adhere to the service definition and operating standards to be eligible to receive payment of waiver expenses. Waiver service codes can be found in the MICH HCBS Waiver Services Resource document. (Refer to the Directory Appendix for document location information.)	

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CHAPTER	SECTION	CHANGE	COMMENT
MI Coordinated Health	1.2.B.1. Adaptive Medical Equipment and Supplies	The 8th paragraph was revised to read: Where feasible, the HIDE SNP and/or ~~direct service~~ Adaptive Medical Equipment and Supplies provider shall seek confirmation of the need for the item from the enrollee's physician. The 12th paragraph was revised to read: ~~Direct service~~ Adaptive Medical Equipment and Supplies providers must enroll in Medicare and Medicaid as a Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) provider, pharmacy, etc., as appropriate. Medicare and Medicaid enrollment must be verified at the beginning of service delivery and annually thereafter.	
MI Coordinated Health	1.2.B.2. Adult Day Program	The 5th paragraph was revised to read: A referral from a HIDE SNP for an ~~waiver~~ enrollee shall replace any screening or assessment activities performed for other Adult Day Program individuals at the setting. The direct Adult Day Program service provider shall accept copies of the HIDE SNP's assessments and ICP to eliminate duplicate assessment and service planning activities.	
MI Coordinated Health	1.2.B.3. Assistive Technology	The 4th paragraph was revised to read: Items must be of direct medical or physical benefit to the enrollee. Where feasible, the HIDE SNP and/or ~~direct service~~ Assistive Technology provider must seek confirmation of the need for the item from the enrollee's physician. It must be documented in the ICP that the item is the most cost-effective alternative to meeting the enrollee's needs. Items must meet applicable standards of manufacture, design, and installation. There must be documentation that the best value in warranty coverage was obtained at the time of purchase.	

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MI Coordinated Health	1.2.B.4. Chore Services	The 1st paragraph was revised to read: Chore Services include those duties needed to maintain the home in a clean, sanitary, and safe environment to provide safe access inside the home, and yard maintenance and snow plowing to provide access to and egress outside of the home. This service includes tasks such as heavy household chores (washing floors, windows, and walls), tacking loose rugs and tiles, moving heavy items of furniture, mowing, raking, cleaning hazardous debris such as fallen branches and trees, weatherization, and pest control. The service may include materials and disposable supplies used to complete chore tasks. The HIDE SNP may also use waiver funds to purchase or rent the equipment or tools used to perform chore tasks for ~~waiver~~ enrollees.	

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CHAPTER	SECTION	CHANGE	COMMENT
MI Coordinated Health	1.2.B.5. Environmental Modifications	The 7th paragraph was revised to read: The enrollee, with the direct assistance of the HIDE SNP care coordinator/LTSS coordinator when necessary, must make a reasonable effort to access all available funding sources, such as housing commission grants, Michigan State Housing Development Authority (MSHDA) and community development block grants. The enrollee's record must include evidence of efforts to apply for alternative funding sources and the acceptances or denials of these funding sources. The MICH waiver is a funding source of last resort. • HIDE SNP care coordinators must document any attempts they make to secure alternate funding (discussion with family on resources, internet research, phone calls, emails, etc.) in their case notes. • A signed and dated statement by the HIDE SNP care coordinator that they have made diligent attempts and were unable to find and/or secure alternative payment sources will satisfy this requirement for the Environmental Modification service. • If, in the HIDE SNP care coordinator's assessment, the process to secure alternate funding sources (once initiated) will create a barrier to timely access to needed services that will have a negative impact on the enrollee's health and welfare, the HIDE SNP care coordinator should document this assessment and may proceed with implementing the environmental modification. The 10th paragraph was revised to read: The HIDE SNP may use MICH funds for labor costs and to purchase materials used to complete the modification to prevent or remedy a safety hazard. The ~~direct service~~ Environmental Modifications provider shall provide the equipment or tools needed to perform the tasks unless another source can provide the equipment or tools at a lower cost or free of charge and the provider agrees to use those tools.	

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
MI Coordinated Health	1.2.B.6. Expanded Community Living Supports	In the 2nd paragraph, 2nd bullet point, the last sub-bullet point was revised to read: ➢ Observing and reporting to the HIDE SNP care coordinator any changes in the enrollee's condition and the home environment In the 4th paragraph, the 1st bullet point was revised to read: • The HIDE SNP may not use MICH funds to purchase or lease vehicles for providing transportation services to ~~waiver~~ enrollees. The 16th paragraph was revised to read: With the assistance of the enrollee and/or enrollee's caregiver, the HIDE SNP or ~~direct service~~ ECLS provider shall determine an emergency notification plan for each enrollee pursuant to each visit for emergencies and provider no-shows or late arrivals.	
MI Coordinated Health	1.2.B.8. Home Delivered Meals	The 2nd paragraph was revised to read: Each HIDE SNP must have written eligibility criteria for ~~persons~~ each enrollee receiving home delivered meals through the waiver which include, at a minimum:	
MI Coordinated Health	1.2.B.9. Individual Directed Goods and Services	The 3rd paragraph was revised to read: Goods and Services are only approved by CMS for self-direction enrollees. Experimental or prohibited treatments are excluded. Goods and Services must be documented in the ~~IPOS~~ ICP and must be clearly linked to an assessed enrollee need in the ICP.	

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
MI Coordinated Health	1.2.B.10. Non-Medical Transportation	The 3rd paragraph was revised to read: Transportation vehicles must be properly licensed and registered by the State and must be covered with liability insurance. MICH funds may not be used to purchase or lease vehicles for providing transportation services to ~~waiver~~ enrollees. All paid drivers for transportation providers supported entirely or in part by MICH funds shall be physically capable and willing to assist ~~persons~~ enrollees requiring help to and from and to get in and out of vehicles. The provider shall offer such assistance unless expressly prohibited by either a labor contract or insurance policy. The provider shall train all paid drivers for transportation programs supported entirely or in part by waiver funds to cope with medical emergencies, unless expressly prohibited by a labor contract or insurance policy. Each provider shall operate in compliance with PA 1 of 1985 regarding seatbelt usage.	
MI Coordinated Health	1.2.B.11. Personal Emergency Response System	The 6th and 7th paragraphs were revised to read: PERS is limited to ~~persons~~ enrollees who either live alone or who are left alone for significant periods of time on a routine basis and who could not summon help in an emergency without this device. The HIDE SNP may authorize PERS units for ~~persons~~ enrollees who do not live alone if both the ~~waiver~~ enrollee and the person with whom they reside would require extensive routine supervision without a PERS unit in the home. An example of this is two individuals/enrollees who live together, and both are physically and/or cognitively unable to assist the other individual/enrollee in the event of an emergency. The provider must staff the response center with trained personnel 24 hours per day, 365 days per year. The response center will provide accommodations for ~~persons~~ enrollees with limited English proficiency.	

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CHAPTER	SECTION	CHANGE	COMMENT
MI Coordinated Health	1.2.B.13. Private Duty Nursing	Under "Medical Criteria III", the last sub-bullet point was reformatted and revised to read: ▪ Monitoring fluid and electrolyte balances where imbalances may occur rapidly due to complex medical problems or medical fragility. Monitoring by a skilled nurse would include maintaining strict intake and output, monitoring skin for edema or dehydration, and watching for cardiac and respiratory signs and symptoms. Taking routine blood pressure and pulse once per shift that does not require any skilled assessment, judgment or intervention at least once every three hours during a 24-hour period, as documented in the nursing notes, would not be considered skilled nursing. ~~All nurses providing PDN to waiver enrollees must maintain a current State of Michigan nursing license and meet licensure requirements and standards according to Michigan laws found under MCL 333.17201-17242. PDN may include medication administration according to MCL 333.7103(1).~~ All nurses providing PDN to ~~waiver~~ enrollees must maintain a current State of Michigan nursing license and meet licensure requirements and standards according to Michigan laws found under MCL 333.17201-17242. PDN may include medication administration according to MCL 333.7103(1). The 3rd paragraph was revised to read: This service must be ordered by a physician, physician's assistant, clinical nurse specialist, or nurse practitioner. The HIDE SNP is responsible for ensuring there is a physician order for the PDN services authorized. The physician may issue this order directly to the provider furnishing PDN services. However, the HIDE SNP is responsible for ensuring the ~~PDN~~ provider has a copy of these orders and delivers PDN services according to the orders. The HIDE SNP shall maintain a copy of the physician orders in the enrollee's health record. The enrollee's physician, physician's assistant, clinical nurse specialist, or nurse practitioner must order PDN services and work in conjunction with the HIDE SNP and provider agency to ensure services are delivered according to that order.	

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
		The 4th paragraph was revised to read: Through a person-centered planning process, the HIDE SNP shall determine the amount, scope and duration of services to be provided. The ~~direct service~~ Private Duty Nursing provider shall maintain close contact with the authorizing HIDE SNP to promptly report changes in each enrollee's condition and/or treatment needs upon observation of such changes. The ~~direct service~~ Private Duty Nursing provider shall send case notes to the HIDE SNP care coordinator on a regular basis, preferably monthly but no less than quarterly, to update the HIDE SNP care coordinator on the condition of the enrollee.	
MI Coordinated Health	1.2.B.15. Vehicle Modifications	The 4th paragraph was revised to read: The waiver agency and/or ~~direct service~~ Vehicle Modification provider must pursue payment by other sources, as applicable, before the waiver agency authorizes payment.	
MI Coordinated Health	1.3 Coordination of Services Covered Outside of the SMAC	In the 1st paragraph, the 5th bullet point was revised to read: • Services including, but not limited to, therapies (speech, language, physical, occupational) provided to ~~persons~~ enrollees with intellectual and/or developmental disabilities (I/DD) that are billed through PIHPs, CMHSP providers, or Intermediate School Districts	
MI Coordinated Health	1.4 Services Excluded from HIDE SNP Coverage but Covered by Medicaid	The 2nd bullet point was revised to read: • ~~Beneficiaries~~ Enrollees diagnosed with inborn errors of metabolism that have been authorized for and use metabolic formulas (Healthcare Common Procedure Coding System [HCPCS] codes B4157 and B4162) will receive all of their Medicaid services through the Medicaid FFS Program.	

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CHAPTER	SECTION	CHANGE	COMMENT
MI Coordinated Health	2.2 Dental Services	Text was revised to read: ~~Beneficiaries enrolled in a HIDE SNP~~ Enrollees will receive their dental coverage through their HIDE SNP. Each HIDE SNP contracts with a dental provider group or vendor to provide dental services administered according to the contract. The contract is between the HIDE SNP and the dental provider group or vendor, and enrollees must receive services from a participating provider to be covered. Questions regarding eligibility, prior authorization or the provider network should be directed to the enrollee's HIDE SNP. It is important to verify eligibility at every appointment before providing dental services. Dental services provided to an ineligible enrollee will not be reimbursed. For dental program coverage policy, refer to the Dental chapter of this Manual.	
MI Coordinated Health	2.8 Nursing Facility	The 5th paragraph was revised to read: The HIDE SNP may negotiate coinsurance for days 21 through 100 of a skilled care or rehabilitation ~~day~~ stay in accordance with federal regulations (42 CFR 422.202(a)(1)). Since the HIDE SNP negotiates rates with their provider networks as determined by their contract, the HIDE SNP coinsurance rates vary and do not always equal the Medicare Part A coinsurance rate. The total payment to the Nursing Facility for days 1~~-~~ through 100 cannot exceed the Medicare allowable amount.	
MI Coordinated Health	2.9.B. Hospital Services	In the 1st paragraph, the 1st bullet point was revised to read: • The hospital agrees to provide emergent services and elective admission services, arranged by a physician who has admitting privileges at the hospital, to ~~Medicaid~~ enrollees who are enrolled in HIDE SNPs with which the hospital does not have a contract.	
MI Coordinated Health	6.1 General Information	The last paragraph was revised to read: Actuarially sound rates for HIDE SNPs are capitation rates ~~means satisfying~~ that satisfy relevant federal requirements (42 CFR Sec. 438.4[a]) and comport with generally accepted actuarial practices and regulatory requirements.	

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
MI Coordinated Health	Section 7 – HIDE SNP Provider Enrollment	The 1st through 4th paragraphs were revised to read: Pursuant to 42 CFR 438.602(b)(1), all ~~network~~ providers of the HIDE SNP must enroll with the Michigan Medicaid Program. MDHHS will screen and enroll, and periodically revalidate, all enrolled Medicaid providers. ~~The HIDE SNP must require all its network providers to enroll in the Michigan Medicaid Program via the State's Medicaid Management Information System (MMIS).~~ The HIDE SNP may execute ~~network~~ provider agreements, pending the outcome of screening, enrollment, and revalidation, of up to 120 days but must terminate a ~~network~~ provider immediately upon notification from the State that the ~~network~~ provider cannot be enrolled or the expiration of one 120-day period without enrollment of the provider, and notify affected enrollees. The HIDE SNP must verify and monitor its ~~network~~ providers' Medicaid enrollment by reviewing a Weekly CHAMPS Provider Enrollment File (5938) Exchange to be provided by MDHHS. The 8th and 9th paragraphs were revised to read: Atypical providers are organizations that do not provide health care. Atypical providers may be enrolled in CHAMPS ~~or Bridges~~ and do not perform medical services (e.g., Home Help, NEMT, AFC). Atypical providers may submit HIPAA transactions, but they do not meet the HIPAA definition of a healthcare provider and may not have an NPI number. • Note: Fiscal Intermediaries (FIs) and agencies providing services that require EVV (in MICH: State Plan personal care, respite, ECLS) are able to enroll in CHAMPS, but other atypical providers (aside from NEMT) do not have a pathway to enrollment (e.g., PERS providers do not enroll in CHAMPS). The HIDE SNP can refer to the HCBS Waiver Services Resource document for additional information on which atypical providers may be enrolled. (Refer to the Directory Appendix for document location information.)	

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
		MDHHS does not prohibit payment to out-of-state, out-of-network pharmacies and providers who provide ~~Medicaid~~ enrollees with emergency medical services. Payment for out-of-state, out-of-network medical services are subject to Medicaid policy and applicable health policies and procedures. (Refer to the Out-of-Network Services subsection of this chapter for additional information.)	
MI Coordinated Health	Section 8 – Continuity of Care	In the 6th paragraph, 2nd bullet point, the last sub-bullet point was revised to read: ➢ The continuity of care period is as follows: • 180 calendar days for enrollees receiving services through the PIHP under the Michigan 1115 Behavioral Health Demonstration or HSW. • 90 calendar days for all other enrollees. The 11th and 12th paragraphs were revised to read: Generally, HIDE SNPs must start processing a request for continuity of care within five ~~working~~ business days after the request is received. The HIDE SNP has a maximum of 30 calendar days to complete the request. However, if the enrollee's medical condition requires more immediate attention (e.g., an upcoming appointment), the HIDE SNP must complete the request within 15 calendar days. If there is a risk of harm to the enrollee or rescheduling of the appointment ~~would be~~ is required, the request must be completed within three calendar days of the request. The HIDE SNP may verbally convey continuity of care approval with the requester and record such approval in the enrollee's record. If the criteria for the prior relationship (as outlined above) are satisfied, an out-of-network provider can be reimbursed retroactively for services provided without an approved continuity of care request as long as the provider submits the request for payment within 30 calendar days of the first date of service.	

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
MI Coordinated Health	8.2 Nursing Facilities	The last paragraph was revised to read: This continuity of care protection is available as long as the enrollee resides in the NF. Continuity of care in a NF is automatic. The enrollee does not have to make a request for continuity of care. The HIDE SNP must refill prescriptions for enrollees in a NF for a minimum of 91 calendar days and the HIDE SNP must refill the drug multiple times during the first 90 calendar days of enrollment, as needed. This allows the prescriber time to change the drugs to those on the drug list or ask for an exception.	
MI Coordinated Health	9.1 Person-Centered Planning	The 2nd paragraph was revised to read: The person-centered planning process is led by the enrollee and involves ~~families~~ family, friends, authorized/legal representative or guardian, and professionals as they desire or require. The process must be conducted in-person unless the enrollee declines the opportunity to participate in-person.	
MI Coordinated Health	9.2.D. HIDE SNP Care Coordinator Training	Text was revised to read: The HIDE SNP must develop and implement a comprehensive training program for care coordination staff, including trainings required by federal rules, MOC requirements, and MDHHS directed topic areas. The training program must be completed within 30 calendar days of hire. The HIDE SNP must ensure HIDE SNP care coordinators receive training in accordance with the SMAC.	
MI Coordinated Health	9.2.E. HIDE SNP Care Coordinator Responsibilities	The 1st paragraph was revised to read: The HIDE SNP care coordinator will be responsible for care coordination for each enrollee. The enrollee must be provided information on how to contact their HIDE SNP care coordinator.	

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
		In the last paragraph, last bullet point, the 3rd sub-bullet point was revised to read: ➢ The HIDE SNP care coordinator must make every effort to ensure that HCBS is in place upon hospital discharge to avoid unnecessary NF placements. The HIDE SNP care coordinator must be able to arrange for expedited assessments and other mechanisms to ensure prompt initiation of appropriate HCBS. If the enrollee is being discharged from a NF or hospital, the HIDE SNP care coordinator must coordinate efforts with the NF social worker, discharge planner, CTS transition navigator when applicable, or other staff to ensure a smooth transition.	
MI Coordinated Health	9.2.F. Enrollee HIDE SNP Care Coordinator Assignments and Change Requests	The last paragraph was revised to read: The enrollee must be notified, in writing, within ~~two weeks~~ 14 calendar days of the reassignment of the HIDE SNP care coordinator. The notification must include the name and contact information for the new HIDE SNP care coordinator. This applies to both enrollee (also authorized/legal representative or guardian) requested changes and HIDE SNP related changes.	
MI Coordinated Health	9.2.G. HIDE SNP Care Coordinator Caseloads	The 1st paragraph was revised to read: There is a mandatory limit on HIDE SNP care coordinator caseloads based on a point system: The 2nd and 3rd paragraphs were revised to read: The caseload must not exceed 600 points per HIDE SNP care coordinator. The HIDE SNP must establish processes to minimize enrollee reassignments as part of meeting HIDE SNP care coordinator caseload limit requirements (e.g. assigning enrollees so that HIDE SNP care coordinators are not at or close to the maximum point limit).	

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
		The 5th paragraph was revised to read: Caseload limits include unable to reach and unwilling to participate enrollees on HIDE SNP care coordinator caseloads. The HIDE SNP must ensure adequate staffing to meet the needs of the program and enrollees without exceeding MDHHS defined ratios. The 7th paragraph was revised to read: If the HIDE SNP is unable to comply with HIDE SNP care coordinator caseload ratio requirements due to constraints posed by being located in a region with a county that is classified as Rural or Counties with Extreme Access Considerations (CEAC) by CMS, it may make a request for a rural exception. Requests for rural exceptions must be submitted to the HIDE SNP's contract manager and must include, at minimum, the following information: The last paragraph was revised to read: The HIDE SNP must regularly monitor and report HIDE SNP care coordinator caseload data in accordance with the requirements of this section and the SMAC.	
MI Coordinated Health	9.2.H. Requirements for HIDE SNP Care Coordinators Who Serve Enrollees with HCBS Needs	The 1st paragraph was revised to read: In addition to meeting the basic HIDE SNP care coordinator qualifications described above, HIDE SNP care coordinators serving enrollees with HCBS needs must: The 3rd paragraph was revised to read: The HIDE SNP must ensure ~~enrollees~~ providers contracted to conduct the care coordination activities meet the qualifications set forth in the Care Coordination section of the SMAC.	

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
MI Coordinated Health	Section 10 – Enrollee Stratification, Assessments, and Individualized Care Plan (ICP)	In the 5th paragraph, the 5th bullet point was revised to read: • Enrollees who are within their first 90 calendar days in the HIDE SNP after transitioning from Home Help	
MI Coordinated Health	10.1 Health Risk Assessments (HRAs)	The 2nd paragraph and first two bullet points were revised as follows: In instances where enrollees are unable to be reached for ongoing assessments, the HIDE SNP will need to leverage available information (e.g. MDHHS 270/271 process, 834s, the enrollee, CMS, other sources, etc.) to conduct outreach and document attempts. The HIDE SNP must attempt to reach the enrollee at least three times within the first 90 calendar days of enrollment. • The HIDE SNP must continue to attempt to contact enrollees who were classified as unable to reach after the first 90 calendar days of enrollment. • One contact attempt must be made at least monthly after the first 90 calendar days. The contact attempts must be informed by claims data analysis and regular coordination with providers and FDRs, which must also be conducted monthly. In the 4th paragraph, the 2nd bullet point was revised to read: • When the results of the screening indicate a need for further follow-up, the HIDE SNP must make a referral to the PIHP within five calendar days of identifying the need.	
MI Coordinated Health	10.3 Additional Assessments	The 1st paragraph was revised to read: Additional assessments will be conducted by appropriately trained and knowledgeable licensed health professionals who have experience working with individuals who have HCBS or LTSS service needs. The licensed health professional is not required to meet HIDE SNP care coordinator credentials or other specified credentials unless indicated otherwise.	

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
MI Coordinated Health	10.6 Nursing Facility Level of Care Determination (LOCD)	The 1st paragraph was revised to read: The Michigan Medicaid Nursing Facility Level of Care Determination (LOCD) tool must be conducted for all enrollees according to the Michigan Medicaid Nursing Facility Level of Care Determination requirements in Medicaid policy (refer to the Nursing Facility Level of Care Determination chapter of this Manual) and additional guidance provided by MDHHS. For the MICH program ~~only~~, the Nursing Facility Level of Care Frailty Review criteria will be applied at the time the LOCD is conducted for the enrollee if the enrollee does not meet LOCD criteria under Doors 1-7 (Door 8 after Frailty Review criteria). Additionally, for the MICH program, the LOCD must be conducted by a HIDE SNP care coordinator holding a credential as described in the HIDE SNP Care Coordinator subsection of this chapter.	
MI Coordinated Health	10.7 Timing of the LOCD Tool	The 3rd bullet point was revised to read: • HCBS Waiver materials must be submitted to MDHHS via CHAMPS within 30 calendar days of the LOCD being conducted by the HIDE SNP.	
MI Coordinated Health	10.10.A. Individualized Care Plan (ICP)	The 4th paragraph was revised to read: The HIDE SNP must complete the initial ICP within 90 calendar days of enrollment. The HIDE SNP must attempt to reach the enrollee at least three times within the first 90 calendar days of enrollment for completion of the ICP. The last paragraph was revised to read: Existing person-centered service plans or plans of care can be incorporated into the ICP. The HIDE SNP must review the adopted plan with the enrollee to determine if revisions are necessary to address the enrollee's prioritized goals and meet the enrollee's needs. The ICP must be signed by the enrollee and the enrollee's assigned HIDE SNP care coordinator. The ICP must be contained in the enrollee's health record and shared with the enrollee and the ICT.	

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
MI Coordinated Health	10.10.B. ICP Monitoring	In the 7th paragraph, the last bullet point was revised to read: • Be signed by the enrollee and the enrollee's assigned HIDE SNP care coordinator	
MI Coordinated Health	Section 11 – Self-Determination	The 4th paragraph was revised to read: ~~HCBS Waiver~~ Enrollees must be informed of the option to self-direct their own services when applicable. The HIDE SNP care coordinator must ensure enrollees are informed of the option to self-direct their services when their ICPs are created or updated. The 7th paragraph was revised to read: Self-determination provides ~~MICH HCBS Waiver~~ enrollees the option to direct and control certain waiver services. For those ~~MICH HCBS Waiver~~ enrollees who choose to participate in arrangements that support self-determination, the enrollee (or chosen representative(s)) has decision-making authority over providers of waiver services, including:	
MI Coordinated Health	13.2 Person-Centered Planning	The 1st paragraph was revised to read: The person-centered planning process and ICP for ~~MICH HCBS Waiver~~ enrollees must be compliant with the HCBS Final Rule (CMS-2249F; CMS- 2296-F) released by CMS on January 16, 2014. At a minimum, the ICP must include the following components:	
MI Coordinated Health	Section 22 – Appeals	The last paragraph was revised to read: The HIDE SNP must honor oral requests for appeal. When a HIDE SNP receives an oral request for a standard (i.e., non-expedited) appeal, it should send the enrollee confirmation of the appeal (including facts, reason for appeal, etc.) in writing. HIDE SNPs should not wait for the enrollee to send a written follow-up or otherwise require a written response. The internal decision should be rendered within 30 calendar days of the oral request as required by the SMAC.	

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Non-Emergency Medical Transportation	Section 6 – Covered Services	The 4th paragraph was revised to read: Transportation providers and beneficiaries may be reimbursed for mileage, tolls, parking fees, approved meals and lodging expenses, Medi-Van and wheelchair lift equipped transportation, and medically necessary attendants. The transportation provider or beneficiary must submit a complete MSA-4674 (Medical Transportation Statement), as well as any accompanying documentation (receipts, invoices, etc.), for all trip-associated costs to the authorizing party within 12 months from the date of service to receive reimbursement. Medicaid FFS authorizing parties may accept the submission of a complete MSA-4674 form and receipts via fax and secure email. Transportation providers and beneficiaries may submit original forms and receipts if they choose, but sending original forms and receipts is not required for reimbursement. Authorizing parties receiving a completed MSA-4674 may obtain missing information, including signatures, via telephone conversation with the appropriate party. This verification method should only be used to obtain missing information related to a submitted form and not as a method for completing the full MSA-4674. Providers and beneficiaries are encouraged to keep an original or copy of forms and receipts submitted to MDHHS for reimbursement.	Adding clarifying language to include receipts and invoicing to assist in understanding of invoicing requirements.
Nursing Facility Level of Care Determination	3.8.A. LOCD Doors Addressed by Passive Assessment	Text relative to Door 2 was revised to read: Door 2: ~~The passive redetermination process can confirm all criteria.~~ The passive redetermination process can partially confirm criteria from the MDS (nursing facilities). The passive redetermination can confirm criteria from the iHC.	Update due to technical changes in MDS assessment.
Directory Appendix	ELIGIBILITY VERIFICATION – CHAMPS Eligibility Inquiry	Information under "INFORMATION AVAILABLE/PURPOSE" was revised to read: For Medicaid providers to verify eligibility for the Medicaid, CSHCS, MOMS, and MIChild programs. ~~Refer to the Benefit Plan ID table in the Beneficiary Eligibility Chapter for a complete list of Benefit Plan IDs that are provided in the eligibility response.~~ Providers need to utilize the Benefit Plan ID(s) indicated in the eligibility response to determine coverage for a specific DOS.	Update.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Directory Appendix	BEHAVIORAL HEALTH/SUD RESOURCES	The following information was added: **Contact/Topic:** Peer-Delivered or -Operated Support Services **Email:** MDHHS Peer Services Area (PSA) at MDHHS-PeerSupport@michigan.gov **Website:** www.mipeers.org **Information Available/Purpose:** Application process and requirements for PSS and PRC certification; recertification information; MDHHS Peer Portal; scheduled training; etc.	Update.
Directory Appendix	COMMUNITY HEALTH WORKER SERVICES – MI Medicaid CHW Registry	Email address was added for the Help Desk: mychwregistry@michwa.org	Update.
Forms Appendix	MSA-0725; Application for Payment of Health Insurance Premiums	Version was updated (12/2023).	
Forms Appendix	DHS-54A; Medical Needs	The form was removed from the Forms Appendix.	Adult Services forms can be accessed on the Adult Services Forms and Publications webpage. A link to the webpage is available in the Home Help section of the Directory Appendix.

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Medicaid Provider Manual
July 2026 Updates

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MSA 15-31	9/1/2015 NOTE: This is in addition to previous incorporation notes.	Hospital Reimbursement Appendix	Section 5 - Capital	Paragraphs 1 through 4 were revised to read: Effective January 1, 2015, MDHHS will reimburse inpatient capital using a hospital-specific prospective rate. A prospective per-discharge amount will be calculated for medical/surgical hospitals, including critical access hospitals and children's hospitals. State-owned psychiatric hospitals, freestanding rehabilitation hospitals and distinct part rehabilitation units will be reimbursed a prospective per diem capital rate. Transfer claims will not receive a prospective capital payment. When calculating the prospective capital rates, data from the second previous state fiscal year will be used. For example, to calculate ~~January~~ October 1, 2015 capital rates, data from cost reports with fiscal years that end between October 1, ~~2012~~ 2013 and September 30, ~~2013~~ 2014 will be used. ~~Fee-for-Service (FFS) data will be used to calculate capital amounts.~~ The capital amount for the medical/surgical component of the hospital is established using the following lines (or comparable lines from succeeding cost reports) from the hospital's cost report. The FFS component of the data for routine capital costs is obtained from the CMS 2552-10, Worksheet D, Part I, Title XIX, Column 7, Lines 30-35 and 43. The ancillary capital costs are obtained from the CMS 2552-10, Worksheet D, Part II, Title XIX, Column 5, Lines 50-77 and 90-92. For the Managed Care Organization (MCO) component of the data, the routine capital costs will use the days listed from Michigan Medicaid Form (MMF), MCO Summary Page, Title XIX, Inpatient Med Surg multiplied by the corresponding per diem amounts listed in CMS 2552-10 Worksheet D, Part I, Title XIX, Column 5. The ancillary capital costs will use the program charges from MMF, MCO Detail Page, Title XIX, Inpatient Med Surg multiplied by the corresponding capital cost ratios listed in the CMS 2552-10 Worksheet D, Part II, Title XIX, Column 3. The sum of routine and ancillary cost for FFS and MCO components is then divided by the medical/surgical ~~FFS~~ discharges for the same period to calculate the hospital-specific prospective per discharge rate ~~for Managed Care Organizations (MCOs) and FFS~~.

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

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
				The capital amount for freestanding rehabilitation hospitals or distinct part rehabilitation units is established using the following lines from the hospital's cost report. The FFS component of the data for routine capital costs is obtained from the CMS 2552-10, Worksheet D, Part I, Title XIX, Column 7, Line 41. The ancillary capital costs are obtained from the CMS 2552-10, Worksheet D, Part II, Title XIX, Column 5, Lines 50-76.99 and 90-92. For the MCO component of the data, the routine capital costs will use the days listed from MMF, MCO Summary Page, Title XIX, Inpatient Rehab multiplied by the corresponding per diem amounts listed in CMS 2552-10 Worksheet D, Part I, Title XIX, Column 5. The ancillary capital costs will use the program charges from MMF, MCO Detail Page, Title XIX, Inpatient Rehab multiplied by the corresponding capital cost ratios listed in the CMS 2552-10 Worksheet D, Part II, Title XIX, Column 3. The sum of the routine and ancillary cost for FFS and MCO is then divided by the ~~FFS~~ rehabilitation Medicaid days for the same period to calculate the hospital-specific prospective per diem rate ~~for MCOs and FFS~~.
MMP 25-28	8/29/2025 NOTE: This is in addition to previous incorporation notes (additional from MMP 25-56).	Behavioral Health and Intellectual and Developmental Disability Supports and Services	Section 14 – Children's Home and Community-Based Services Waiver (CWP)	The last paragraph was removed: ~~Services, equipment and Environmental Accessibility Adaptations (EAAs) that require prior authorization from MDHHS must be submitted to the CWP Clinical Review Team at MDHHS. The team is comprised of a physician, registered nurse, psychologist, and licensed master's social worker with consultation by a building specialist and an occupational therapist.~~

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BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			14.1 Key Provisions	The 3rd paragraph was revised to read: Application for the CWP is made through the ~~CMHSP~~ PIHP. The ~~CMHSP~~ PIHP is responsible for the coordination of the child's waiver services. The case manager, the child and their family, friends, and other professional members of the planning team work cooperatively to identify the child's needs and to secure the necessary services. All services and supports must be included in the Individual Plan of Services (IPOS). ~~The IPOS must be reviewed, approved and signed by the physician.~~
			14.2 Eligibility	The following text was added as the 1st paragraph: MDHHS uses Decision Support Model (DSM) criteria from the Michigan Child and Adolescent Needs and Strengths (MichiCANS) tool. The DSM identifies candidates for CWP and determines whether children may meet the Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) level of care. The following paragraph was revised to read: ~~The following eligibility requirements must be met:~~ In addition to use of the MichiCANS DSM, the Qualified Intellectual Disabilities Professional (QIDP) must attest via the attestation form that the child, youth, or young adult meets all of the following eligibility criteria: The following text was added at the end of the subsection: This information is submitted to MDHHS waiver staff for review. MDHHS will verify that the child, youth, or young adult meets waiver eligibility to be added to the enrollment pool. MDHHS staff will extend invitations to enroll in the waiver based upon slot availability.
			14.2.A. Community Living Supports	The subsection title was revised to read: ~~Community Living Supports~~ Enrollment/Disenrollment

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			14.3.C. Environmental Accessibility Adaptations (EAAs)	The last paragraph was revised to read: Additional square footage may be prior authorized ~~following a MDHHS specialized housing consultation~~ through the PRAR process. Community Mental Health Services Programs (CMHSPs) will submit an original Prior Review and Approval Request (PRAR) form for authorization request to the overseeing PIHP if it is determined that adding square footage is the only alternative available to make the home accessible and the most cost-effective alternative for housing. Additional square footage is limited to the space necessary to make the home wheelchair-accessible for a child with mobility impairments to prevent institutionalization; the amount will be determined by the direct medical or remedial need of the beneficiary. The family must exhaust all applicable funding options, such as the family's ability to pay, housing commission grants, MSHDA and community development block grants. Acceptances or denials by these funding sources must be documented in the child's records.

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MMP 25-39	8/29/2025	Behavioral Health and Intellectual and Developmental Disability Supports and Services	20.5.D. Provider Infrastructure Requirements	In the 1st paragraph (table), under "Health Home Partners", the 3rd bullet point was revised to read: • Peer Support Specialist, Peer Recovery Coach, Youth Peer Support Specialist, Parent Support Partner, Community Health Worker, Medical Assistant, SSI/SSDI Outreach, Access & Recovery (SOAR) Navigator, Housing Specialist (3.00-~~4.00~~ 5.00 FTE) In the 2nd paragraph, the following topics were added: **Housing Specialist** • Must have a minimum of a bachelor's degree from an accredited four-year institution of higher learning, with specialization in psychology, mental health and human services, behavioral health, behavioral sciences, social work, human development, special education, counseling, rehabilitation, sociology, nursing, or closely related field; OR • Have a bachelor's degree from an accredited four-year educational institution in an unrelated field and at least one year of full-time equivalent relevant human services experience **Parent Support Partner** • Must be a parent or primary caregiver of a child with behavioral health needs and have lived experience navigating children's public mental health services • Must meet the Association for Children's Mental Health (ACMH) requirements for Parent Support Partner Training • Must be supervised by licensed professional members of the care team

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				SOAR Navigator • Must complete SOAR training through a SOAR Technical Assistance Center approved training program.
		Acronym Appendix		Addition of: ACMH - Association for Children's Mental Health SOAR – SSI/SSDI, Outreach, Access & Recovery SSDI - Social Security Disability Insurance
MMP 26-01	3/18/2026	Medicaid Health Plans	2.8 Mental Health	The last paragraph was revised to read: For specialty behavioral health needs, MHPs must coordinate with the appropriate PIHP/CMHSP to ensure that medically necessary mental health services are provided to the ~~beneficiary~~ enrollee. The Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter provides coverage policies for PIHPs/CMHSPs.

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			2.8.A. Mental Health Assessment Requirements for Comprehensive Health Care Program (CHCP) Enrollees	Addition of new subsection; includes the following subsections: 2.8.A.1. Assessment Tools 2.8.A.1.A. Michigan Child and Adolescent Needs and Strengths (MichiCANS) Screener 2.8.A.1.B. Level of Care Utilization System (LOCUS) 2.8.A.2. Allowable Providers 2.8.A.2.A. Enrollable Providers 2.8.A.2.B. Bachelor's Level Providers 2.8.A.3. Training 2.8.A.4. Billing Guidelines and Reimbursement Considerations 2.8.A.4.A. MHP Enrollees 2.8.A.4.B. Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC), Tribal Health Center (THC) and Tribal FQHC Providers Refer to the chapter in the MDHHS Medicaid Provider Manual for full content.
		Directory Appendix	Health Plan Information	Addition of: **Contact/Topic:** Standardized Mental Health Assessment Resources **Web Address:** www.michigan.gov/mdhhs/mihealthylife >> Mental Health Framework **Information Available/Purpose:** Information regarding the Mental Health Framework requirements. Resources include a Standardized Mental Health Assessment Guide and training information for the LOCUS and MichiCANS Screener tools.
MMP 26-02	1/23/2026	General Information for Providers	Section 9 – Prior Authorization	Extensive revisions were made throughout the section. Refer to the chapter in the MDHHS Medicaid Provider Manual for full content.

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		Billing & Reimbursement for Dental Providers	Section 2 – General Information/Prior Authorization	The 1st paragraph was revised to read: The Dental Prior ~~Approval~~ Authorization Request (MSA-1680-B) is a form designed to obtain authorization for those services that require prior authorization (PA), as indicated in the Dental Chapter. Refer to the Additional Code/Coverage Resource Materials subsection of the General Information for Providers Chapter for additional information regarding coverage parameters.
		Dental	3.2 Completion Instructions	The 1st paragraph was revised to read: The Dental Prior ~~Approval~~ Authorization Request form (MSA-1680-B) is used to obtain authorization. An electronic fill-in enabled version of the MSA-1680-B is available on the MDHHS website. (Refer to the Directory Appendix for website information.)
		Healthy Michigan Plan	5.2.C. Prior Authorization	The 1ts paragraph was revised to read: When billing FFS, providers must obtain PA to continue therapy beyond the maximum benefit. Requests for PA must be submitted on the Occupational Therapy-Physical Therapy-Speech Therapy Prior ~~Approval Request/~~Authorization Request ~~form~~ (MSA-115). (Refer to the Forms Appendix for additional information.)
		Hearing Services and Devices	3.1 Prior Authorization Form and Completion Instructions	The 1st paragraph was revised to read: Requests for PA must be submitted on the Special Services Prior ~~Approval Request/~~Authorization Request ~~form~~ (MSA-1653-B). (Refer to the Forms Appendix or the MDHHS website for a copy of the form.) Medical documentation (e.g., medical clearance, audiogram, and hearing aid recommendation from an audiologist) must accompany the MSA-1653-B.
		Hospital	Throughout chapter	Revisions to changes in form titles were made relative to the following forms: • MSA-115 • MSA-6544-B

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		Medical Supplier	1.8.A. Prior Authorization Form	The 1st paragraph was revised to read: Requests for PA must be submitted on the Special Services Prior ~~Approval Request/~~Authorization Request ~~form~~ (MSA-1653-B) or, for mobility and custom seating items, submit the Complex Seating and Mobility Device Prior ~~Approval Request/~~Authorization Request ~~form~~ (MSA-1653-D). (Refer to the Forms Appendix for a copy of the PA form and completion instructions.) In addition, the medical documentation specific to each type of device requested must accompany the form. The information on the PA request form must be:
			2.39 Speech Generating Devices	Under "PA Requirements", the 2nd paragraph was revised to read: PA is required for all SGDs, eye control mechanisms, upgrades, modifications, accessories, repairs, replacements and device trials. Required documentation must accompany the ~~Special Services Prior Approval Request/Authorization (~~MSA-1653-B~~)~~ when requesting authorization for all original and replacement/upgrade SGD requests.
		Practitioner	1.9.A. To Obtain Prior Authorization	The 1st paragraph was revised to read: Requests for PA for practitioner services such as surgeries, procedures, office-administered pharmaceuticals, biologicals, and out-of-state-care must be submitted utilizing the Practitioner ~~Special Services~~ Prior ~~Approval Request/~~Authorization Request ~~form~~ (MSA-6544-B). (Refer to the Forms Appendix for a copy of the form or download the form from the MDHHS website.) The form must be completed in its entirety. Supportive medical documentation must accompany the form.

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			3.16.B.1. Prior Authorization Requirements for Carve-Out Injectable Drugs and Biological Products	The 2nd paragraph was revised to read: When indicated on the MDHHS-maintained list, PA requests will require a completed ~~Practitioner Special Services Prior Approval Request/Authorization form (~~MSA-6544-B~~)~~, a Program Review Division (PRD) documentation checklist, and all supporting documentation. Providers are to contact the PRD to obtain the PRD documentation checklist for drugs and biological products that require PA. Once all required documentation is collated, information must be submitted according to form MSA-6544-B completion and submission instructions. (Refer to the Forms Appendix for a copy of the form and completion instructions and to the Directory Appendix for PRD contact information.)
			3.25.C. Prior Authorization	The 1st paragraph was revised to read: PA is required for weight loss surgeries. Requests must include a completed, signed, and dated MSA-6544-B~~ – Practitioner Special Services Prior Approval – Request/Authorization form~~. If submitting the prior authorization request electronically via direct data entry in the Community Health Automated Medicaid Processing System (CHAMPS), this PA request form is not required. PA requests must include the medical history, past and current treatment and results, complications encountered, results of the health behavior/ psychosocial assessment (when indicated), and expected benefits or prognosis for the method requested.
		Special Programs	9.6 Prior Authorization	The 1st paragraph was revised to read: Pediatric Outpatient Intensive Feeding Program services require prior authorization. Requests for prior authorization must be submitted utilizing ~~form MSA-6544-B (~~the Practitioner ~~Special Services~~ Prior ~~Approval – Request/~~Authorization~~)~~ Request (MSA-6544-B) and include documentation to support medical necessity such as height/weight measurements and previously attempted therapeutic interventions. (Refer to the Prior Authorization subsection of the Practitioner Chapter for additional information.) Medicaid forms can be accessed on the MDHHS website. (Refer to the Directory Appendix for website information.)

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		Therapy Services	3.1 Form and Completion Instructions	The 1st paragraph was revised to read: Prior authorization requests must be submitted on the Occupational Therapy-Physical Therapy-Speech Therapy Prior ~~Approval Request/~~Authorization Request ~~form~~ (MSA-115). (Refer to the Forms Appendix or the MDHHS website for a copy of the form.) Required medical documentation must accompany the form.
			7.4 Evaluation and Follow-Up for Speech-Generating Devices/Voice Prostheses	The 2nd paragraph was revised to read: Prior authorization is required for all SGDs. The Special Services Prior ~~Approval Request/~~Authorization Request ~~form~~ (MSA-1653-B) must be submitted for all original, replacement, upgrade, or repair of SGDs. (Refer to the Forms Appendix for additional information.) The SLP evaluation must be shared with the provider submitting the SGD prior authorization request. Refer to the Speech Generating Devices subsection of the Medical Supplier Chapter for additional coverage and PA information regarding SGDs.
		Directory Appendix	Prior Authorization	Revisions were made throughout the section. Refer to the appendix in the MDHHS Medicaid Provider Manual for full content.
			Therapy Services	The following "Contact/Topic" category was revised as follows: Occupational Therapy - Physical Therapy – Speech Therapy Prior ~~Approval Request/~~Authorization ~~Form~~ Request (MSA-115)
		Forms Appendix	MSA-1653-D; Complex Seating and Mobility Device Prior Approval-Request/Authorization	Form was revised; version date is 3/2026. NOTE: The form also had a title change – new title is "Complex Seating and Mobility Device Prior Authorization Request".

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			MSA-1680-B; Dental Prior Approval Authorization Request	Form was revised; version date is 3/2026. NOTE: The form also had a title change – new title is "Dental Prior Authorization Request".
			MSA-2081; Genetic and Molecular Laboratory Test Authorization Request	Form was revised; version date is 3/2026.
			MSA-1656; Evaluation and Medical Justification for Complex Seating Systems and Mobility Devices	On the 1st page, the 1st paragraph was revised to read: This form should be completed for NEW or REPLACEMENT mobility device(s) and seating systems. It must be submitted with the Complex Seating and Mobility Device Prior ~~Approval – Request/~~Authorization Request (MSA-1653-D). The evaluation and justification must be submitted within 90 days of the date the evaluation was completed. The version date was revised to read 3/2026.
			MSA-115; Occupational Therapy – Physical Therapy – Speech Therapy Prior Approval Request/ Authorization	Form was revised; version date is 3/2026. NOTE: The form also had a title change – new title is "Occupational Therapy – Physical Therapy – Speech Therapy Prior Authorization Request".
			MSA-6544-B; Practitioner Special Services Prior Approval – Request/Authorization	Form was revised; version date is 3/2026. NOTE: The form also had a title change – new title is "Practitioner Prior Authorization Request".
			MSA-1653-B; Special Services Prior Approval – Request/Authorization	Form was revised; version date is 3/2026. NOTE: The form also had a title change – new title is "Special Services Prior Authorization Request".

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MMP 26-04	1/29/2026	Billing & Reimbursement for Professionals	6.22 Plan First (new subsection; the following subsections were re-numbered)	New subsection text reads: Medicaid covers payment associated with services covered under the limited Plan First Benefit Program. Services not covered under the Plan First Benefit Program are not paid by Medicaid. Medicaid will not reimburse Medicare Part A and Part B premiums, coinsurance and/or deductibles. Medicaid will not issue payment for services not covered under the limited Plan First Benefit Program. (Refer to the Plan First Family Planning chapter of this Manual for additional information.) The beneficiary may be responsible for payment of non-covered Medicare/Plan First services regardless of crossover claims received.
MMP 26-06	2/27/2026	Hospital Reimbursement Appendix	7.8 Rural Access Pool	In the 1st paragraph, the last bullet point was revised to read: • A hospital must be located in a county with a population of not more than ~~165,000~~ 195,000 and within a city, village, or township with a population of not more than ~~12,000~~ 15,000. The population threshold will be measured against population counts from the ~~2000~~ 2020 federal decennial census.
MMP 26-07 & MMP 26-13	2/27/2026 4/16/2026	Behavioral Health and Intellectual and Developmental Disability Supports and Services	21.11 Children's Home and Community Based Services Waiver (CWP) (new subsection)	Addition of new subsection; includes the following subsections: 21.11.A. Eligibility Criteria 21.11.A.1. Ages Birth Through 5 21.11.A.2. Ages 6-18 Refer to the chapter in the MDHHS Medicaid Provider Manual for full content.

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MMP 26-09	4/1/2026	Home Help	5.2 Medical Eligibility	Text was revised to read: The client's medical need for Home Help services must be certified using ~~the Medical Needs form (DHS-54A). (Refer to the Forms Appendix for a copy of the DHS-54A.)~~ one of the following medical needs forms: ~~The DHS-54A must be signed and dated~~ • Form MDHHS-6200 or form DHS-54A, Medical Needs. (The MDHHS-6200 can be downloaded from the Adult Services Forms and Publications web page. Refer to the Directory Appendix for webpage information.) The form must be completed by an approved Medicaid provider enrolled in CHAMPS who holds one of the following professional licenses: ➢ Physician (MD or DO) ➢ Physician assistant ➢ Nurse practitioner ➢ Occupational therapist ➢ Physical therapist • A United States Department of Veterans Affairs (VA) Form 10-10M. The form must be completed by a Veterans Health Administration (VHA) medical provider. ~~A Veterans Health Administration (VHA) medical provider may complete a DHS-54A or a VA Form 10-10M.~~ The client or their representative is responsible for obtaining the medical certification of need, but it must be completed by one of the medical professionals listed above. The medical professional must enter their National Provider Identifier (NPI) number on the ~~DHS-54A or VA Form 10-10M~~ medical needs form and indicate whether they are a Medicaid-enrolled provider.

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				The medical professional certifies the client's need for services is related to an existing medical condition, physical disability, or cognitive disability. The medical professional does not prescribe or authorize personal care services. Needed services are determined by the comprehensive assessment conducted by the ASW.
			5.4 Status of Responsible Relatives	The 2nd paragraph was revised to read: An **unable** responsible relative has disabilities of their own that prevent them from providing care. These disabilities must be documented and verified by a medical professional on an MDHHS-6200 or a DHS-54A. ~~(Refer to the Forms Appendix for a copy of the DHS-54A.)~~ (The MDHHS-6200 can be downloaded from the Adult Services Forms and Publications webpage. Refer to the Directory Appendix for webpage information.)
			8.4.B.1. Agency Caregiver and Agency Employee Enrollment	In the 1st paragraph, the following bullet point was added: • All agency caregivers who provide Home Help services successfully complete CHAMPS revalidation and are actively enrolled in CHAMPS at the time they provide Home Help services. NOTE: The agency owner is responsible for monitoring the revalidation status of all agency caregivers providing Home Help services. The "View Servicing Provider Details" step in the agency's CHAMPS enrollment can be used for this purpose.
MMP 26-10	2/27/2026	Electronic Visit Verification	Section 5 – EVV Compliance	Text was revised to read: ~~Programs that require the use of EVV for their HHCS or PCS must be compliant with the EVV policies within this chapter. Failure to comply with these requirements may result in non-payment of Medicaid services.~~ Providers must follow the EVV reporting requirements to ensure: • Compliance with the federal mandate and with state Medicaid policy; • Ongoing enrollment as a Michigan Medicaid provider; and • Payment for services appropriately provided through MDHHS.

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			5.1 EVV Usage – Manual Edits (new subsection)	New subsection text reads: MDHHS requires visit information to be reported electronically using either a mobile device or Interactive Voice Response (IVR) (Telephony). If an EVV visit is missing clock-in or clock-out information or the visit information was entered incorrectly, the provider is required to make any type of edit or correction; this is deemed a manual edit. Manual edits are accepted but should never be the primary method to capture visit information. Manual edits should be kept to a minimum to ensure compliance. Any of the following will result in a non-compliant visit requiring manual entry or manual edit: • A missing clock-in time. • A missing clock-out time. • A missing clock-in and clock-out time. • A missing caregiver. • A missing phone number when IVR is used. • Missing Global Positioning System (GPS) coordinates when mobile application is used. • Manually entering or changing a visit clock-in or visit clock-out time. For example, if the provider changes an electronically logged visit clock-in and/or clock-out. To meet state and federal compliance requirements, MDHHS expects agency providers, including FMS providers, to achieve a quarterly threshold of 85 percent of EVV records for verified visits without manual edits. This will be calculated by taking the total number of EVV records for verified visits which have no manual edits in a quarter and dividing it by the total number of EVV records for verified visits received in a quarter. If a provider is providing FFS and managed care EVV services, and/or contracted by multiple MCEs, the provider is expected to achieve the quarterly threshold per individual payer (MDHHS and MCEs).

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				MDHHS or the designated MCE are responsible for reviewing quarterly compliance thresholds of providers in their program. MDHHS is responsible for monitoring the FFS programs (Home Health FFS and Home Help). MCEs are responsible for monitoring the managed care programs. Providers and payers are expected to monitor compliance throughout a quarter using available resources through HHAeXchange (HHAX) portals. HHAX will generate a monthly Compliance Report that will be sent to each provider and payer to ensure all involved in the monitoring process are using the same data. Providers who are associated with multiple payers will receive reports for each. MDHHS and MCEs will use the monthly reports to calculate quarterly compliance. **Manual Edit Quarterly Review Schedule** **Review Period** / **Quarterly Review Schedule** October - December / January January - March / April April - June / July July - September / October Corrective action for providers that do not meet a quarterly threshold of 85 percent of EVV records without manual edits must be enforced by MDHHS or the designated MCE and could include: • Direction to retrain agency staff and direct caregivers. • Mandatory attendance at a state- or MCE-sponsored training. • Submission of a compliance plan for MDHHS or MCE to monitor. • Formal meeting with MDHHS or MCE to report on compliance progress.

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				If persistent non-compliance is not resolved through the corrective actions above, further action may be taken at the discretion of MDHHS or MCE. MDHHS will allow a grace period where no corrective actions will be taken for newly enrolled providers, when a new program or EVV implementation is required, or other situation as approved by MDHHS. This grace period will begin in the quarter when the situation occurs (such as enrollment) and extend through the following full quarter. For example, if a new EVV provider enrolls in February, their grace period for EVV compliance is from January 1 to June 30.
		Acronym Appendix		Addition of: HHAX = HHAeXchange
MMP 26-11	2/27/2026	Nursing Facility Certification, Survey & Enforcement Appendix	2.3 Criteria for Evaluation of Medicaid Bed Certification Applications	Text was revised to read: The ~~State Medicaid Agency (~~SMA~~) (MDHHS Health Services~~ will collaborate with the ~~State Survey Agency (~~SSA~~) (Department of Licensing and Regulatory Affairs [LARA])~~ when making ~~a~~ determinations regarding the approval or denial of any application for Medicaid bed certification and provider enrollment. MDHHS will grant Medicaid bed certification if the application meets ~~all~~ the following: • A verification from the SSA that the beds listed in the applications are Medicare-certified~~.~~ and • The SSA finds that the facility named in the application is in substantial compliance with federal regulations at the time of application. • ~~If there is an accepted submitted plan of correction for any survey activity occurring following the date of the application submission, the facility named in the application will be deemed to have satisfactory survey performance.~~

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			2.4 Medicaid Nursing Facility Bed Certification Process	Text was revised to read: The following chart contains definitions related to bed certification criteria and application process in this subsection and in the Criteria for Evaluation of Medicaid Bed Certification Applications subsection of this chapter. **Application Period** — The dates when a NF may submit an application for an effective date of the following quarter. This period will always be the first day of each quarter through the 45th day before the effective date. (See table below.) **Substantial Compliance** — A level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm. All plans of correction are completed and corrected, and the enforcement cycle is closed. **Time of Application** — The date within the application period when a complete and correct application is submitted to MDHHS. Current providers who wish to change their Medicaid-certified beds (increase, decrease, or relocate) and providers who wish to enroll in the Medicaid Program may do so as outlined in this subsection. Providers must submit a complete and correct application (see below) during the application period in order to have their application reviewed. It is the responsibility of the applicant to ensure all application materials are complete, accurate and included in the application submission. Failure to submit a complete and correct application during the application period will result in a denial. ~~A written application to change Medicaid-certified beds must contain the following:~~ • ~~Number and location of facility beds.~~

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				~~• Current certification designation of all facility beds by unit or wing.~~ • ~~Requested number and proposed location of increased, decreased, or relocated Medicaid beds, with an attached layout of the facility showing the current and proposed distribution of beds.~~ A complete application to change Medicaid-certified beds must contain the following: • Application BCHS-HFD-100 and Appendix D; and • Two floor plans that are printable and readable and include: ➢ an accurate current plan; and ➢ a proposed plan with the requested number of Medicaid beds identified. Floor plans must include: ➢ Room numbers and the number of beds in each room; ➢ Location of all facility beds, office spaces, dining, and other nonresident rooms by wings or units; ➢ Total number of beds by wing or unit; and ➢ Current bed designation of all facility beds (Medicare-only, dually certified, or licensed only). Mark any Non-Available Bed Plans or building program agreement, if applicable; • Any decertification requests must also include a current census. • Any relocation requests must also include the current census and how many residents will be relocated as a result. ~~A provider may apply for a change in Medicaid bed certifications any time throughout the year up to once per quarter.~~

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				A provider may apply for a change in Medicaid bed certifications during the application period preceding the effective date (shown in the chart below) up to once per quarter. Any applications received outside of the application periods will not be reviewed. Providers may resubmit untimely applications during the following application periods.

Effective Date of Bed Certification	January 1	April 1	July 1	October 1
Application Period	October 1 – November 17	January 1 – February 15	April 1 – May 17	July 1 – August 17

Application criteria, as defined in the Criteria for Evaluation of Medicaid Bed Certification Applications section above, will be reviewed to ensure criteria are met at the time of application. Note: Application materials and criteria related to the bed certification process can only be reviewed within the application period by any entity. Any communication received after the application period relative to substantial compliance will not be considered.

The change in bed certifications will take place after approval is granted effective on the first of the month beginning the next quarter of the provider's cost reporting year. Changes in bed certifications will not be approved on a retroactive basis.

~~In addition to the process outlined below, nursing facilities~~ NFs must abide by the procedures outlined in the State Operations Manual, Chapter 3, Section 3202, Change in Size or Location of Participating SNF and/or NF.

MDHHS will respond to Medicaid bed certification applications with a determination ~~within 45 days of receipt of all requested information~~ before the effective day requested.

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