MDHHS
Michigan Department of Health & Human Services

BULLETIN

Michigan Medicaid Policy (MMP) | Health Services

Bulletin Number: MMP 26-26

Distribution: All Providers

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Subject: Revisions to MI Coordinated Health Program Policy

Effective: August 1, 2026

Programs Affected: Medicaid, MI Coordinated Health

On November 26, 2025, the Michigan Department of Health and Human Services (MDHHS) issued Bulletin MMP 25-47 introducing a new MI Coordinated Health (MICH) chapter within the MDHHS Medicaid Provider Manual effective January 1, 2026. This bulletin serves to revise or clarify various policy requirements included in the MI Coordinated Health (MICH) chapter of the MDHHS Medicaid Provider Manual.

MICH Service Areas

The Highly Integrated Dual Eligible Special Needs Plan (HIDE SNP) must operate in one or more of the eligible regions throughout the state for the provision of covered services. The HIDE SNP must provide services in accordance with the State Medicaid Agency Contract (SMAC) to MICH enrollees residing in all counties within the region(s) it is approved to cover. Regions are defined and numbered as follows:

- Region 1: Alger, Baraga, Delta, Dickinson, Houghton, Iron, Keweenaw, Luce, Mackinac, Marquette, Ontonagon, Schoolcraft
- Region 8: Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph, Van Buren
- Region 10: Macomb
- Region 12: Wayne

Individualized Care Plan (ICP) Requirements

The person-centered planning process and ICP for MICH Home and Community Based Services (HCBS) waiver enrollees must be compliant with the HCBS Final Rule (CMS-2249F; CMS-2296-F) released by the Centers for Medicare & Medicaid Services (CMS) on January 16, 2014.

The ICP must reflect the services and supports (paid and unpaid) that will assist the enrollee to achieve identified goals and the providers of those services and supports, including natural

supports. Natural supports are unpaid supports that choose to volunteer their time to assist enrollees in lieu of MICH services and supports.

When the enrollee selects controlled residential settings, such as licensed Adult Foster Care (AFC) or Homes for the Aged (HFA), the following must be included in the ICP:

- The chosen setting.
    - The setting options must be identified and documented in the ICP and must be based on the enrollee's needs, preferences and, for residential settings, resources available for room and board.
- The enrollee's resources.
- Whether or not the enrollee chooses to have a roommate, as well as any specific preferences for roommates, bathroom schedules, etc.
- Preference for engaging in community activities outside the home, and whether or not the enrollee needs assistance with arranging transportation, finding work, or otherwise getting involved in the community outside the home and how to make that happen.
- Personal safety risks and any interventions that may affect the enrollee's ability to engage in community activities outside the home without supervision.
- Any modifications to existing policy and procedure and home and community-based setting requirements (including HCBS Final Rule) at the home to accommodate an enrollee's assessed needs; indicate established timeframes for periodic review of these modifications.
    - For provider-owned or -controlled settings, any modification of the additional conditions under 42 CFR § 441.301(c)(4)(vi)(A) through (D) must be supported by a specific assessed need and justified in the ICP and the following will be documented in the ICP:
        - A specific and individualized assessed need for the modification
        - Positive interventions and supports used prior to any modifications to the person-centered service plan
        - Less intrusive methods of meeting the need that have been tried but did not work
        - A clear description of the condition that is directly proportionate to the specific assessed need
        - Regular collection and review of data to measure the ongoing effectiveness of the modification
        - Established time limits for periodic reviews to determine if the modification is still necessary or can be terminated
        - Informed consent of the enrollee
        - An assurance that interventions and supports will cause no harm to the enrollee

Behavioral Health State Plan Concurrent Enrollment

The HIDE SNP must provide MICH HCBS waiver services in accordance with the requirements of the CMS-approved 1915(c) waiver. MICH enrollees may also qualify for benefits under the Behavioral Health State Plan or the Behavioral Health 1915(i) State Plan Amendment (SPA) and the Habilitations Support Waiver (HSW). Concurrent enrollment is permitted under the following guidelines:

- **HSW:** MICH enrollees may also participate in the Habilitation Supports Waiver (HSW). Concurrent enrollment in the HSW and MICH HCBS waiver is not permitted.

- **BH 1915(i) SPA:** MICH enrollees may also participate in the BH 1915(i) SPA. Those enrolled in both MICH and the BH 1915(i) SPA may concurrently enroll in the MICH HCBS waiver (given eligibility requirements are met).

- **Behavioral Health Home (BHH)/ Substance Use Disorder Health Home (SUDHH):** MICH enrollees may be enrolled in a BHH or SUDHH. Those enrolled in both MICH and a BHH or SUDHH may concurrently enroll in the MICH HCBS waiver (given eligibility requirements are met).

The HIDE SNP must collaborate with the Prepaid Inpatient Health Plan (PIHP) to support coordination of services and alignment of care management activities in a timely and non-duplicative manner. The HIDE SNP should refer to the SMAC for additional requirements on coordination with PIHPs.

Adaptive Medical Equipment and Supplies Waiver Service Standard

Adaptive Medical Equipment and Supplies include enteral formula administered orally once the State Plan coverage amount is exceeded (900 units). (Refer to the Medical Supplier chapter of the MDHHS Medicaid Provider Manual for additional information.) Liquid nutritional supplement orders must be renewed every six months by a physician, physician's assistant, or nurse practitioner (in accordance with scope of practice).

Removal of the Recommendation for Use of the Personal Care Services (PCS) Reasonable Time Schedule (RTS)

The HIDE SNP must ensure that adequate minutes of services are provided to meet the enrollee's needs based on the observation of the enrollee's abilities during the in-person assessment. The RTS is no longer recommended and will no longer be provided as a guide.

MICH HCBS Waiver Expanded Community Living Supports (ECLS) and PCS Intersection

MICH HCBS waiver ECLS may be provided in addition to PCS if the enrollee requires hands-on assistance with some activities of daily living (ADL) and instrumental activities of daily living (IADL), as covered under State Plan PCS, and requires prompting, cueing, guiding, teaching, observing, reminding, or other support (not hands-on) to complete ADL and IADL independently to ensure safety, health, and welfare of the enrollee.

ECLS and State Plan PCS can be provided for the same ADL or IADL during the same day but at different times.

- **Example:** Mrs. Jane just needs prompting/cueing/supervision in the morning but needs additional hands-on assistance in the evening due to being more tired at the end of the day. This is an acceptable use of the services as long as they are assessed, billed, and paid for according to the appropriate service code.

ECLS can be provided in addition to State Plan PCS for different time periods under the same ADL or IADL. The distinction must be apparent by unique minutes in the approved ICP.

- **Example:** Mr. Brown takes 20 minutes to take a shower. He needs hands-on assistance for 8 minutes during the shower while he washes his hair. The remaining 12 minutes of his shower requires only supervision. Eight minutes can be provided through PCS, while the remaining 12 minutes of supervision can be provided through ECLS.

Cessation of Services when a MICH HCBS Waiver Enrollee Moves out of State

If a MICH HCBS waiver enrollee moves out of state permanently, the HIDE SNP may discontinue waiver services once the enrollee no longer resides in the service area. The HIDE SNP is not required to cover waiver services through the date of disenrollment (the last day of the month) when the enrollee moves out of state.

The HIDE SNP, at its own discretion, may help the waiver enrollee access resources in other states to aid in the transition to the new service area. The HIDE SNP does remain responsible for all other non-HCBS waiver-covered MICH services until an enrollee’s date of disenrollment after a move out of state. The HIDE SNP may utilize a single case agreement, as defined by the SMAC, to ensure the enrollee's access to non-HCBS waiver services when the enrollee has moved permanently out of state or out of the HIDE SNP's service area until the enrollee's date of disenrollment.

HIDE SNP Provider Enrollment

The HIDE SNP is prohibited from making payments to all typical network and out-of-network providers who appear on a claim and are not enrolled in the Community Health Automated Medicaid Processing System (CHAMPS). This also applies to the following atypical providers who are eligible to enroll in CHAMPS under MICH:

- Adaptive Medical Equipment and Supplies/Assistive Technology providers (must enroll in Medicare and/or Medicaid as a Durable Medical Equipment provider, pharmacy, etc., as appropriate).
- Fiscal Intermediaries (FIs) and agencies providing services that require Electronic Visit Verification (EVV) (including State Plan PCS, ECLS and Respite agency providers).
- Non-Emergency Medical Transportation (NEMT) providers.

Criminal History Review

All typical and atypical providers who will be entering the residence of an enrollee, and any person with a five percent or more direct or indirect ownership interest in the provider, must consent to a criminal history review as a condition of participation.

The HIDE SNP must have completed the criminal history review and a reference check before authorizing the provider to provide services in an enrollee's residence. At a minimum, the scope of the criminal history review is statewide.

The HIDE SNP and Michigan Department of Health and Human Services (MDHHS) will conduct annual reviews to ensure mandatory criminal history reviews have been conducted in compliance with direction given by MDHHS or otherwise required by federal and state law, policy or operating standards.

Refer to the General Information for Providers chapter of the MDHHS Medicaid Provider Manual for additional information. In the MICH program, the requirements and criteria outlined in the General Information for Providers chapter apply to both typical and atypical MICH providers who will be entering the residence of an enrollee and any person with a five percent or more direct or indirect ownership interest in the provider.

Criminal History Screening for a Caregiver who is Providing PCS to an Enrollee Who is Transitioning to MICH from the Home Help Program

When an enrollee who was receiving PCS through the Home Help program transitions their enrollment to MICH, the HIDE SNP is responsible for continued coverage of their PCS starting on day one of the enrollment with MICH.

MDHHS provides the HIDE SNP with a monthly Home Help Report that identifies caregivers who are serving an enrollee who is transitioning their enrollment to MICH from the Home Help program. The HIDE SNP must utilize the Home Help Report to expedite the provider onboarding process for the transitioning enrollee's caregiver.

The onboarding process includes completion of the criminal history review. The HIDE SNP must ensure that the criminal history review is completed as soon as possible, but no later than within 30 calendar days of enrollment with MICH. The HIDE SNP must have completed the criminal history review before authorizing the provider to provide services in an enrollee's residence. To avoid a disruption in services during the 30 calendar day period after enrollment with MICH, confirmation that the caregiver has an active CHAMPS enrollment can serve as proof of a current criminal history review. The HIDE SNP must consistently check 5938 files as they become available on a weekly basis to confirm that CHAMPS enrollment is active.

The flexibility to rely on active CHAMPS enrollment as proof of a current criminal history review applies only during the 30 calendar-day period after enrollment in MICH (to allow time for the HIDE SNP to complete the criminal history review and onboard the provider) for those enrollees who have transitioned to MICH from the Home Help program.

Nursing Facility Level of Care Determination (LOCD) Tier Assignments and Capitation Payments

To determine eligibility for the MICH HCBS waiver or Medicaid nursing facility (NF) services, the HIDE SNP will ensure that the LOCD tool is conducted as necessary for enrollees demonstrating NF level of care needs identified in the Health Risk Assessment (HRA), for those enrollees residing in a NF at the time of enrollment, and for those enrollees enrolled in the MICH HCBS waiver.

The entity completing the tool will record the findings in CHAMPS for MDHHS to make final eligibility determinations and authorize appropriate tier assignment and the HIDE SNP Capitation Payment. For MICH HCBS waiver enrollees in CHAMPS with no LOCD or LOCD Door 0, the HIDE SNP will receive the Tier 3 capitation payment. In the case where a MICH HCBS waiver enrollee has filed a timely LOCD appeal, the Tier 2 capitation payment will be manually entered by MDHHS.

Program Enrollment Type (PET) Codes

Program Enrollment Type (PET) codes identify an enrollee's type of admission or managed care enrollment along with their living arrangement.

When an enrollee qualifies for and elects MICH HCBS waiver enrollment, the HDE-HCBS PET code will be assigned when MICH HCBS waiver enrollment is entered in CHAMPS.

When an enrollee is disenrolled from the MICH HCBS waiver, the HIDE SNP must enter the disenrollment in CHAMPS, which will remove the HCBS PET code.

Manual Maintenance

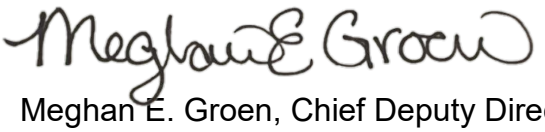
Retain this bulletin until the information is incorporated into the MDHHS Medicaid Provider Manual.

Questions

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Health and Human Services, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mailed to ProviderSupport@michigan.gov. When you submit an e-mail, 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 800-292-2550. Atypical Providers may phone toll-free 800-979-4662.

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

Approved



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