MI - Submission Package - MI2020MS0003O - (MI-20-1501) - Health Homes

CMS-10434 OMB 0938-1188

Package Information

Package ID	MI2020MS0003O	**Submission Type**	Official
Program Name	Opioid Health Home	**State**	MI
SPA ID	MI-20-1501	**Region**	Chicago, IL
Version Number	1	**Package Status**	Submitted
Submitted By	Erin Black	**Submission Date**	7/1/2020
		Regulatory Clock	90 days remain
		Review Status	Review 1

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | MI2020MS0003O | MI-20-1501 | Opioid Health Home

Package Header

Package ID MI2020MS0003O
SPA ID MI-20-1501
Submission Type Official
Initial Submission Date 7/1/2020
Approval Date N/A
Effective Date N/A
Superseded SPA ID N/A
Reviewable Unit Instructions

State Information

State/Territory Name: Michigan
Medicaid Agency Name: Michigan Department of Health and Human Services

Submission Component

(•) State Plan Amendment
(•) Medicaid
( ) CHIP

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | MI2020MS0003O | MI-20-1501 | Opioid Health Home

Package Header

Package ID MI2020MS0003O
SPA ID MI-20-1501
Submission Type Official
Initial Submission Date 7/1/2020
Approval Date N/A
Effective Date N/A
Superseded SPA ID N/A
Reviewable Unit Instructions

SPA ID and Effective Date

SPA ID MI-20-1501

Reviewable Unit	Proposed Effective Date	Superseded SPA ID
Health Homes Intro	10/1/2020	MI-18-1500
Health Homes Geographic Limitations	10/1/2020	MI-18-1500
Health Homes Population and Enrollment Criteria	10/1/2020	MI-18-1500
Health Homes Providers	10/1/2020	MI-18-1500
Health Homes Payment Methodologies	10/1/2020	MI-18-1500
Health Homes Services	10/1/2020	MI-18-1500

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | MI2020MS0003O | MI-20-1501 | Opioid Health Home

Package Header

Package ID MI2020MS0003O
SPA ID MI-20-1501
Submission Type Official
Initial Submission Date 7/1/2020
Approval Date N/A
Effective Date N/A
Superseded SPA ID N/A
Reviewable Unit Instructions

Executive Summary

Summary Description Including Goals and Objectives

The Michigan Department of Health and Human Services (MDHHS) is seeking approval from Centers of Medicare and Medicaid Services (CMS) to revise the current Opioid Health Home (OHH) State Plan Amendment (SPA) to optimize and expand the OHH in select Michigan counties. The OHH will provide comprehensive care management and coordination of services to Medicaid beneficiaries with an opioid use disorder diagnosis. For enrolled beneficiaries, the OHH will function as the central point of contact for directing patient-centered care across the broader health care system. Beneficiaries will work with an interdisciplinary team of providers to develop a person-centered health action plan to best manage their care. The model also elevates the role and importance of Peer Recovery Coaches and Community Health Workers to foster direct empathy and raise overall health and wellness. In doing so, this will attend to a beneficiary's complete health and social needs. Participation is voluntary and enrolled beneficiaries may opt-out at any time. Michigan has three goals for the OHH program: 1) improve care management of beneficiaries with opioid use disorder; 2) improve care coordination between physical and behavioral health care services; and 3) improve care transitions between primary, specialty, and inpatient settings of care.

Michigan's OHH model is comprised of a team of providers, including a Lead Entity (LE) and its contracted designated Health Home Partners (HHP). Providers must meet the specific qualifications set forth in the SPA, this policy, and provide the six federally required core health home services. Michigan's OHHs must coordinate with other community-based providers to manage the full breadth of beneficiary needs.

MDHHS will provide a monthly case rate to the LE based on the number of OHH beneficiaries with at least one OHH service during a given month. HHPs must contract or establish a memorandum of understanding (MOU) with an LE in order to be a designated HHP and to receive payment. The LE will reimburse the HHP for delivering health home services. Finally, MDHHS will employ a pay-for-performance (P4P) incentive that will reward providers based on outcomes. MDHHS will only claim federal match for P4P incentive payments after P4P qualifications have been met and providers have been paid.

Federal Budget Impact and Statute/Regulation Citation

Federal Budget Impact

	Federal Fiscal Year	Amount
First	2021	$6200000
Second	2022	$6200000

Federal Statute / Regulation Citation

Section 1945 of the Social Security Act

Supporting documentation of budget impact is uploaded (optional).

Name	Date Created	
No items available		

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | MI2020MS0003O | MI-20-1501 | Opioid Health Home

Package Header

Package ID MI2020MS0003O
SPA ID MI-20-1501
Submission Type Official
Initial Submission Date 7/1/2020
Approval Date N/A
Effective Date N/A
Superseded SPA ID N/A
Reviewable Unit Instructions

Governor's Office Review

- ○ No comment
- ○ Comments received
- ○ No response within 45 days
- ◉ Other

Describe Kate Massey, Director
Medical Services Administration

Submission - Medicaid State Plan

MEDICAID | Medicaid State Plan | Health Homes | MI2020MS0003O | MI-20-1501 | Opioid Health Home

CMS-10434 OMB 0938-1188

The submission includes the following:

- [ ] Administration
- [ ] Eligibility
- [x] Benefits and Payments
  - [x] Health Homes Program

Do not use "Create New Health Homes Program" to amend an existing Health Homes program. Instead, use "Amend existing Health Homes program," below.

- ( ) Create new Health Homes program
- (•) Amend existing Health Homes program
- ( ) Terminate existing Health Homes program

Opioid Health Home

Health Homes SPA - Reviewable Units

Only select Reviewable Units to include in the package which you intend to change.

*

	Reviewable Unit Name	Included in Another Submission Package	Source Type
[x]	Health Homes Intro	●	APPROVED
[x]	Health Homes Geographic Limitations	●	APPROVED
[x]	Health Homes Population and Enrollment Criteria	●	APPROVED
[x]	Health Homes Providers	●	APPROVED
[ ]	Health Homes Service Delivery Systems	●	APPROVED
[x]	Health Homes Payment Methodologies	●	APPROVED

☑	Health Homes Services	●	APPROVED
☐	Health Homes Monitoring, Quality Measurement and Evaluation	●	APPROVED

1 – 8 of 8

Submission - Public Notice/Process

MEDICAID | Medicaid State Plan | Health Homes | MI2020MS0003O | MI-20-1501 | Opioid Health Home

Package Header

Package ID MI2020MS0003O
SPA ID MI-20-1501
Submission Type Official
Initial Submission Date 7/1/2020
Approval Date N/A
Effective Date N/A
Superseded SPA ID N/A
Reviewable Unit Instructions

Name of Health Homes Program

Opioid Health Home

☑ Public notice was provided due to proposed changes in methods and standards for setting payment rates for services, pursuant to 42 CFR 447.205.

Upload copies of public notices and other documents used

Name	Date Created	
P6-Clip Saginaw	6/11/2020 1:36 PM EDT	

Submission - Tribal Input

MEDICAID | Medicaid State Plan | Health Homes | MI2020MS0003O | MI-20-1501 | Opioid Health Home

Package Header

Package ID MI2020MS0003O
SPA ID MI-20-1501
Submission Type Official
Initial Submission Date 7/1/2020
Approval Date N/A
Effective Date N/A
Superseded SPA ID N/A
Reviewable Unit Instructions

Name of Health Homes Program:

Opioid Health Home

One or more Indian Health Programs or Urban Indian Organizations furnish health care services in this state

- (•) Yes
- ( ) No

This state plan amendment is likely to have a direct effect on Indians, Indian Health Programs or Urban Indian Organizations, as described in the state consultation plan.

- (•) Yes
- ( ) No

[x] The state has solicited advice from Indian Health Programs and/or Urban Indian Organizations, as required by section 1902(a)(73) of the Social Security Act, and in accordance with the state consultation plan, prior to submission of this SPA.

Complete the following information regarding any solicitation of advice and/or tribal consultation conducted with respect to this submission:

Solicitation of advice and/or Tribal consultation was conducted in the following manner:

- [ ] All Indian Health Programs
- [ ] All Urban Indian Organizations

States are not required to consult with Indian tribal governments, but if such consultation was conducted voluntarily, provide information about such consultation below:

- [x] All Indian Tribes

Date of consultation:	Method of consultation:
2/19/2020	Letter of Notification to Tribal Chairs and Health Directors

The state must upload copies of documents that support the solicitation of advice in accordance with statutory requirements, including any notices sent to Indian Health Programs and/or Urban Indian Organizations, as well as attendee lists if face-to-face meetings were held. Also upload documents with comments received from Indian Health Programs or Urban Indian Organizations and the state's responses to any issues raised. Alternatively indicate the key issues and summarize any comments received below and describe how the state incorporated them into the design of its program.

Name	Date Created	
L 20-04	6/11/2020 1:40 PM EDT	PDF

Indicate the key issues raised (optional)

- [ ] Access
- [ ] Quality
- [ ] Cost

- [ ] Payment methodology
- [ ] Eligibility
- [ ] Benefits
- [ ] Service delivery
- [ ] Other issue

Submission - Other Comment

MEDICAID | Medicaid State Plan | Health Homes | MI2020MS0003O | MI-20-1501 | Opioid Health Home

Package Header

Package ID MI2020MS0003O
SPA ID MI-20-1501
Submission Type Official
Initial Submission Date 7/1/2020
Approval Date N/A
Effective Date N/A
Superseded SPA ID N/A
Reviewable Unit Instructions

SAMHSA Consultation

Name of Health Homes Program

Opioid Health Home

Date of consultation
4/26/2018

☑ The State provides assurance that it has consulted and coordinated with the Substance Abuse and Mental Health Services Administration (SAMHSA) in addressing issues regarding the prevention and treatment of mental illness and substance abuse among eligible individuals with chronic conditions.

Health Homes Intro

MEDICAID | Medicaid State Plan | Health Homes | MI2020MS0003O | MI-20-1501 | Opioid Health Home

Package Header

Package ID	MI2020MS0003O	**SPA ID**	MI-20-1501
Submission Type	Official	**Initial Submission Date**	7/1/2020
Approval Date	N/A	**Effective Date**	10/1/2020
Superseded SPA ID	MI-18-1500		

User-Entered

Reviewable Unit Instructions

Program Authority

1945 of the Social Security Act

The state elects to implement the Health Homes state plan option under Section 1945 of the Social Security Act.

Name of Health Homes Program

Opioid Health Home

Executive Summary

Provide an executive summary of this Health Homes program including the goals and objectives of the program, the population, providers, services and service delivery model used

The Michigan Department of Health & Human Services (MDHHS) is seeking approval from the Centers for Medicaid and Medicare Services (CMS) to revise the current OHH SPA to optimize and expand the OHH in select Michigan counties. The OHH will provide comprehensive care management and coordination services to Medicaid beneficiaries with an opioid use disorder. Michigan's OHH model is comprised of a partnership between a Lead Entity (LE) and Health Home Partners (HHPs) that can best serve the needs of each unique beneficiary. HHPs will be comprised of two settings – HHP Opioid Treatment Programs (OTPs) and HHP Office Based Opioid Treatment Providers (OBOTs). The State will provide a monthly case rate to the LE based on OHH beneficiaries with at least one OHH service. The LE will pay HHPs directly on behalf of the State. LEs and HHPs must meet the provider qualifications set forth in the SPA, MDHHS policy and provide the six federally required core health home services. HHPs must contract or establish memorandums of understanding with a LE. The LE and HHPs must be connected to other community-based providers to manage the full breadth of beneficiary needs. Finally, MDHHS will employ a pay-for- performance (P4P) incentive that will reward providers based on outcomes. MDHHS will only claim federal match for P4P incentive payments after P4P qualifications have been met and providers have been paid. Michigan has three overarching goals for the OHH program: 1) improve care management of beneficiaries with opioid use disorders, including Medication Assisted Treatment (MAT); 2) improve care coordination between physical and behavioral health care services; and 3) improve care transitions between primary, specialty, and inpatient settings of care.

General Assurances

☑ The state provides assurance that eligible individuals will be given a free choice of Health Homes providers.

☑ The states provides assurance that it will not prevent individuals who are dually eligible for Medicare and Medicaid from receiving Health Homes services.

☑ The state provides assurance that hospitals participating under the state plan or a waiver of such plan will be instructed to establish procedures for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated Health Homes providers.

☑ The state provides assurance that FMAP for Health Homes services shall be 90% for the first eight fiscal quarters from the effective date of the SPA. After the first eight quarters, expenditures will be claimed at the regular matching rate.

☑ The state provides assurance that it will have the systems in place so that only one 8-quarter period of enhanced FMAP for each health homes enrollee will be claimed.

☑ The state provides assurance that there will be no duplication of services and payment for similar services provided under other Medicaid authorities.

Health Homes Geographic Limitations

MEDICAID | Medicaid State Plan | Health Homes | MI2020MS0003O | MI-20-1501 | Opioid Health Home

Package Header

Package ID MI2020MS0003O
SPA ID MI-20-1501
Submission Type Official
Initial Submission Date 7/1/2020
Approval Date N/A
Effective Date 10/1/2020
Superseded SPA ID MI-18-1500

User-Entered

Reviewable Unit Instructions

- ○ Health Homes services will be available statewide
- ◉ Health Homes services will be limited to the following geographic areas
- ○ Health Homes services will be provided in a geographic phased-in approach

Specify the geographic limitations of the program

- ◉ By county
- ○ By region
- ○ By city/municipality
- ○ Other geographic area

Specify which counties:

1. Alcona
2. Alger
3. Alpena
4. Antrim
5. Baraga
6. Benzie
7. Calhoun
8. Charlevoix
9. Cheboygan
10. Chippewa
11. Crawford
12. Delta
13. Dickinson
14. Emmet
15. Gogebic
16. Grand Traverse
17. Houghton
18. Iosco
19. Iron
20. Kalamazoo
21. Kalkaska
22. Keweenaw
23. Leelanau
24. Luce
25. Mackinac
26. Macomb
27. Manistee
28. Marquette
29. Menominee
30. Missaukee
31. Montmorency
32. Ogemaw
33. Ontonagon
34. Oscoda
35. Otsego
36. Presque Isle
37. Roscommon
38. Schoolcraft
39. Wexford

Health Homes Population and Enrollment Criteria

MEDICAID | Medicaid State Plan | Health Homes | MI2020MS0003O | MI-20-1501 | Opioid Health Home

Package Header

Package ID MI2020MS0003O
SPA ID MI-20-1501
Submission Type Official
Initial Submission Date 7/1/2020
Approval Date N/A
Effective Date 10/1/2020
Superseded SPA ID MI-18-1500

User-Entered

Reviewable Unit Instructions

Categories of Individuals and Populations Provided Health Homes Services

The state will make Health Homes services available to the following categories of Medicaid participants

☑ Categorically Needy (Mandatory and Options for Coverage) Eligibility Groups

☑ Medically Needy Eligibility Groups

Mandatory Medically Needy

☑ Medically Needy Pregnant Women

☑ Medically Needy Children under Age 18

Optional Medically Needy (select the groups included in the population)

Families and Adults

☑ Medically Needy Children Age 18 through 20

☑ Medically Needy Parents and Other Caretaker Relatives

Aged, Blind and Disabled

☑ Medically Needy Aged, Blind or Disabled

☑ Medically Needy Blind or Disabled Individuals Eligible in 1973

Health Homes Population and Enrollment Criteria

MEDICAID | Medicaid State Plan | Health Homes | MI2020MS0003O | MI-20-1501 | Opioid Health Home

Package Header

Package ID MI2020MS0003O
SPA ID MI-20-1501
Submission Type Official
Initial Submission Date 7/1/2020
Approval Date N/A
Effective Date 10/1/2020
Superseded SPA ID MI-18-1500
User-Entered
Reviewable Unit Instructions

Population Criteria

The state elects to offer Health Homes services to individuals with:

- [ ] Two or more chronic conditions
- [x] One chronic condition and the risk of developing another

Specify the conditions included:

- [ ] Mental Health Condition
- [x] Substance Use Disorder
- [ ] Asthma
- [ ] Diabetes
- [ ] Heart Disease
- [ ] BMI over 25
- [ ] Other (specify):

Specify the criteria for at risk of developing another chronic condition:

Opioid Use Disorder as represented by the F11 code in the ICD-10 dataset.

- [ ] One serious and persistent mental health condition

Health Homes Population and Enrollment Criteria

MEDICAID | Medicaid State Plan | Health Homes | MI2020MS0003O | MI-20-1501 | Opioid Health Home

Package Header

Package ID MI2020MS0003O
SPA ID MI-20-1501
Submission Type Official
Initial Submission Date 7/1/2020
Approval Date N/A
Effective Date 10/1/2020
Superseded SPA ID MI-18-1500
User-Entered
Reviewable Unit Instructions

Enrollment of Participants

Participation in a Health Homes is voluntary. Indicate the method the state will use to enroll eligible Medicaid individuals into a Health Home:

- ○ Opt-In to Health Homes provider
- ○ Referral and assignment to Health Homes provider with opt-out
- ◉ Other (describe)

Name:

Hybrid Autoenrollment Process

Description:

Enrollment Processes
Potential Opioid Health Home (OHH) enrollees will be identified using a multifaceted approach. The Michigan Department of Health and Human Services (MDHHS) will provide a generated list that will pull potential enrollees from MDHHS administrative claims data into the Waiver Support Application (WSA) monthly. The Lead Entity (LE) will identify potential enrollees from the WSA and coordinate with a Health Home Partner (HHP) to fully enroll the Medicaid beneficiary into the OHH benefit.

Lead Entities will provide information about the OHH to all potential enrollees through community referrals, peer support specialist networks, other providers, courts, health departments, law enforcement, and other community-based settings. LEs will strategically provide these settings with informational brochures, posters, and other outreach materials to facilitate awareness and engagement of the OHH.

- Lead Entity Identification of Potential Enrollees

The LE will be responsible for identifying potential enrollees that have a qualifying OHH diagnosis in the WSA to a perspective HHP and provide information regarding OHH services to the Medicaid beneficiary in coordination with the HHP.

- Provider Recommended Identification of Potential Enrollees

Health Home Partners are permitted to recommend potential enrollees for the OHH benefit via the WSA. OHH providers must provide documentation that indicates whether a potential OHH enrollee meets all eligibility for the health home benefit, including diagnostic verification, obtaining consent, and establishment of an individualized care plan. The LE must review and process all recommended enrollments in the WSA. MDHHS reserves the right to review and verify all enrollments.

The LE will work with HHPs and the beneficiary to identify the optimal setting of care (e.g., Opioid Treatment Program vs. Office Based Opioid Treatment Provider, geographic considerations, historical relationships, etc.). The LE will document the assigned HHP in the WSA. The beneficiary may opt-out (disenroll) at any time with no impact on other entitled Medicaid services.

Health Homes Providers

MEDICAID | Medicaid State Plan | Health Homes | MI2020MS0003O | MI-20-1501 | Opioid Health Home

Package Header

Package ID MI2020MS0003O
SPA ID MI-20-1501
Submission Type Official
Initial Submission Date 7/1/2020
Approval Date N/A
Effective Date 10/1/2020
Superseded SPA ID MI-18-1500
User-Entered
Reviewable Unit Instructions

Types of Health Homes Providers

☑ Designated Providers

Indicate the Health Homes Designated Providers the state includes in its program and the provider qualifications and standards

☐ Physicians
☐ Clinical Practices or Clinical Group Practices
☐ Rural Health Clinics
☐ Community Health Centers
☐ Community Mental Health Centers
☐ Home Health Agencies
☐ Case Management Agencies
☐ Community/Behavioral Health Agencies
☐ Federally Qualified Health Centers (FQHC)
☑ Other (Specify)

Provider Type	Description
Lead Entity (LE)	• Be a regional entity as defined in Michigan's Mental Health Code (330.1204b). • Be an MDHHS department-designated community mental health entity who may contract for and spend funds for the prevention of substance use disorder and for the counseling and treatment of individuals with substance use disorder, as defined in Michigan's Mental Health Code (Michigan Codified Law 330.1269). • Have authority to access Michigan Medicaid claims and encounter data for the OHH target population. • Have authority to access Michigan's WSA and CareConnect360. • Must have the capacity to evaluate, select, and support providers who meet the

Provider Type	Description
	standards for HHPs, including: • Identification of providers who meet the HHP standards • Provision of infrastructure to support HHPs in care coordination • Collecting and sharing member-level information regarding health care utilization and medications • Providing quality outcome protocols to assess HHP effectiveness • Developing training and technical assistance activities that will support HHPs in effective delivery of HH services • Must maintain a network of providers that support the HHPs to service beneficiaries with an opioid use disorder.
Health Home Partner (HHP)	• Enroll or be enrolled in Michigan Medicaid and agree to comply with all Michigan Medicaid program requirements. • Must meet applicable Federal and State licensing standards in addition to Medicaid provider certification and enrollment requirements as one of the following: o Community Mental Health Services Program (Community Mental Health Center) o Federally Qualified Health Center/Primary Care Safety Net Clinic o Hospital based Physician Group o Opioid Treatment Program o Physician based Clinic o Physician or Physician Practice o Rural Health Clinics o Substance Use Disorder Provider other than Opioid Treatment Program o Tribal Health Center

☐ Teams of Health Care Professionals

☐ Health Teams

Provider Infrastructure

Describe the infrastructure of provider arrangements for Health Home Services

The LE will be responsible for recruiting health homes partners that provide an array of MAT options, including Opioid Treatment Programs (OTPs) and Office-based Opioid Treatment providers (OBOTs). OTPs must meet all state and federal licensing requirements of an OTP. OBOT providers must attain the proper federal credentials from the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Drug Enforcement Agency (DEA) to provide MAT. The following represents the care team requirement per 100 enrollees:

- Health Home Director (0.50 FTE)
- Behavioral Health Specialist (0.25 FTE)
- Nurse Care Manager (1.00 FTE)
- Peer Recovery Coach, Community Health Worker, Medical Assistant (2.00-4.00 FTE)
- Medical Consultant (0.10 FTE)
- Psychiatric Consultant (0.05 FTE)

All providers referenced above must meet the following criteria:

Health Home Director
- Must have professional working experience relative to Substance Use Disorders with leadership experience in care management and coordination activities

Behavioral Health 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 who has 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; OR a who has Master's Degree in social work, education, psychology, counseling, nursing, or closely related field from an accredited graduate

Nurse Care Manager
- Must be a licensed registered nurse in Michigan

Peer Recovery Coach, Community Health Worker or Medical Assistant
- Must obtain appropriate certification/training

Medical Consultant
- Must be a primary care physician, physician's assistant, or nurse practitioner

Psychiatric Consultant
- Must be a licensed psychologist, psychiatrist, psychiatric nurse practitioner (can be off-site)

In addition to the above Required Provider Infrastructure Requirements, eligible OHH providers should coordinate care with the following professions:
- Dentist
- Dietician/Nutritionist
- Pharmacist
- Peer support specialist
- Diabetes educator
- School personnel
- Others as appropriate

Supports for Health Homes Providers

Describe the methods by which the state will support providers of Health Homes services in addressing the following components

1. Provide quality-driven, cost-effective, culturally appropriate, and person- and family- centered Health Homes services
2. Coordinate and provide access to high quality health care services informed by evidence-based clinical practice guidelines
3. Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders
4. Coordinate and provide access to mental health and substance abuse services
5. Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care
6. Coordinate and provide access to chronic disease management, including self-management support to individuals and their families
7. Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services
8. Coordinate and provide access to long-term care supports and services
9. Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services
10. Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate
11. Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level

Description

Participating sites must adhere to the State's provider qualifications and standards in order to maintain active status. These standards include the eleven key components for providers listed above. All Health Homes must participate in State-sponsored activities designed to support approved sites in transforming services delivery. This includes a mandatory Health Home orientation for the designated providers and clinical support staff before the program is officially implemented. The orientation will include all HHPs and include detailed training on program expectations to ensure provider readiness. Ongoing
technical assistance will be made available through additional trainings and webinars after implementation. Individual assistance will be provided on an as needed basis by state or contractual staff. The state also anticipates forming Health Home workgroups and listserv forums for Health Home administrators and staff to communicate amongst each other and share best practices, solutions to potential service barriers or issues, monitoring and performance reporting concerns, and other needs. In addition, the state intends to develop and update a program specific website with provider resources and forms. The state will also serve as a resource, as needed, to connect providers to applicable state and local programs that would aid in the overall needs and goals of the Health Home beneficiary.

Other Health Homes Provider Standards

The state's requirements and expectations for Health Homes providers are as follows

The State's minimum requirements and expectations for Health Homes providers are as follows:

The Michigan OHH Lead Entity must:
1. Be a regional entity as defined in Michigan's Mental Health Code (330.1204b).
2. Be an MDHHS department-designated community mental health entity who may contract for and spend funds for the prevention of substance use disorder and for the counseling and treatment of individuals with substance use disorder, as defined in Michigan's Mental Health Code (Michigan Codified Law 330.1269).
3. Have authority to access Michigan Medicaid claims and encounter data for the OHH target population.
4. Must have the capacity to evaluate, select, and support providers who meet the standards for HHPs, including:
   a. Identification of providers who meet the HHP standards
   b. Provision of infrastructure to support HHPs in care coordination
   c. Collecting and sharing member-level information regarding health care utilization and medications
      I. Providing quality outcome protocols to assess HHP effectiveness
      I) Developing training and technical assistance activities that will support HHPs in effective delivery of health home services
5. Must maintain a network of providers that support the HHPs to service beneficiaries with an opioid use disorder.
6. Must pay providers directly on behalf of the State for the OHH Program at the State defined rate.
7. The LE must be contracted with MDHHS to execute the enrollment, payment, and administration of the OHH with providers; MDHHS will retain overall oversight and direct administration of the LE; The LE will also serve as part of the Health Homes team by providing care management and care coordination services.

The Lead Entity and the Health Home Partner jointly must:
1. HHPs must be enrolled in the Michigan Medicaid program and in compliance with all applicable program policies
2. HHPs must enroll and execute any necessary agreement(s)/contract(s) with the LE; HHPs must also sign the MDHHS-5745 with MDHHS
3. HHPs must adhere to all federal and state laws regarding Section 2703 Health Homes recognition/certification, including the capacity to perform all core services specified by CMS. Providers shall meet the following recognition/certification standards:
   a. Achieve Patient Centered Medical Home (PCMH) from national recognizing body (NCQA, AAAHC, JC, CARF) before the OHH becomes operational. PCMH application can be pending at the time of implementation.
   b. Achieve CMS Stage 2 Meaningful Use (can be in-progress at the time of implementation).
4. Provide 24-hour, seven days a week availability of information, screening for services and emergency consultation services to beneficiaries
5. Ensure access to timely services for enrollees, including seeing enrollees within seven days and 30 days of discharge from an acute care or psychiatric inpatient stay
6. Ensure person-centered and integrated recovery action planning that coordinates and integrates all clinical and non-clinical health care related needs and services
7. Provide quality-driven, cost-effective health home services in a culturally competent manner that addresses health disparities and improves health literacy
8. Utilize the MDHHS-5515 Consent to Share Behavioral Health and Substance Use Disorder Information
9. Demonstrate the ability to perform each of the following functional requirements. This includes documentation of the processes and methods used to execute these functions.
   a. Coordinate and provide the six core services cited in Section 2703 of the Affordable Care Act
   b. Coordinate and provide access to high-quality health care services, including recovery services, informed by evidence-based clinical practice guidelines
   c. Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders
   d. Coordinate and provide access to physical, mental health, and substance use disorder services
   e. Coordinate and provide access to chronic disease management, including self- management support to individuals and their families
   f. Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices as appropriate
   g. Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level
10. Demonstrate the ability to report required data for both state and federal monitoring of the program
11. Ensure Priority Populations as outlined in amendment #2 in the LE contract with MDHHS, have priority assess to treatment. Access timeliness standards and interim services requirements for these populations are provided below.

Name	Date Created	
OHH Provider Requirements and Expectations V1 (3.23.20)	6/11/2020 2:06 PM EDT	

Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | MI2020MS0003O | MI-20-1501 | Opioid Health Home

Package Header

Package ID MI2020MS0003O
SPA ID MI-20-1501
Submission Type Official
Initial Submission Date 7/1/2020
Approval Date N/A
Effective Date 10/1/2020
Superseded SPA ID MI-18-1500
User-Entered
Reviewable Unit Instructions

Payment Methodology

The State's Health Homes payment methodology will contain the following features

☑ Fee for Service

☐ Individual Rates Per Service

☑ Per Member, Per Month Rates

☑ Fee for Service Rates based on

☐ Severity of each individual's chronic conditions

☑ Capabilities of the team of health care professionals, designated provider, or health team

☐ Other

☐ Comprehensive Methodology Included in the Plan

☑ Incentive Payment Reimbursement

☑ Fee for Service Rates based on

☐ Severity of each individual's chronic conditions

☐ Capabilities of the team of health care professionals, designated provider, or health team

☑ Other

Describe below

Pay for Performance (see attached Payment Methodology)

Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided

See the payment methodology attached.

☐ PCCM (description included in Service Delivery section)

☐ Risk Based Managed Care (description included in Service Delivery section)

☐ Alternative models of payment, other than Fee for Service or PMPM payments (describe below)

Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | MI2020MS0003O | MI-20-1501 | Opioid Health Home

Package Header

Package ID	MI2020MS0003O	**SPA ID**	MI-20-1501
Submission Type	Official	**Initial Submission Date**	7/1/2020
Approval Date	N/A	**Effective Date**	10/1/2020
Superseded SPA ID	MI-18-1500		
	User-Entered		
Reviewable Unit Instructions			

Agency Rates

Describe the rates used

- (●) FFS Rates included in plan
- ( ) Comprehensive methodology included in plan
- ( ) The agency rates are set as of the following date and are effective for services provided on or after that date

Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | MI2020MS0003O | MI-20-1501 | Opioid Health Home

Package Header

Package ID	MI2020MS0003O	**SPA ID**	MI-20-1501
Submission Type	Official	**Initial Submission Date**	7/1/2020
Approval Date	N/A	**Effective Date**	10/1/2020
Superseded SPA ID	MI-18-1500		
	User-Entered		
Reviewable Unit Instructions			

Rate Development

Provide a comprehensive description in the SPA of the manner in which rates were set

1. In the SPA please provide the cost data and assumptions that were used to develop each of the rates
2. Please identify the reimbursable unit(s) of service
3. Please describe the minimum level of activities that the state agency requires for providers to receive payment per the defined unit
4. Please describe the state's standards and process required for service documentation, and
5. Please describe in the SPA the procedures for reviewing and rebasing the rates, including
    - the frequency with which the state will review the rates, and
    - the factors that will be reviewed by the state in order to understand if the rates are economic and efficient and sufficient to ensure quality services.

Comprehensive Description See the payment methodology attached.

Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | MI2020MS0003O | MI-20-1501 | Opioid Health Home

Package Header

Package ID	MI2020MS0003O	**SPA ID**	MI-20-1501
Submission Type	Official	**Initial Submission Date**	7/1/2020
Approval Date	N/A	**Effective Date**	10/1/2020
Superseded SPA ID	MI-18-1500		
	User-Entered		
Reviewable Unit Instructions			

Assurances

☑ The State provides assurance that it will ensure non-duplication of payment for services similar to Health Homes services that are offered/covered under a different statutory authority, such as 1915(c) waivers or targeted case management.

Describe below how non-duplication of payment will be achieved MDHHS has built into its MMIS, the ability to exclude benefit plans that may duplicate and offer payment for similar services provided under Medicaid. MDHHS will utilize this capability to prevent duplication and payment of services provided under other Medicaid authorities.

☑ The state has developed payment methodologies and rates that are consistent with section 1902(a)(30)(A).

☑ The State provides assurance that all governmental and private providers are reimbursed according to the same rate schedule, unless otherwise described above.

☑ The State provides assurance that it shall reimburse providers directly, except when there are employment or contractual arrangements consistent with section 1902(a)(32).

Optional Supporting Material Upload

Name	Date Created	
OHH Payment Methodology V1 (3.23.20)	6/11/2020 2:17 PM EDT	

Health Homes Services

MEDICAID | Medicaid State Plan | Health Homes | MI2020MS0003O | MI-20-1501 | Opioid Health Home

Package Header

Package ID MI2020MS0003O
SPA ID MI-20-1501
Submission Type Official
Initial Submission Date 7/1/2020
Approval Date N/A
Effective Date 10/1/2020
Superseded SPA ID MI-18-1500

User-Entered

Reviewable Unit Instructions

Service Definitions

Provide the state's definitions of the following Health Homes services and the specific activities performed under each service

Comprehensive Care Management

Definition

Comprehensive care management begins with an assessment that will assist the provider and beneficiary in the development of the beneficiaries' individualized care plan. This care plan will be tailored to meet the beneficiaries' needs and goals. Individualized care plans will be measurable, well-defined, clinically relevant and monitored by members of the care delivery team. Issues identified during the assessment will be incorporated into the care plan which is documented in the EHR. Behavioral and physical health services will be integrated. Family members or other non-compensated support person(s) will be involved, when applicable. Health homes will track participants' treatment, outcomes, and self-management goals utilizing validated measurement tools, as appropriate, throughout their participation in the program. Periodic reassessment of patient will occur, including health status, service utilization, and to ascertain appropriate community supports have been secured. Adjustments to the treatment plan may be necessary as applicable, including moving from one setting of care to another (e.g., OBOT HHP to OTP HHP, and vice-versa)

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

Health homes are required to have a functioning Electronic Health Record (EHR) to participate. LEs and HHPs will utilize their EHR to facilitate progress made on the overall care plan and adjust the plan accordingly in unison with the needs of the beneficiary. Health Homes will provide reporting via the EHR. Issues identified during the assessment will be incorporated into the care plan which is documented in the EHR.

HHPs must join the LEs centralized, claims-based health information exchange (HIE). This will assist care coordinators with maintaining a comprehensive care plan for each beneficiary enrolled in the health home.

Scope of service

The service can be provided by the following provider types

☑ Behavioral Health Professionals or Specialists

Description

Behavioral Health Provider (e.g., Case Worker or Addictions Counselor with MSW or related degree)
*Screening/evaluation of individuals for mental health and substance use disorders
*Referral to licensed mental health provider and/or SUD therapist as necessary
*Brief intervention for individuals with behavioral health problems
*Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic
*Supports primary care providers in identifying and behaviorally intervening with patients
*Focuses on managing a population of patients versus specialty care
*Works with patients to identify chronic behavior, discuss impact, develop improvement strategies and specific goal-directed interventions
*Develops and maintains relationships with community based mental health and substance abuse providers
*Identifies community resources (i.e. support groups, workshops, etc.) for patient to utilize to maximize wellness
*Provides patient education

☑ Nurse Practitioner

Description

Physician, Nurse Practitioner, Physician's Assistant
*Serves as the OHH Primary Care Provider (must have appropriate licensure and/or certification from the State)

☑ Nurse Care Coordinators

Description

Nurse Care Manager (Coordinator) (e.g., RN)
*Participates in the selection of strategies to implement evidence-based wellness and prevention initiatives
*Participates in initial care plan development including specific goals for all enrollees
*Communicates with medical providers, subspecialty providers including mental health and substance abuse service providers, long term care and hospitals regarding records including admission/discharge
*Provides education in health conditions, treatment recommendation, medications and strategies to implement care plan goals including both clinical and non-clinical needs
*Monitors assessments and screenings to assure findings are integrated in the care plan
*Facilitates the use of the EHR and other HIT to link services, facilitate communication among team members and provide feedback
*Monitors and report performance measures and outcomes
*Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic

☐ Nurses

☐ Medical Specialists

☑ Physicians

Description

Physician, Nurse Practitioner, Physician's Assistant
*Serves as the OHH Primary Care Provider (must have appropriate licensure and/or certification from the State)

☑ Physician's Assistants

Description

Physician, Nurse Practitioner, Physician's Assistant
*Serves as the OHH Primary Care Provider (must have appropriate licensure and/or certification from the State)

☐ Pharmacists

☐ Social Workers

☐ Doctors of Chiropractic

☐ Licensed Complementary and alternative Medicine Practitioners

☐ Dieticians

☐ Nutritionists

☑ Other (specify)

Provider Type	Description
Community Health Workers	Must be at least 18 years of age Must possess a high school diploma or equivalent Must be supervised by licensed professional members of the care team MDHHS requires the completion of a CHW Certificate Program or equivalent
Certified Peer Recovery Coaches	Must obtain requisite peer certification per the Medicaid Provider Manual
Health Home Partners	Any of the selected provider types above at the HHP.
Lead Entity	• Provides leadership for implementation and coordination of health home activities • Coordinates all enrollment into the health home on behalf of providers • Coordinates with LE care management staff and OHH providers to identify a beneficiary's optimal setting of care • Coordinates and utilizes HIT with the OHH provider team to maximize care coordination and care management • Serves as a liaison between the health homes site and MDHHS

Provider Type	Description
	staff/contractors • Champions practice transformation based on health home principles • Coordinates all enrollment into the health home on behalf of providers • Develops and maintains working relationships with primary and specialty care providers including Community Mental Health Service Providers and inpatient facilities • Collects and reports on data that permits an evaluation of increased coordination of care and chronic disease management • Monitors Health Home performance and leads quality improvement efforts • Designs and develops prevention and wellness initiatives, and referral tracking • Training and technical assistance • Data management and reporting

Care Coordination

Definition

Care coordination is the organization of activities between participants responsible for different aspects of a patient's care designed to facilitate delivery of appropriate services across all elements of the broader health care system. It includes management of integrated primary and specialty medical services, behavioral health services, and social, educational, vocational, and community services and supports to attain the goals of holistic, high quality, cost-effective care and improved patient outcomes. Components of care coordination include knowledge of and respect for the patient's needs and preferences, information sharing/communication between providers, patient, and family members, resource management and advocacy.

A key support role includes the Peer Recovery Coach and Community Health Worker (CHW). Peer Recovery Coach services are provided by a person in a journey of recovery from addictions or co-occurring disorders who identifies with a beneficiary based on a shared background and life experience. The Peer Recovery Coach serves as a personal guide and mentor for beneficiaries seeking, or already in, recovery from substance use disorders. Peer Recovery Coaches support a beneficiary's journey toward recovery and wellness by creating and sustaining networks of formal and informal services and supports while role modeling the many pathways to recovery as everyone determines his or her own way. The Peer Recovery Coach helps to remove barriers and obstacles and links the beneficiary to resources in the recovery community.

Services provided by a Peer Recovery Coach support beneficiaries to become and stay engaged in the recovery process and reduce the likelihood of relapse. Activities are targeted to beneficiaries at all places along the path to recovery, including outreach for persons who are still active in their addiction, up to and including individuals who have been in recovery for several years.

Peer Recovery Coaches embody a powerful message of hope, helping beneficiaries achieve a full and meaningful life in the community. The Peer Recovery Coach can assist with tasks such as setting recovery goals, developing recovery action plans, and solving problems directly related to recovery.

The Peer Recovery Coach supports each beneficiary to fully participate in communities of their choosing in the environment most supportive of their recovery and that promotes housing of their choice to build recovery connections and supports. Utilizing a strength-based perspective and emphasizing assessment of recovery capital, services are designed to include prevention strategies and the integration of physical and behavioral health services to attain and maintain recovery and prevent relapse. Beneficiaries utilizing Peer Recovery Coach services must freely choose the individual who is providing Peer Recovery Coach services.

The Peer Recovery Coach shall receive regular supervision by a case manager, treatment practitioner, prevention staff or an experienced Certified Peer Recovery Coach who has over two continuous years in recovery and over two years in the direct provision of recovery coach services and supports.

CHWs are professionals identified by the American Public Health Association. CHWs are frontline public health workers who have an understanding of the community they serve. The CHW to serves as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. A CHW also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy.

Peer Recovery Coaches, CHWs, and other Care Coordinators will, at a minimum, provide:
*Emphasis will be placed on in-person contacts; however telephonic outreach may be used for lower-risk Health Home members who require less frequent face to face contact
*Appointment making assistance, including coordinating transportation
*Development and implementation of care plan
*Medication adherence and monitoring
*Referral tracking
*Use of facility liaisons, as available (i.e., nurse care managers)
*Patient care team huddles
*Use of case conferences, as applicable
*Tracking test results
*Requiring discharge summaries

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

LEs and HHPs will utilize their EHR to record care coordination and health promotion activities and adjust these activities, as appropriate. The EHR can provide educational material for the beneficiary to assist with overall health promotion.

Scope of service

The service can be provided by the following provider types

☑ Behavioral Health Professionals or Specialists

Description

Behavioral Health Provider (e.g., Case Worker or Addictions Counselor with MSW or related degree)
*Screening/evaluation of individuals for mental health and substance use disorders
*Referral to licensed mental health provider and/or SUD therapist as necessary
*Brief intervention for individuals with behavioral health problems
*Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic
*Supports primary care providers in identifying and behaviorally intervening with patients
*Focuses on managing a population of patients versus specialty care
*Works with patients to identify chronic behavior, discuss impact, develop improvement strategies and specific goal-directed interventions
*Develops and maintains relationships with community based mental health and substance abuse providers
*Identifies community resources (i.e. support groups, workshops, etc.) for patient to utilize to maximize wellness
*Provides patient education

☐ Nurse Practitioner

☑ Nurse Care Coordinators

Description

Nurse Care Manager (Coordinator) (e.g., RN)
*Participates in the selection of strategies to implement evidence-based wellness and prevention initiatives
*Participates in initial care plan development including specific goals for all enrollees
*Communicates with medical providers, subspecialty providers including mental health and substance abuse service providers, long term care and hospitals regarding records including admission/discharge
*Provides education in health conditions, treatment recommendation, medications and strategies to implement care plan goals including both clinical and non-clinical needs
*Monitors assessments and screenings to assure findings are integrated in the care plan
*Facilitates the use of the EHR and other HIT to link services, facilitate communication among team members and provide feedback
*Monitors and report performance measures and outcomes
*Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic

☐ Nurses

☐ Medical Specialists

☐ Physicians

☐ Physician's Assistants

☐ Pharmacists

☐ Social Workers

☐ Doctors of Chiropractic

☐ Licensed Complementary and alternative Medicine Practitioners

☐ Dieticians

☐ Nutritionists

☑ Other (specify)

Provider Type	Description
Certified Peer Recovery Coaches	Must obtain requisite peer certification per the Medicaid Provider Manual
Community Health Workers	Must be at least 18 years of age Must possess a high school diploma or equivalent Must be supervised by licensed professional members of the care team MDHHS requires the completion of a CHW Certificate Program or equivalent
Health Home Partners	Any of the selected provider types above at the HHP.
Lead Entity	• Provides leadership for implementation and coordination of health home activities • Coordinates all enrollment into the health home on behalf of providers • Coordinates with LE care management staff and OHH providers to identify a beneficiary's optimal setting of care • Coordinates and utilizes HIT with the OHH provider team to maximize care coordination and care management • Serves as a liaison between the health homes site and MDHHS staff/contractors • Champions practice transformation based on health home principles • Coordinates all enrollment into the health home on behalf of providers • Develops and maintains working relationships with primary and specialty care providers including Community Mental Health Service Providers and inpatient facilities • Collects and reports on data that permits an evaluation of increased coordination of care and chronic disease management • Monitors Health Home performance and leads quality improvement efforts • Designs and develops prevention and wellness initiatives, and referral tracking • Training and technical assistance • Data management and reporting

Health Promotion

Definition

Health Promotion begins with the initial health homes visit or while establishing a formal care plan. The health home will assess the readiness to change and provide the beneficiary with the appropriate level of encouragement and support for the adoption of these healthy behaviors and/or lifestyle changes. Healthy behaviors and/or lifestyle interventions include but are not limited to:
*Development of self-management plans
*Evidenced-based wellness and promotion
*Patient education
*Patient and family activation
*Addressing clinical and social needs
*Patient-centered training (e.g., diabetes education, nutrition education)
*Connection to resources for smoking prevention and cessation, substance use disorder treatment and prevention, nutritional counseling, obesity reduction and prevention, increasing physical activity, disease specific or chronic care management self-help resources, and other services, such as housing based on beneficiaries' needs and preferences.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

LEs and HHPs will utilize their EHR to record care coordination and health promotion activities and adjust these activities, as appropriate. The EHR can provide educational material for the beneficiary to assist with overall health promotion.

Scope of service

The service can be provided by the following provider types

☑ Behavioral Health Professionals or Specialists	**Description** Behavioral Health Provider (e.g., Case Worker or Addictions Counselor with MSW or related degree) *Screening/evaluation of individuals for mental health and substance use disorders

*Referral to licensed mental health provider and/or SUD therapist as necessary
*Brief intervention for individuals with behavioral health problems
*Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic
*Supports primary care providers in identifying and behaviorally intervening with patients
*Focuses on managing a population of patients versus specialty care
*Works with patients to identify chronic behavior, discuss impact, develop improvement strategies and specific goal-directed interventions
*Develops and maintains relationships with community based mental health and substance abuse providers
*Identifies community resources (i.e. support groups, workshops, etc.) for patient to utilize to maximize wellness
*Provides patient education

☐ Nurse Practitioner

☑ Nurse Care Coordinators

Description

Nurse Care Manager (Coordinator) (e.g., RN)
*Participates in the selection of strategies to implement evidence-based wellness and prevention initiatives
*Participates in initial care plan development including specific goals for all enrollees
*Communicates with medical providers, subspecialty providers including mental health and substance abuse service providers, long term care and hospitals regarding records including admission/discharge
*Provides education in health conditions, treatment recommendation, medications and strategies to implement care plan goals including both clinical and non-clinical needs
*Monitors assessments and screenings to assure findings are integrated in the care plan
*Facilitates the use of the EHR and other HIT to link services, facilitate communication among team members and provide feedback
*Monitors and report performance measures and outcomes
*Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic

☐ Nurses

☐ Medical Specialists

☐ Physicians

☐ Physician's Assistants

☐ Pharmacists

☐ Social Workers

☐ Doctors of Chiropractic

☐ Licensed Complementary and alternative Medicine Practitioners

☐ Dieticians

☐ Nutritionists

☑ Other (specify)

Provider Type	Description
Certified Peer Recovery Coaches	Must obtain requisite peer certification per the Medicaid Provider Manual
Community Health Workers	Must be at least 18 years of age Must possess a high school diploma or equivalent Must be supervised by licensed professional members of the care team MDHHS requires the completion of a CHW Certificate Program or equivalent

Provider Type	Description
Health Home Partners	Any of the selected provider types above at the HHP.
Lead Entity	• Provides leadership for implementation and coordination of health home activities • Coordinates all enrollment into the health home on behalf of providers • Coordinates with LE care management staff and OHH providers to identify a beneficiary's optimal setting of care • Coordinates and utilizes HIT with the OHH provider team to maximize care coordination and care management • Serves as a liaison between the health homes site and MDHHS staff/contractors • Champions practice transformation based on health home principles • Coordinates all enrollment into the health home on behalf of providers • Develops and maintains working relationships with primary and specialty care providers including Community Mental Health Service Providers and inpatient facilities • Collects and reports on data that permits an evaluation of increased coordination of care and chronic disease management • Monitors Health Home performance and leads quality improvement efforts • Designs and develops prevention and wellness initiatives, and referral tracking • Training and technical assistance • Data management and reporting.

Comprehensive Transitional Care from Inpatient to Other Settings (including appropriate follow-up)

Definition

Comprehensive transitional care services connect the beneficiary to needed health services available within the community. Health services include care provided outside of the health home. Health homes will be expected to coordinate and track their participants:
*Notification of admissions/discharge
*Receipt of care record, continuity of care document, or discharge summary
*Post-discharge outreach to assure appropriate follow-up services
*Medication reconciliation
*Pharmacy coordination
*Proactive care (versus reactive care)
*Specialized transitions when necessary (e.g., age, corrections)
*Home visits

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

Utilizing the LEs HIE will allow for seamless transitions of care within the region. Moreover, CareConnect360, an MDHHS supported application, is anticipated to support Health Home services by providing access to admission, discharge, and transfer information. CareConnect360 will also provide a resource to health homes providers to track labs, and pharmacy data. In addition, the application will include data on health status and utilization patterns based on claims data. Together, this will allow for seamless transitions of care so that the beneficiary is received and accommodated appropriately at every health service and community setting. Michigan's LEs have access to CareConnect360 and will leverage the application as appropriate.

Scope of service

The service can be provided by the following provider types

	Description
☑ Behavioral Health Professionals or Specialists	Behavioral Health Provider (e.g., Case Worker or Addictions Counselor with MSW or related degree) *Screening/evaluation of individuals for mental health and substance use disorders *Referral to licensed mental health provider and/or SUD therapist as necessary *Brief intervention for individuals with behavioral health problems *Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic *Supports primary care providers in identifying and behaviorally intervening with patients *Focuses on managing a population of patients versus specialty care *Works with patients to identify chronic behavior, discuss impact, develop

improvement strategies and specific goal-directed interventions
*Develops and maintains relationships with community based mental health and substance abuse providers
*Identifies community resources (i.e. support groups, workshops, etc.) for patient to utilize to maximize wellness
*Provides patient education

☐ Nurse Practitioner

☑ Nurse Care Coordinators

Description

Nurse Care Manager (Coordinator) (e.g., RN)
*Participates in the selection of strategies to implement evidence-based wellness and prevention initiatives
*Participates in initial care plan development including specific goals for all enrollees
*Communicates with medical providers, subspecialty providers including mental health and substance abuse service providers, long term care and hospitals regarding records including admission/discharge
*Provides education in health conditions, treatment recommendation, medications and strategies to implement care plan goals including both clinical and non-clinical needs
*Monitors assessments and screenings to assure findings are integrated in the care plan
*Facilitates the use of the EHR and other HIT to link services, facilitate communication among team members and provide feedback
*Monitors and report performance measures and outcomes
*Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic

☐ Nurses

☐ Medical Specialists

☐ Physicians

☐ Physician's Assistants

☐ Pharmacists

☐ Social Workers

☐ Doctors of Chiropractic

☐ Licensed Complementary and alternative Medicine Practitioners

☐ Dieticians

☐ Nutritionists

☑ Other (specify)

Provider Type	Description
Certified Peer Recovery Coaches	Must obtain requisite peer certification per the Medicaid Provider Manual
Community Health Workers	Must be at least 18 years of age Must possess a high school diploma or equivalent Must be supervised by licensed professional members of the care team MDHHS requires the completion of a CHW Certificate Program or equivalent
Health Home Partners	Any of the selected provider types above at the HHP.
Lead Entity	• Provides leadership for implementation and coordination of health home activities • Coordinates all enrollment into the health home on behalf of providers • Coordinates with LE care management staff and OHH providers to identify a beneficiary's optimal setting of care

Provider Type	Description
	• Coordinates and utilizes HIT with the OHH provider team to maximize care coordination and care management • Serves as a liaison between the health homes site and MDHHS staff/contractors • Champions practice transformation based on health home principles • Coordinates all enrollment into the health home on behalf of providers • Develops and maintains working relationships with primary and specialty care providers including Community Mental Health Service Providers and inpatient facilities • Collects and reports on data that permits an evaluation of increased coordination of care and chronic disease management • Monitors Health Home performance and leads quality improvement efforts • Designs and develops prevention and wellness initiatives, and referral tracking • Training and technical assistance • Data management and reporting.

Individual and Family Support (which includes authorized representatives)

Definition

Individual and family support services reduce barriers to the beneficiaries' care coordination, increase skills and engagement and improve overall health outcomes. Specific activities may include, but are not limited to:
*Use of community supports (e.g., community health workers, peer supports, support groups, self-care programs, as appropriate)
*Facilitation of improved adherence to treatment
*Advocacy for individual and family needs
*Efforts to assess and increase health literacy
*Use of advance directives
*Assistance with maximizing level of functioning in the community
*Assistance with the development of social networks

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

The HIE, EHR, and CareConnect360 will assist providers in supporting beneficiaries and their families with helpful information to empower and educate themselves and subsequently maximize self-management of health.

Scope of service

The service can be provided by the following provider types

☑ Behavioral Health Professionals or Specialists	**Description** Behavioral Health Provider (e.g., Case Worker or Addictions Counselor with MSW or related degree) *Screening/evaluation of individuals for mental health and substance use disorders *Referral to licensed mental health provider and/or SUD therapist as necessary *Brief intervention for individuals with behavioral health problems *Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic *Supports primary care providers in identifying and behaviorally intervening with patients *Focuses on managing a population of patients versus specialty care *Works with patients to identify chronic behavior, discuss impact, develop improvement strategies and specific goal-directed interventions *Develops and maintains relationships with community based mental health and substance abuse providers *Identifies community resources (i.e. support groups, workshops, etc.) for patient to utilize to maximize wellness *Provides patient education
☐ Nurse Practitioner	
☑ Nurse Care Coordinators	**Description** Nurse Care Manager (Coordinator) (e.g., RN) *Participates in the selection of strategies to implement evidence-based wellness and prevention initiatives

*Participates in initial care plan development including specific goals for all enrollees
*Communicates with medical providers, subspecialty providers including mental health and substance abuse service providers, long term care and hospitals regarding records including admission/discharge
*Provides education in health conditions, treatment recommendation, medications and strategies to implement care plan goals including both clinical and non-clinical needs
*Monitors assessments and screenings to assure findings are integrated in the care plan
*Facilitates the use of the EHR and other HIT to link services, facilitate communication among team members and provide feedback
*Monitors and report performance measures and outcomes
*Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic

- [ ] Nurses
- [ ] Medical Specialists
- [ ] Physicians
- [ ] Physician's Assistants
- [ ] Pharmacists
- [ ] Social Workers
- [ ] Doctors of Chiropractic
- [ ] Licensed Complementary and alternative Medicine Practitioners
- [ ] Dieticians
- [ ] Nutritionists
- [x] Other (specify)

Provider Type	Description
Certified Peer Recovery Coaches	Must obtain requisite peer certification per the Medicaid Provider Manual
Community Health Workers	Must be at least 18 years of age Must possess a high school diploma or equivalent Must be supervised by licensed professional members of the care team MDHHS requires the completion of a CHW Certificate Program or equivalent
Health Home Partners	Any of the selected provider types above at the HHP.
Lead Entity	• Provides leadership for implementation and coordination of health home activities • Coordinates all enrollment into the health home on behalf of providers • Coordinates with LE care management staff and OHH providers to identify a beneficiary's optimal setting of care • Coordinates and utilizes HIT with the OHH provider team to maximize care coordination and care management • Serves as a liaison between the health homes site and MDHHS staff/contractors • Champions practice transformation based on health home principles • Coordinates all enrollment into the health home on behalf of providers • Develops and maintains working relationships with primary and specialty care providers including Community Mental Health Service Providers and inpatient facilities • Collects and reports on data that permits an evaluation of increased coordination of care and chronic disease management • Monitors Health Home performance and leads quality

Provider Type	Description
	improvement efforts • Designs and develops prevention and wellness initiatives, and referral tracking • Training and technical assistance • Data management and reporting.

Referral to Community and Social Support Services

Definition

Referrals to community and social support services provide recipients with referrals to a wide array of support services that help recipients overcome access or service barriers, increase self-management skills and improve overall health. Specific activities may include, but are not limited to:
*Collaboration/coordination with community-based organizations and other key community stakeholders
*Emphasis on resources closest to the patient's home with least barriers
*Identification of community-based resources
*Availability of resource materials pertinent to patient needs
*Assist in attainment of other resources, including benefit acquisition
*Referral to housing resources as needed
*Referral tracking and follow-up

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

While the community and social services supports network may not have direct access to the enrollee's health record, MDHHS anticipates that the HIE, EHR, and CareConnect360 will afford providers the ability to track, follow-up and evaluate referrals to these services. In addition, HIT will provide beneficiaries and their families with helpful resource materials to empower and educate themselves and subsequently maximize self-management of health.

Scope of service

The service can be provided by the following provider types

☑ Behavioral Health Professionals or Specialists	**Description** Behavioral Health Provider (e.g., Case Worker or Addictions Counselor with MSW or related degree) *Screening/evaluation of individuals for mental health and substance use disorders *Referral to licensed mental health provider and/or SUD therapist as necessary *Brief intervention for individuals with behavioral health problems *Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic *Supports primary care providers in identifying and behaviorally intervening with patients *Focuses on managing a population of patients versus specialty care *Works with patients to identify chronic behavior, discuss impact, develop improvement strategies and specific goal-directed interventions *Develops and maintains relationships with community based mental health and substance abuse providers *Identifies community resources (i.e. support groups, workshops, etc.) for patient to utilize to maximize wellness *Provides patient education
☐ Nurse Practitioner	
☑ Nurse Care Coordinators	**Description** Nurse Care Manager (Coordinator) (e.g., RN) *Participates in the selection of strategies to implement evidence-based wellness and prevention initiatives *Participates in initial care plan development including specific goals for all enrollees *Communicates with medical providers, subspecialty providers including mental health and substance abuse service providers, long term care and hospitals regarding records including admission/discharge *Provides education in health conditions, treatment recommendation, medications and strategies to implement care plan goals including both clinical and non-clinical needs *Monitors assessments and screenings to assure findings are integrated in the care plan *Facilitates the use of the EHR and other HIT to link services, facilitate communication among team members and provide feedback

*Monitors and report performance measures and outcomes
*Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic

- [ ] Nurses
- [ ] Medical Specialists
- [ ] Physicians
- [ ] Physician's Assistants
- [ ] Pharmacists
- [ ] Social Workers
- [ ] Doctors of Chiropractic
- [ ] Licensed Complementary and alternative Medicine Practitioners
- [ ] Dieticians
- [ ] Nutritionists
- [x] Other (specify)

Provider Type	Description
Certified Peer Recovery Coaches	Must obtain requisite peer certification per the Medicaid Provider Manual
Community Health Workers	Must be at least 18 years of age Must possess a high school diploma or equivalent Must be supervised by licensed professional members of the care team MDHHS requires the completion of a CHW Certificate Program or equivalent
Health Home Partners	Any of the selected provider types above at the HHP.
Lead Entity	• Provides leadership for implementation and coordination of health home activities • Coordinates all enrollment into the health home on behalf of providers • Coordinates with LE care management staff and OHH providers to identify a beneficiary's optimal setting of care • Coordinates and utilizes HIT with the OHH provider team to maximize care coordination and care management • Serves as a liaison between the health homes site and MDHHS staff/contractors • Champions practice transformation based on health home principles • Coordinates all enrollment into the health home on behalf of providers • Develops and maintains working relationships with primary and specialty care providers including Community Mental Health Service Providers and inpatient facilities • Collects and reports on data that permits an evaluation of increased coordination of care and chronic disease management • Monitors Health Home performance and leads quality improvement efforts • Designs and develops prevention and wellness initiatives, and referral tracking • Training and technical assistance • Data management and reporting.

Health Homes Services

MEDICAID | Medicaid State Plan | Health Homes | MI2020MS0003O | MI-20-1501 | Opioid Health Home

Package Header

Package ID MI2020MS0003O
SPA ID MI-20-1501
Submission Type Official
Initial Submission Date 7/1/2020
Approval Date N/A
Effective Date 10/1/2020
Superseded SPA ID MI-18-1500
User-Entered
Reviewable Unit Instructions

Health Homes Patient Flow

Describe the patient flow through the state's Health Homes system. Submit with the state plan amendment flow-charts of the typical process a Health Homes individual would encounter

See attached.

Name	Date Created	
OHH Patient Flow V1 (6.10.20)	6/11/2020 2:37 PM EDT	

This view was generated on 7/1/2020 3:30 PM EDT

OHH Provider Requirements and Expectations

Detailed Requirements and Expectations
At a minimum, the following care team is required:

- Health Home Director (e.g., Lead Entity Care Coordinator)
  - Provides leadership for implementation and coordination of health home activities
  - Coordinates all enrollment into the health home on behalf of providers
  - Coordinates with LE care management staff and HHPs to identify a beneficiary's optimal setting of care
  - Coordinates and utilizes HIT with the HHP team to maximize care coordination and care management
  - Serves as a liaison between the health homes site and MDHHS staff/contractors
  - Champions practice transformation based on health home principles
  - Coordinates all enrollment into the health home on behalf of providers
  - Develops and maintains working relationships with primary and specialty care providers including Community Mental Health Service Providers and inpatient facilities
  - Collects and reports on data that permits an evaluation of increased coordination of care and chronic disease management
  - Monitors Health Home performance and leads quality improvement efforts
  - Designs and develops prevention and wellness initiatives, and referral tracking
  - Training and technical assistance
  - Data management and reporting

- Behavioral Health Specialist (e.g., Case Worker, Counselor, or Therapist with related degree)
  - Screens individuals for mental health and substance use disorders
  - Refers beneficiaries to a licensed mental health provider and/or licensed and certified SUD therapist as necessary
  - Conducts brief intervention for individuals with behavioral health problems
  - Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic
  - Supports primary care providers in identifying and behaviorally intervening with patients
  - Focuses on managing a population of patients versus specialty care
  - Works with patients to identify chronic behavior, discuss impact, develop improvement strategies and specific goal-directed interventions
  - Develops and maintains relationships with community based mental health and substance abuse providers
  - Identifies community resources (i.e. support groups, workshops, etc.) for patient to utilize to maximize wellness
  - Provides patient education

- Nurse Care Manager (e.g., licensed registered nurse)
  - Participates in the selection of strategies to implement evidence-based wellness

and prevention initiatives
    - Participates in initial care plan development including specific goals for all enrollees
    - Communicates with medical providers, subspecialty providers including mental health and substance abuse service providers, long term care and hospitals regarding records including admission/discharge
    - Provides education in health conditions, treatment recommendation, medications and strategies to implement care plan goals including both clinical and non-clinical needs
    - Monitors assessments and screenings to assure findings are integrated in the care plan
    - Facilitates the use of the EHR and other HIT to link services, facilitate communication among team members and provide feedback
    - Monitors and report performance measures and outcomes
    - Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic

- Peer Recovery Coach, Community Health Worker, Medical Assistant (with appropriate certification/training)
    - Coordinates and provides access to individual and family supports, including referral to community social supports
    - Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic
    - Identifies community resources (i.e. social services, workshops, etc.) for patient to utilize to maximize wellness and recovery capital
    - Conducts referral tracking
    - Coordinates and provides access to chronic disease management including self- management support
    - Implements wellness and Prevention initiatives
    - Facilitates health education groups
    - Provides education on health conditions and strategies to implement care plan goals including both clinical and non-clinical needs

- Medical Consultant (i.e., primary care physician, physician's assistant, or nurse practitioner)
    - Provides medical consultation to assist the care team in the development of the beneficiary's care plan, participate in team huddles when appropriate, and monitor the ongoing physical aspects of care as needed

- Psychiatric Consultant
    - Care team must have access to a licensed mental health service professional (i.e., psychologist, psychiatrist, psychiatric nurse practitioner) providing psychotherapy consult and treatment plan development services. This provider will be responsible for communicating treatment methods and expert advice to Behavioral Health Provider (incorporated into care team). It will be the responsibility of the Behavioral Health Provider (and/or other members of care

team as assigned), to develop licensed mental health provider's treatment into patient care plan.

1. Enrollment/Recognition/Certification

a. OHH providers must be enrolled in the Michigan Medicaid program and in compliance with all applicable program policies
b. Be an Opioid Treatment Program, Community Mental Health Services Program, Section 330 Health Center program grantee of any type, Federally-Qualified Health Center Look-Alike, Tribal 638 facility, or Urban Indian organization
c. OHH providers must enroll in their Lead Entity's (LE) provider panel and execute any necessary agreement(s)/contract(s) with the LE; HHPs must also sign an attestation with MDHHS
d. MDHHS will contractually charge the LE with executing the enrollment, payment, and administration of the OHH with providers; MDHHS will retain overall oversight and direct administration of the LE
e. OHH providers must adhere to all federal and state laws regarding Section 2703 Health Homes recognition/certification, including the capacity to perform all core services specified by CMS. Providers shall meet the following recognition/certification standards:
    i. Achieve Patient Centered Medical Home (PCMH) from national recognizing body (NCQA, AAAHC, JC, CARF) before the OHH becomes operational. PCMH application can be pending at the time of implementation

2. A personal care team will be assigned to each patient

a. Ensure each patient has an ongoing relationship with a personal member of their care team who is trained to provide first contact and support continuous and comprehensive care, where both the patient and the care team recognize each other as partners in care. Behavioral health is embedded into primary care and vice-versa, with real-time consult available to primary care providers or behavioral health providers
b. Care teams are staffed according to model selected and the setting of care (i.e., OTP vs. OBOT)

3. Whole Person Orientation

a. Provide or take responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life, acute care, chronic care, preventive services, long term care, and end of life care
b. Meaningful use of technology for patient communication
c. Develop a person-centered care plan for everyone that coordinates and integrates all clinical and non-clinical health care related needs and services

4. Coordinated/Integrated Care

a. Dedicate a care coordinator responsible for assisting members with medication adherence, appointments, referral scheduling, tracking follow-up results from referrals, understanding health insurance coverage, reminders, transition of care, wellness education, health support and/or lifestyle modification, and behavior changes and communication with external specialists
b. Communicate with patient, and authorized family and caregivers in a culturally and linguistically appropriate manner
c. Monitor, arrange, and evaluate appropriate evidence-based and/or evidence-informed preventive services and health promotion

d. Directly provide or have an Memorandum of Agreement/Understanding (MOA/U) in place to coordinate or provide:
    i. Recovery services and social health services (available in the community), including Medication Assisted Treatment
    ii. Primary care services
    iii. Mental health/behavioral health and substance use disorder services
    iv. Chronic disease management
    v. Behavior modification interventions aimed at supporting health management (Including but not limited to, obesity counseling, tobacco treatment/cessation, and health coaching)
    vi. Coordinated access to long term care supports and services
    vii. Oral health services
e. Conduct outreach to local health systems and establish bi-directional referral processes
f. Comprehensive transitional care from inpatient to other settings, including appropriate follow-up
g. Review and reconciliation of medications
h. Assessment of social, educational, housing, transportation, and vocational needs that may contribute to disease and/or present as barriers to self-management (Social workers, Peer Recovery Coaches, CHWs)
i. Maintain a reliable system and written standards/protocols for tracking patient referrals

5. Emphasis on Quality and Safety

a. Health homes providers must adhere to all applicable privacy, consent, and data security statutes
b. Demonstrate use of clinical decision support within the practice workflow specific to the conditions identified in the health homes project
c. Demonstrate use of a population management tool such as a patient registry and the ability to evaluate results and implement interventions that improve outcomes
d. Each Health Home shall implement formal screening tools such as GAIN, SBIRT, PHQ9, GAD, STD/STI, diabetes, and asthma risk tests to assess treatment needs
e. Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level

6. Enhanced Access

a. Provide for 24/7 access to the care team that includes, but is not limited to, a phone triage system with appropriate scheduling during and after regular business hours to avoid unnecessary emergency room visits and hospitalizations
b. Monitor access outcomes such as the average 3rd next available appointment and same day scheduling availability
c. Use of email, text messaging, patient portals and other technology as available to the practice to communicate with patients is encouraged
d. Implement policies and procedures to operation with open access scheduling and available same day appointments

7. Health Information Technology

a. Must have an Electronic Health Record (EHR) in place with capability of behavioral health information integration
b. Must utilize/synchronize to the LE's Health Information Exchange to assure care coordination is seamless within the OHH model
c. Provider must have achieved or are in the process of achieving Meaningful Use Stage 2 as defined by the Centers for Medicare & Medicaid Services
d. Demonstrate a capacity to use health information technology to link services, facilitate communication among team members as well as between the health team and individual and family caregivers, and provide feedback to practices; as feasible and appropriate
e. Health Home providers must have the capacity to electronically report to the state or its contracted affiliates information about the provision of core services and outcome measures

8. OHH Team

a. Support OHH team participation in all related activities and trainings including travel costs associated with Health Home activities
b. Work collaboratively with MDHHS and contractors to adapt and adopt program processes for Health Home care team use in the participating sites(s)
c. Actively engage in Health Home process and outcome achievement activities including ongoing coaching, data feedback and customized improvement plans to meet initiative goals
d. Commit a management staff member (such as the Health Home Coordinator) and a clinician champion serving on the care team(s) at the participating site(s) to contribute actively to and support the project
e. Commit a staff member to serve as the liaison to the beneficiary's assigned managed care health plan.

MDHHS Opioid Health Home (OHH) Payment Methodology

Overview

MDHHS will provide a monthly case rate to the LE based on the number of OHH beneficiaries with at least one OHH service within the month. The LE will reimburse Health Home Partners (HHP) for delivering health home services.

Additionally, MDHHS will employ a pay-for- performance (P4P) incentive that will reward providers based on outcomes. MDHHS will only claim federal match for P4P incentive payments after P4P qualifications have been met and providers have been paid.

Rate Workup

Staffing Model

OHH payment rates are based on a staffing model per 100 beneficiaries with salary, fringe benefit, and indirect cost information derived from current compensation surveys produced by the Community Mental Health Association of Michigan (i.e., Prepaid Inpatient Health Plans, Community Mental Health Services Programs) and the Michigan Primary Care Association (i.e., Federally Qualified Health Centers). Rates reflect the following staffing model for the OHH per 100 enrollees:

Lead Entity (per 100 patients)

- Health Home Director (0.50 FTE)
- Behavioral Health Specialist (0.25 FTE)
- Nurse Care Manager (1.00 FTE)
- Peer Recovery Coach, Community Health Worker, Medical Assistant (2.00-4.00 FTE)
- Medical Consultant (0.10 FTE)
- Psychiatric Consultant (0.05 FTE)

Rate Amounts

The OHH payment rates reflect a monthly case rate per OHH beneficiary with at least one proper and successful OHH service within a given month. The payment for OHH services is subject to recoupment from the PIHP if the beneficiary does not receive an OHH service during the calendar month. Rates will be effective on or after October 1, 2020. Rate information will be maintained on the MDHHS website at www.michigan.gov/OHH. Rates will be evaluated annually and updated as appropriate.

The case rates were developed by utilizing provider compensation surveys from the Community Mental Health Association of Michigan (2019) and the Michigan Primary Care Association (2019), which represent the PIHP and OTP, and OBOT component of the rates, respectively. The State also utilized 2018 fringe rate data from the US Department of Labor's Bureau of Labor and Statistics.

OHH Case Rates to LE

PMPM	PMPM with P4P
$364.48	$382.70

Details regarding this structure are as follows:

HHPs must provide at least one OHH service within the service month. HHPs must submit the OHH service encounter code in addition to any pertinent ICD-10 Z-codes (to indicate the any applicable social determinants of health) to the Lead Entity.

Payment for OHH services is dependent on the submission of appropriate service encounter codes. Valid OHH encounters must be submitted by HHPs to the LE within 90 days of providing an OHH service to assure timely service verification. The payment for OHH services is subject to recoupment from the LE if the beneficiary does not receive an OHH service during the calendar month.

Rates will be effective on or after October 1, 2020. Rate information will be maintained on the MDHHS website at www.michigan.gov/OHH. Rates will be evaluated annually and updated as appropriate.

Pay-for-Performance (P4P) vis a vis 5% Withhold

MDHHS will afford P4P via a 5% performance withhold. The LE must distribute P4P monies to HHPs that meet the quality improvement benchmarks in accordance with the timelines and processes delineated below. The State will only claim federal match once it determines quality improvement benchmarks have been met and providers have been paid. If quality improvement benchmarks are not met by any of the HHPs within a given performance year, the State share of the withhold will be reserved by MDHHS and reinvested for OHH monthly case rate payments. Subsequent performance years will operate in accordance with this structure.

Metrics, Assessment, and Distribution

The methodology for metrics, specifications, and benchmarks will be effective October 1, 2020 and will be maintained on the MDHHS website: www.michigan.gov/OHH.

Opioid Health Home (OHH) Patient Flow

Enrollee Identification and Assignment

Enrollment Processes

Potential Opioid Health Home (OHH) enrollees will be identified using a multifaceted approach. The Michigan Department of Health and Human Services (MDHHS) will provide a generated list that will pull potential enrollees from MDHHS administrative claims data into the Waiver Support Application (WSA) monthly. The Lead Entity (LE) will identify potential enrollees from the WSA and coordinate with a Health Home Partner (HHP) to fully enroll the Medicaid beneficiary into the OHH benefit.

Lead Entities will provide information about the OHH to all potential enrollees through community referrals, peer support specialist networks, other providers, courts, health departments, law enforcement, and other community-based settings. LEs will strategically provide these settings with informational brochures, posters, and other outreach materials to facilitate awareness and engagement of the OHH.

Lead Entity Identification of Potential Enrollees

The LE will be responsible for identifying potential enrollees that have a qualifying OHH diagnosis in the WSA to a perspective HHP and provide information regarding OHH services to the Medicaid beneficiary in coordination with the HHP.

Provider Recommended Identification of Potential Enrollees

Health Home Partners are permitted to recommend potential enrollees for the OHH benefit via the WSA. OHH providers must provide documentation that indicates whether a potential OHH enrollee meets all eligibility for the health home benefit, including diagnostic verification, obtaining consent, and establishment of an individualized care plan. The LE must review and process all recommended enrollments in the WSA.

Beneficiary Consent

Potential enrollees must provide HHPs a signed consent to share behavioral health information for care coordination purposes form (MDHHS-5515) to receive the OHH benefit. The MDHHS-5515 must be collected and stored in the beneficiary's health record with attestation in the WSA. The MDHHS-5515 can be found on the MDHHS website at www.michigan.gov/mdhhs >> Keeping Michigan Healthy >> Behavioral Health and Developmental Disability >> Behavioral Health Information Sharing & Privacy. The form will also be available at the designated HHPs office and on the LE's website. HHPs are responsible for verifying receipt of the signed consent form and providing proper documentation to MDHHS via the LE. All documents must be maintained in compliance with MDHHS record-keeping requirements.

Beneficiary Disenrollment

Full enrollment into the OHH benefit plan is contingent on beneficiary completion of the Consent to Share Behavioral Health Information for Care Coordination Purposes (MDHHS-5515), verification of diagnostic eligibility, and the LE electronically enrolling the beneficiary in the WSA. Once the Medicaid beneficiary is assigned to a health home, the HHP will work with the beneficiary to complete the enrollment process.

Failure to verify consent or diagnostic eligibility will prevent the Medicaid beneficiary from enrolling into the OHH benefit. Medicaid beneficiaries may opt-out (disenroll) from the OHH at any time with no impact on their eligibility for other Medicaid services.

Beneficiary Changing Health Home Partner Sites

While the enrollee's stage in recovery and individualized plan of care will be utilized to determine the appropriate setting of care, beneficiaries will have the ability to change HHPs to the extent feasible within the LE's designated OHH network. To maximize continuity of care and the patient-provider relationship, MDHHS expects beneficiaries to establish a lasting relationship with their chosen HHP. However, beneficiaries may change HHP, and should notify their current HHP immediately if they intend to do so. The LE and HHP will work together to identify a recommended HHP setting where the potential health home enrollee will likely be most successful. After receiving the recommendation from the LE and HHP, the beneficiary will have the opportunity to choose their preferred HHP. The variety and number of HHPs may vary by region. The current and future HHP must discuss the timing of the transfer and communicate transition options to the beneficiary. The change should occur on the first day of the next month with respect to the new HHP appointment availability. Only one HHP may be paid per beneficiary per month for health home services.

STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

GRETCHEN WHITMER
GOVERNOR

ROBERT GORDON
DIRECTOR

February 19, 2020

NAME
TITLE
ADDRESS
CITY STATE ZIP

Dear Tribal Chair and Health Director:

RE: Opioid Health Home (OHH) Expansion

This letter, in compliance with Section 1902(a)(73) and Section 2107(e)(1)(C) of the Social Security Act, serves as notice to all Tribal Chairs and Health Directors of the intent by the Michigan Department of Health and Human Services (MDHHS) to submit a State Plan Amendment (SPA) request to the Centers for Medicare & Medicaid Services (CMS).

The OHH will provide comprehensive care management and coordination services to Medicaid beneficiaries with opioid use disorder in Michigan's Prepaid Inpatient Health Plan (PIHP) Regions 1, 2, 9, and Calhoun and Kalamazoo Counties within PIHP Region 4. The SPA will serve an estimated 1,500-2,000 beneficiaries once fully implemented. The program will utilize opioid treatment programs and office-based opioid treatment providers. A region's PIHP will coordinate enrollment and care with selected providers. Tribal Health Centers and Urban Health Centers that meet OHH provider qualifications and standards are encouraged to participate. The anticipated effective date of this SPA is October 1, 2020.

The OHH will function as the central point of contact for directing patient-centered care across the broader health care system. Designated providers will be required to maintain a robust care coordination program to reduce avoidable health care costs and improve the overall quality of life for the beneficiary. This may include referrals to appropriate community and support services as needed. Native American beneficiaries with a qualifying health condition will be eligible to enroll in the program. Participation is voluntary, and enrolled beneficiaries may opt-out at any time.

There is no public hearing scheduled for this SPA. Input regarding this SPA is highly encouraged, and comments regarding this notice of intent may be submitted to Lorna Elliott-Egan, MDHHS Liaison to the Michigan tribes. Lorna can be reached at 517-284-4034, or via email at Elliott-EganL@michigan.gov. **Please provide all input by April 4, 2020.**

In addition, MDHHS is offering to set up group or individual consultation meetings to discuss the SPA, according to the tribes' preference. Consultation meetings allow tribes the opportunity to address any concerns and voice any suggestions, revisions, or objections to be relayed to the author of the proposal. If you would like additional information or wish to schedule a consultation meeting, please contact Lorna Elliott-Egan at the telephone number or email address provided above.

MDHHS appreciates the continued opportunity to work collaboratively with you to care for the residents of our state.

Sincerely,

Kate Massey, Director
Medical Services Administration

cc: Tannisse Joyce, CMS
Keri Toback, CMS
Leslie Campbell, CMS
Nancy Grano, CMS
Chastity Dial, CEO, American Indian Health and Family Services of Southeastern Michigan
Daniel Frye, Director, Indian Health Service - Bemidji Area Office
Lorna Elliott-Egan, MDHHS

Distribution List for L 20-04
February 19, 2020

Mr. Bryan Newland, Tribal Chairman, Bay Mills Indian Community
Ms. Audrey Breakie, Health Director, Bay Mills (Ellen Marshall Memorial Center)
Mr. Thurlow Samuel McClellan, Chairman, Grand Traverse Band Ottawa & Chippewa Indians
Mr. Soumit Pendharkar, Health Director, Grand Traverse Band Ottawa/Chippewa
Mr. Kenneth Meshigaud, Tribal Chairman, Hannahville Indian Community
Ms. G. Susie Meshigaud, Health Director, Hannahville Health Center
Mr. Warren C. Swartz, Jr., President, Keweenaw Bay Indian Community
Ms. Kathy Mayo, Interim Health Director, Keweenaw Bay Indian Community - Donald Lapointe Health/Educ Facility
Mr. James Williams, Jr., Tribal Chairman, Lac Vieux Desert Band of Lake Superior Chippewa Indians
Ms. Sadie Valliere, Health & Human Services Director, Lac Vieux Desert Band
Mr. Larry Romanelli, Ogema, Little River Band of Ottawa Indians
Mr. Daryl Wever, Health Director, Little River Band of Ottawa Indians
Ms. Regina Gasco-Bentley, Tribal Chairman, Little Traverse Bay Band of Odawa Indians
Ms. Jodi Werner, Health Director, Little Traverse Bay Band of Odawa
Mr. Bob Peters, Chairman, Match-E-Be-Nash-She-Wish Potawatomi Indians (Gun Lake Band)
Ms. Kelly Wesaw, Health Director, Match-E-Be-Nash-She-Wish Potawatomi
Mr. Jamie Stuck, Tribal Chairman, Nottawaseppi Huron Band of Potawatomi Indians
Ms. Rosalind Johnston, Health Director, Huron Potawatomi Inc.- Tribal Health Department
Mr. Matthew Wesaw, Tribal Chairman, Pokagon Band of Potawatomi Indians
Mr. Matt Clay, Health Director, Pokagon Potawatomi Health Services
Mr. Ronald Ekdahl, Tribal Chief, Saginaw Chippewa Indian Tribe
Mrs. Karmen Fox, Executive Health Director, Nimkee Memorial Wellness Center
Mr. Aaron Payment, Tribal Chairman, Sault Ste. Marie Tribe of Chippewa Indians
Mr. Leonid Chugunov, Health Director, Sault Ste. Marie Tribe of Chippewa Indians - Health Center

CC: Tannisse Joyce, CMS
Keri Toback, CMS
Leslie Campbell, CMS
Nancy Grano, CMS
Chastity Dial, CEO, American Indian Health and Family Services of Southeastern Michigan
Daniel Frye, Director, Indian Health Service - Bemidji Area Office
Lorna Elliott-Egan, MDHHS

Classified

SECTION **C**

ANNOUNCEMENTS

Monuments & Cemeteries

2 Cemetary Plots, 2 Vaults, 44 x 14 Pink granite Head stone. Mount Everest Lots 364 in the Garden of the Prophets. Retail $7,100, sale price $3,600. 269-778-3739

Professional Services

DON'T OVER PAY YOUR PROPERTY TAXES!
For assistance in lowering your assessed value, call Ken at Premier Appraisal. 25 years exp. 616-452-4414

Public Notices

NOTICE OF A PUBLIC INFORMATION MEETING
FOR
PROPOSED AIRPORT IMPROVEMENTS
AT THE
KALAMAZOO/BATTLE CREEK INTERNATIONAL AIRPORT
KALAMAZOO, MICHIGAN

The Federal Aviation Administration has authorized the Kalamazoo/Battle Creek International Airport to explore the potential environmental impacts of a 1,100-foot extension of Runway 17/35 and realignment of Taxiway C. The proposed project would extend the existing 6,502-foot runway to an overall runway length of 7,652 feet (150 feet to the north and 1,000 feet to the south) and reconfigure Taxiway C at the approach end of Runway 17. A summary of the proposed improvements includes:

- Extend Runway 17 by 150 feet (north end) and extend Runway 35 by 1,000 feet (south end)
- Realign Taxiway C at the approach end of Runway 17
- Extend parallel Taxiway B to match the Runway 17/35 extension
- Relocate an existing railroad spur on the south end of the Airport, including land acquisition
- Obstruction clearing in both Runway 17 and Runway 35 approaches
- Preliminary avigation easements/land acquisition in both Runway 17 and Runway 35 approaches
- Relocate existing navigational aids
- Development of new approach procedures for Runway 17/35 to AC 150/5300-188 Standards
- Completion of a hazardous material investigation on acquired property
- Independent noise analysis to lift/modify the existing noise curfew

All interested persons are advised of a public information meeting being held by the Kalamazoo/Battle Creek International Airport on Wednesday, February 26, 2020 from 5:30 PM to 7:30 PM at the Air Zoo Aerospace & Science Museum located at 6151 Portage Rd, Portage, MI 49002

The purpose of the public meeting is to consider the social, economic and environmental effects, including noise, of the proposed improvements and whether the improvements are in the public interest and consistent with the goals and objectives of the Airport.

The meeting will be an open house format with no formal presentation given. The meeting is a "drop in" event, so attendees may arrive any time between 5:30 PM and 7:30 PM. The event is open to the public and all interested parties are encouraged to attend. The meeting will be an informal, walk-through where individuals will have the opportunity to ask questions, give feedback, and discuss the project. Airport staff and consultant team members will be available to explain the required environmental process, anticipated project schedule, environmental findings to date, alternatives being considered, and the upcoming noise study required to lift/modify the existing noise curfew. Informative displays and maps will be available for review.

In compliance with the Americans with Disabilities Act, individuals needing special accommodations (including auxiliary communicative aids and services) during the meeting should notify Craig Williams, Kalamazoo/Battle Creek International Airport, by e-mail at cawill@kalcounty.com or (269) 388-3668 at least three days prior to the meeting.

The public is encouraged to submit written comments or concerns by mail or email. Comments must be received by Friday, March 27, 2020 to be included in the project record. Send comments to:

Craig Williams, AAE
Airport Director
5235 Portage Rd.
Portage, MI 49002
cawill@kalcounty.com

Find more stories on mlive.com

Local sports news on mlive.com/sports

Public Notices

Notice to Bidders
Athens Area Schools (AAS)
Sinking Fund Series III Release I.

Sealed bid proposals will be accepted from qualified contractors by AAS for the following:

Demo/Abatement of VAT flooring/Vinyl Base/Carpet-East Leroy Elementary
Exterior Site Concrete & Grind, Stain and Polish Concrete Corridors - East Leroy Elementary
Exterior Site Concrete – Athens Highschool/Middle School
VCT and Carpet Installation - East Leroy Elementary
Membrane Roof Replacement – East Leroy Elementary Membrane Roof Replacement – Athens Highschool/Middle School
Locker Replacement - East Leroy Elementary

Proposals may be mailed or delivered to:

Joe Huepenbecker
Superintendent
C/O Athens Area Schools
East Leroy Elementary School
4320 K Drive
East Leroy, MI 49051

Mandatory pre-bid walk-thru to be held as follows:

February 5th, 2020 at 3:30 pm – East Leroy Elementary

Sealed bids will be received until February 19th, 2020 at 2:00 pm local time, at the Athens Area Administration Office / East Leroy Elementary 4320 K Drive, East Leroy, MI 49051, where they will be opened publicly and read aloud in the Administration Office. Late bids will not be accepted.

All bids shall be accompanied by a sworn and notarized statement disclosing any familial relationship (or lack of a relationship) that exists between the owner or any employee of the bidder and any member of the Board of Education of the Athens Area Schools or the Superintendent of the School District. The District shall not accept a bid that does not include a sworn and notarized disclosure statement.

AAS reserves the right to reject any or all bids and to waive irregularities in any bid and to award the bid(s) they deem in the best interest of AAS.

For information and bidding documents contact AAS Construction Manager, Frederick Construction, Inc., Chad Vandyke at (269) 349-8428 ext. 7101.

Bid documents will be available January 31, 2020 online through Builder's Exchange – Kalamazoo, Grand Rapids and Lansing, and Construction Association of Michigan.

Public Notice
Michigan Department of Health and Human Services
Medical Services Administration
Behavioral Health Home (BHH) State Plan Amendment Request

The Michigan Department of Health and Human Services (MDHHS) plans to submit a State Plan Amendment (SPA) request to the Centers for Medicare & Medicaid Services (CMS). The request includes a SPA that will amend and expand Michigan's Behavioral Health Home for beneficiaries with Serious Mental Illness/Serious Emotional Disturbance (SMI/SED).

The anticipated effective date for the BHH SPA is October 1, 2020.

Through this SPA request, MDHHS will amend the qualifying diagnoses, operational components, and expand the BHH to more geographic areas. The new qualifying diagnoses represent the highest cost/utilization ICD-10 codes for SMI/SED. In terms of operational components, the new structure will charge a Lead Entity (i.e., PIHP) with the administrative oversight and payment for health home activities. The Lead Entity will partner with Health Home Partners that meet criteria specified in the SPA. Moreover, the payment will flow through the Lead Entity to the Health Home Partners. The staffing model and rates will be optimized to reflect an integrated care team to serve the highest-need SMI/SED beneficiaries. Currently, the benefit is limited to two regions of PIHP Region 2 – Grand Traverse and Manistee. The BHH will be expanded to all counties within PIHP Regions 1, 2, and 8 to serve an estimated 5,000-6,000 beneficiaries once fully implemented, of which 4,900-5,900 will be new beneficiaries. The specific counties include Alcona, Alger, Alpena, Antrim, Baraga, Benzie, Charlevoix, Cheboygan, Chippewa, Crawford, Delta, Dickinson, Emmet, Gogebic, Grand Traverse, Houghton, Iosco, Iron, Kalkaska, Keweenaw, Leelanau, Luce, Mackinac, Manistee, Marquette, Menominee, Missaukee, Montmorency, Oakland, Ogemaw, Ontonagon, Oscoda, Otsego, Presque Isle, Roscommon, Schoolcraft, and Wexford.

In compliance with 42 CFR § 440.345, individuals under 21 years of age receiving Medicaid benefits will continue to have access to services within the full early and periodic screening, diagnosis and treatment (EPSDT) benefit as defined in Section 1905(r) of the Social Security Act.

The estimated gross cost to the State of Michigan for the State Plan Amendments is $18 million per year ($1.8 million general fund).

There is no public meeting scheduled regarding this notice. Any interested party wishing to request a written copy of the SPA or wishing to submit comments may do so by submitting a request in writing to:

MDHHS/Medical Services Administration, Program Policy Division, PO Box 30479, Lansing MI 48909-7979 or e-mail MSADraftPolicy@michigan.gov by March 1, 2020. A copy of the proposed State Plan Amendment will also be available for review at http://michigan.gov/mdhhs/0,5885,7-339-73970_5080-108153--,00.html.

STATE OF MICHIGAN
COUNTY OF KALAMAZOO
NOTICE TO CREDITORS
DECEDENT'S TRUST

Decedent: Ruth Eleanor Klomparens, Deceased. Date of birth: March 31, 1924.

Trust: Ruth E. Klomparens Estate Settlement Trust Agreement dated August 31, 1995.

NOTICE TO ALL CREDITORS: The decedent, Ruth E. Klomparens, who lived at 124 South Prairie Avenue, Kalamazoo, Michigan 49006, died August 31, 2019. The decedent established the Ruth E. Klomparens Estate Settlement Trust Agreement dated August 31, 1995, will be forever barred unless presented to TRUSTEE, the named Successor Trustee, within four (4) months after the date of publication of this notice.

BE IT further given that the Trust will thereafter be assigned and distributed to the persons entitled to it.

Date: January 26, 2020.

Attorney:
Michael A. Dombos (P49157)
Lewis, Reed & Allen, P.C.
136 East Michigan Avenue
Suite 800
Kalamazoo, Michigan 49007
Phone: (269) 388-7600

Trustee:
PNC Bank, N.A.
Attn: Ashley N. Stephens
245 North Rose Street
Kalamazoo, Michigan 49007
Phone: (269) 337-2537

Find more stories on mlive.com

STATE OF MICHIGAN
COUNTY OF KALAMAZOO
NOTICE TO CREDITORS
Decedent's Trust

In re: Margaret C. Connell Trust dated February 25, 2004. Date of Birth of Decedent: February 19, 1956.

TO ALL CREDITORS:
NOTICE TO CREDITORS: The decedent, Margaret C. Connell, who lived at 4222 S. Westnedge Ave., Kalamazoo, MI, 49008, died on October 26, 2019.

No probate estate is currently contemplated for the decedent.

Creditors of the decedent are notified that all claims against the decedent and the Margaret C. Connell Trust dated February 25, 2004, will be forever barred unless presented to: James S. Connell, named Trustee of the Margaret C. Connell Trust dated February 25, 2004, as amended, or to both the Attorney for the Trustee, Michael J. Willis, and the Trustee, within 4 months after the date of publication of this notice.

Date: January 26, 2020.

Willis Law
Michael J. Willis, J.D., C.P.A. (P62567)
491 W. South Street
Kalamazoo, MI 49007
(269) 492-1040

James S. Connell
68 Park Charles Blvd, North
St. Peters, MO 63376
(636) 9396-4842

Public Notices

STATE OF MICHIGAN
PROBATE COURT
COUNTY OF ALLEGAN

NOTICE TO CREDITORS
Decedent's Estate
FILE NO. 20-62080-DE

Estate of Leonard Roland Yearling. Date of Birth: May 11, 1937.

TO ALL CREDITORS:
NOTICE TO CREDITORS: The decedent, Leonard Roland Yearling, died December 12, 2019.

Creditors of the decedent are notified that all claims against the estate will be forever barred unless presented to Ronald Terry Yearling, personal representative, or to both the probate court at 113 Chestnut St., Allegan, MI 49010 and the personal representative within 4 months after the date of publication of this notice.

Date: January 26, 2020.

Law Office of Cery R. Kennedy
Cery R. Kennedy P80678
5751 Byron Center Ave.
SW Ste. CC
Wyoming, MI 49519
(616) 326-1970

Ronald Terry Yearling
164 48th St.
Grand Junction, MI 49506
(269) 521-3617

STATE OF MICHIGAN
PROBATE COURT
COUNTY OF KALAMAZOO

NOTICE TO CREDITORS
Decedent's Estate
FILE NO. 20200004-DE

Estate of FRANK EAKINS, DECEASED. Date of birth: 07/17/1931.

TO ALL CREDITORS:
NOTICE TO CREDITORS: The decedent, FRANK EAKINS, DECEASED, died November 29, 2019.

Creditors of the decedent are notified that all claims against the estate will be forever barred unless presented to Sandra K. Swanson, personal representative, or to both the probate court at 1536 Gull Road, Kalamazoo and the personal representative within 4 months after the date of publication of this notice, 01/26/2020.

McCarty Law Offices, PLC
Karen A. McCarty P36401
200 W. Allegan Street
Otsego, Michigan 49078
(269) 694-6055

Sandra K. Swanson
29089 Chiswick Ave. SW
Wyoming, Michigan 49509
(616) 648-6826

STATE OF MICHIGAN
PROBATE COURT
COUNTY OF KALAMAZOO

NOTICE TO CREDITORS
Decedent's Estate

Estate of Joseph P. Campbell. Date of birth: 08/19/1936.

TO ALL CREDITORS:
NOTICE TO CREDITORS: The decedent, Joseph P. Campbell, died 09/15/2018.

Creditors of the decedent are notified that all claims against the estate will be forever barred unless presented to Versi D. Hines, personal representative, or to both the probate court at 108 Allen, Kalamazoo and the personal representative within 4 months after the date of publication of this notice, 01/26/2020.

Versi D. Hines
108 Allen
Kalamazoo, MI 49004
269-459-6816

MERCHANDISE

Antiques, Art & Collectibles

COLLECTIBLE TOY SHOW. Sat, Feb. 1st, 9am-5pm. Jackson Fair Grounds. 200 W. Ganson St. $3/person. $1 OFF WITH THIS AD!

FINANCIAL

Business Opportunities

MONARCH BUSINESS BROKERS OFFERS-

A- Package Liquor license transferable anywhere in Barry Cty.

B- Class C-Liquor license for Kalamazoo Cty.

C- 2-gas stations w/ beer & wine takeout near Kalamazoo, both have kitchen facilities.

D- Package liquor stores in Kalamazoo- Three Rivers-Gobles area- some have Seller financing.

269-978-6640

Find more stories on mlive.com

PETS & FARMS

Pets & Supplies

Photo Coming Soon

Akc Yellow Labs. $500 (4 girls 3 boys) Born Oct 20th. Had first shots, dewormed, vet checked healthy. Call or text 2692662141 or email jenefernoe@ymail.com

BASSET HOUND PUPPIES- Family raised, loving and adorable, out of state, new bloodline, both parents on site, hurry & going fast, call & leave message. 616-984-6137

Beagles AKC Champion Sired Puppies lemon & Tri-colored. Parents on site $500 **616-610-2623**

Beautiful AKC English Lab Pups!!! Now borns to 10 Wks!!
Champion Bloodlines Gorgeous, all colors!!!
This also includes Young Adults Trained.
Extra Family Discount
All UTD Shots
$600-$800
810-955-8905 or 810-638-7265

Bernedoodle . 3 Pups. 2 Females. 1 Male. Bernedoodle dam. Poodle stud. Merle coats (gray w/ black spots) with white chests & paws. Born 12/21. Due for homes 2/14. Call Sara 269.760.1023.

Bernedoodles & AKC Poodles - All sizes & ages, variety of colors, training avail., Health tested parents, UTD shots, health guarantee, Allergy friendly! From $800-$3,500. 810-252-3016

BOXER PUPPIES! Purebred, tails & dewclaws removed, 1st shots & worming, vet checked, 8 weeks, ready to go, $450. Call (616) 200-2130.

Photo Coming Soon

Cavalier King Charles AKC puppies available. Vet checked first shots. Very special tri color & Blenheim Please call, text or email Danyelle (586)354-5728, Sreubers@att.net

Chihuahua Puppies- (4) 6 weeks old, $400 each. All puppies come with shot records, & a Puppy Package. For more info call Tracy @ 989-332-3352 or Curtis @ 989-475-1098

Pets & Supplies

ENGLISH CREAM RETRIEVERS- Very cute & playful, had 1st shots & dewormed, $700. 517-726-0706.

German Shepherd Puppies. AKC- champion bloodlines. 3 Black & Tan females and 1 Black & Tan male. OFA, shots, dewormed, microchipped. Price: $1000. Angie (616)308-0462. www.facebook.com/LittleBitOfShepherd/

German Shepherd Pups for Sale, Very Cute & Playful. UTD Shots & Wormed. $400 and $500. 517-726-0706

Havapoo Pups, 11wks, white/black, fury teddy bear looking, boys and girls, 1st shots and vet ✔, $800 - $1,000 call kay 616-706-5960

Labs AKC, all three colors, 1st shots, wormed and dewclaws are removed, $700. 2 litters to choose from. 989-661-2215 or 989-413-0064. Ready now!

POMBROKE WELSH CORGIES- Cute & playful, 1st shots & wormed, $600. 517-726-0706.

PUGS- 1 female and 2 male, had their 1st shots, vet checked, ready to go. $400. 269-845-0823

Pure Bred English Shepherd Puppies. Very playful, nice color . 1st shots & wormed. $400. 269-223-9194

Shih Tzu Puppies - UTD vacc., & deworming, Pre Spoiled & home raised, ready for new homes, $500. 517-945-4279

Shih Tzu Yorkies micro mix - 2 females, $900. 2 Yorkie Chihuahuas, teacup $700. Contact Katy 616-402-4959

Photo Coming Soon

Standard AKC Poodle puppies for sale. Will be 8 weeks on February 17. We have 3 left out of a litter of 7. Price $1,500. Call 616-802-3330 or email shell@mauer.farm

WIEMARANER PUPPIES AKC. Males, & Females. Tails docked. Dew claws removed. 1st shots. **Call: 231-342-5804**

Local sports news on mlive.com/sports

RECREATION

Motor Home For Sale

Photo Coming Soon

1989 Coachmen Catalina, 41219 miles, Ford V8, 28ft 2A/C, $1214 sale price. Contact brennarawl@gmail.com

TRANSPORTATION

SUVs

Photo Coming Soon

1996 Ford F-150 Eddie Bauer. 1996 Ford F-150, 1 owner 57k miles, $2050 sale price, 5.0L garage kept since new. Contact: staceefont@gmail.com

Trucks

2014 Nissan Frontier, Pickup, s/sv/sl/pro AWD, Grey, heated seats, like new, bumper hitch, many features, 2 keyless entries, ext. cab, 43k miles, $18,995 616-261-4549 no sat. calls

Wanted Vehicles

LOOKING TO BUY AN OLD FORESTER PROJECT CAR
In any condition, running or not. Porsche, Jaguar, Mercedes, Maserati, Ferrari, and much more. Fast and easy transaction, cash on the spot. If you have any of these or any other old foreign cars sitting around, please call me at 703-332-2202

Cars Domestic

BUICK 2006 LACROSSE- 96k original miles, no rust, a must see. $4500. 269-692-2661 and leave message.

CADILLAC 2002 DEVILLE- White, 4-door, 68k actual miles, no rust, $4,000. Call 616-438-7217

2006 Grey Buick Rendezvous, station wagon, 3 seats, newer battary, new windshield, no rust, bumper hitch. $1595. 201,014 miles. 616-261-4549. No Sat. calls

Photo Coming Soon

1995 Honda Accord. 28k mi. 2.2L, auto., very clean, asking $800. tarahpenfield@gmail.com

Find more stories on mlive.com

Local sports news on mlive.com/sports

Pets & Supplies

AKC Black Lab Puppies, 6 wks old, utd on shots and wormers, very good temperment, $600 contact Herman Mast 517-541-2368