

MI - Submission Package - MI2024MS0003O - (MI-24-1501) - Health Homes

- Summary
- Reviewable Units
- News
- Related Actions

CMS-10434 OMB 0938-1188

Package Information

Package ID MI2024MS0003O
Program Name Opioid Health Home
SPA ID MI-24-1501
Version Number 1
Submitted By Erin Black

Submission Type Official
State MI
Region Chicago, IL
Package Status Submitted
Submission Date 7/18/2024
Regulatory Clock 90 days remain
Review Status Review 1

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | MI2024MS0003O | MI-24-1501 | Opioid Health Home

Package Header

Package ID	MI2024MS0003O	SPA ID	MI-24-1501
Submission Type	Official	Initial Submission Date	7/18/2024
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Superseded SPA ID	N/A		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 | MI2024MS0003O | MI-24-1501 | Opioid Health Home

Package Header

Package ID	MI2024MS0003O	SPA ID	MI-24-1501
Submission Type	Official	Initial Submission Date	7/18/2024
Approval Date	N/A	Effective Date	N/A
Superseded SPA ID	N/A		
Reviewable Unit Instructions			

SPA ID and Effective Date

SPA ID MI-24-1501

Reviewable Unit	Proposed Effective Date	Superseded SPA ID
Health Homes Intro	10/1/2024	MI-20-1501
Health Homes Geographic Limitations	10/1/2024	MI-22-1501
Health Homes Population and Enrollment Criteria	10/1/2024	MI-20-1501
Health Homes Providers	10/1/2024	MI-20-1501
Health Homes Payment Methodologies	10/1/2024	MI-20-1501
Health Homes Services	10/1/2024	MI-20-1501

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | MI2024MS0003O | MI-24-1501 | Opioid Health Home

Package Header

Package ID	MI2024MS0003O	SPA ID	MI-24-1501
Submission Type	Official	Initial Submission Date	7/18/2024
Approval Date	N/A	Effective Date	N/A
Superseded SPA ID	N/A		
Reviewable Unit Instructions			

Executive Summary

Summary Description Including Goals and Objectives	<p>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) to expand the Opioid Health Home (OHH). A corresponding alternative benefit plan (ABP) SPA will be submitted as well.</p> <p>This proposal of change will expand the OHH statewide and include two additional diagnoses. Currently, the benefit is limited to beneficiaries within Michigan’s Prepaid Inpatient Health Plans (PIHP) Regions 1, 2, 4, 5, 6, 7, 8, 9, 10 with an opioid use disorder diagnosis. The expansion will include the addition of PIHP Region 3 (Allegan, Kent, Lake, Mason, Muskegon, Oceana, Ottawa) and additional diagnoses of alcohol use disorder and stimulant use disorder. The additional diagnoses will allow the current OHH to expand to a Substance Use Disorder Health Home (SUD-HH). The SPA will serve an additional estimated 2,000-3,000 beneficiaries once fully implemented. The SPA also changes the required FTE for Health Home Directors from .50 to .25 and removes medical assistants as part of the required team.</p>
--	---

Federal Budget Impact and Statute/Regulation Citation

Federal Budget Impact

	Federal Fiscal Year	Amount
First	2025	\$2123900
Second	2026	\$2123900

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 | MI2024MS0003O | MI-24-1501 | Opioid Health Home

Package Header

Package ID	MI2024MS0003O	SPA ID	MI-24-1501
Submission Type	Official	Initial Submission Date	7/18/2024
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**

Meghan Groen, Director
Behavioral and Physical Health and
Aging Services Administration

Submission - Medicaid State Plan

MEDICAID | Medicaid State Plan | Health Homes | MI2024MS0003O | MI-24-1501 | Opioid Health Home

CMS-10434 OMB 0938-1188

The submission includes the following:

- ☐ Administration
- ☐ Eligibility
- ☒ Benefits and Payments
- ☒ 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.

*

<input type="checkbox"/>	Reviewable Unit Name	Included in Another Source Type Submission Package
<input checked="" type="checkbox"/>	Health Homes Intro	<input checked="" type="checkbox"/> APPROVED
<input checked="" type="checkbox"/>	Health Homes Geographic Limitations	<input checked="" type="checkbox"/> APPROVED
<input checked="" type="checkbox"/>	Health Homes Population and Enrollment Criteria	<input checked="" type="checkbox"/> APPROVED
<input checked="" type="checkbox"/>	Health Homes Providers	<input checked="" type="checkbox"/> APPROVED
<input type="checkbox"/>	Health Homes Service Delivery Systems	<input type="checkbox"/> APPROVED
<input checked="" type="checkbox"/>	Health Homes Payment Methodologies	<input checked="" type="checkbox"/> APPROVED
<input checked="" type="checkbox"/>	Health Homes Services	<input checked="" type="checkbox"/> APPROVED
<input type="checkbox"/>	Health Homes Monitoring, Quality Measurement and Evaluation	<input type="checkbox"/> APPROVED

1 – 8 of 8

☐ 1945A Health Home Program

Submission - Public Notice/Process

MEDICAID | Medicaid State Plan | Health Homes | MI2024MS0003O | MI-24-1501 | Opioid Health Home

Package Header

Package ID	MI2024MS0003O	SPA ID	MI-24-1501
Submission Type	Official	Initial Submission Date	7/18/2024
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	
Tearsheet - Flint Journal - SUD Health Home	6/26/2024 1:10 PM EDT	

Submission - Tribal Input

MEDICAID | Medicaid State Plan | Health Homes | MI2024MS0003O | MI-24-1501 | Opioid Health Home

Package Header

Package ID MI2024MS0003O
Submission Type Official
Approval Date N/A
Superseded SPA ID N/A

SPA ID MI-24-1501
Initial Submission Date 7/18/2024
Effective Date 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

☒ 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:

- ☒ All Indian Tribes

Date of consultation:	Method of consultation:
4/15/2024	Michigan Tribal Notification letter April 15, 2024

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 24-20	6/26/2024 2:43 PM EDT	

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 | MI2024MS0003O | MI-24-1501 | Opioid Health Home

Package Header

Package ID	MI2024MS0003O	SPA ID	MI-24-1501
Submission Type	Official	Initial Submission Date	7/18/2024
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

- ☒ 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.

Date of consultation
4/26/2018

Health Homes Intro

MEDICAID | Medicaid State Plan | Health Homes | MI2024MS0003O | MI-24-1501 | Opioid Health Home

Package Header

Package ID	MI2024MS0003O	SPA ID	MI-24-1501
Submission Type	Official	Initial Submission Date	7/18/2024
Approval Date	N/A	Effective Date	10/1/2024
Superseded SPA ID	MI-20-1501		
	System-Derived		

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 and include additional diagnoses that allow the current OHH to expand to a Substance Use Disorder Health Home (SUD-HH). The SUD-HH provides comprehensive care management and coordination services to Medicaid beneficiaries with an alcohol use disorder, stimulant use disorder or opioid use disorder. For enrolled beneficiaries, the SUD-HH functions as the central point of contact for directing patient centered care across the broader health care system. The model 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 health and social needs. Participation is voluntary and enrolled beneficiaries may opt-out at any time.

Michigan has five overarching goals for the SUD-HH program: 1) improve care management of beneficiaries including MOUD and medications for alcohol use disorder; 2) improve care coordination between physical and behavioral health care services; 3) improve care transitions between primary, specialty, and inpatient settings of care; 4) improve coordination to dental care; 5) educate on fetal alcohol spectrum disorders.

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 | MI2024MS0003O | MI-24-1501 | Opioid Health Home

Package Header

Package ID	MI2024MS0003O	SPA ID	MI-24-1501
Submission Type	Official	Initial Submission Date	7/18/2024
Approval Date	N/A	Effective Date	10/1/2024
Superseded SPA ID	MI-22-1501		
	System-Derived		

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

Health Homes Population and Enrollment Criteria

MEDICAID | Medicaid State Plan | Health Homes | MI2024MS0003O | MI-24-1501 | Opioid Health Home

Package Header

Package ID	MI2024MS0003O	SPA ID	MI-24-1501
Submission Type	Official	Initial Submission Date	7/18/2024
Approval Date	N/A	Effective Date	10/1/2024
Superseded SPA ID	MI-20-1501		
	System-Derived		

Reviewable Unit Instructions

Categories of Individuals and Populations Provided Health Home Services

The state will make Health Home 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 | MI2024MS0003O | MI-24-1501 | Opioid Health Home

Package Header

Package ID	MI2024MS0003O	SPA ID	MI-24-1501
Submission Type	Official	Initial Submission Date	7/18/2024
Approval Date	N/A	Effective Date	10/1/2024
Superseded SPA ID	MI-20-1501		
	System-Derived		

Reviewable Unit Instructions

Population Criteria

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

- ☐ Two or more chronic conditions
- ☒ One chronic condition and the risk of developing another

Specify the conditions included:

- ☐ Mental Health Condition
- ☒ Substance Use Disorder
- ☐ Asthma
- ☐ Diabetes
- ☐ Heart Disease
- ☐ BMI over 25
- ☐ Other (specify):

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

Beneficiaries with a substance use disorder specifically alcohol use disorder, opioid use disorder, and stimulant use disorder are eligible for health home services who also are at risk of developing mental health conditions, asthma, diabetes, heart disease, BMI over 25 and other: COPD

- ☐ One serious and persistent mental health condition

Health Homes Population and Enrollment Criteria

MEDICAID | Medicaid State Plan | Health Homes | MI2024MS0003O | MI-24-1501 | Opioid Health Home

Package Header

Package ID	MI2024MS0003O	SPA ID	MI-24-1501
Submission Type	Official	Initial Submission Date	7/18/2024
Approval Date	N/A	Effective Date	10/1/2024
Superseded SPA ID	MI-20-1501		
	System-Derived		

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 Substance Use Disorder Health Home (SUD-HH) 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. The selection of a health home provider is optional, the beneficiary may have other choices of health home providers, and the beneficiary may disenroll from the benefit at any time. Enrolling into the health home benefit does not restrict access to other providers nor does it limit access to other Medicaid benefits. Enrollment into health home is voluntary and the potential enrollee must agree to receive health home services and provide consent that is maintained in the enrollee's health record.

Lead Entities will provide information about the SUD-HH 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 SUD-HH.

- Lead Entity Identification of Potential Enrollees
The LE will be responsible for identifying potential enrollees that have a qualifying SUD-HH diagnosis in the WSA to a perspective HHP and provide information regarding SUD-HH 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 SUD-HH benefit via the WSA. SUD-HH providers must provide documentation that indicates whether a potential SUD-HH 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 | MI2024MS0003O | MI-24-1501 | Opioid Health Home

Package Header

Package ID	MI2024MS0003O	SPA ID	MI-24-1501
Submission Type	Official	Initial Submission Date	7/18/2024
Approval Date	N/A	Effective Date	10/1/2024
Superseded SPA ID	MI-20-1501		
	System-Derived		

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)	<ul style="list-style-type: none">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 standards for HHPs, including:<ul style="list-style-type: none">Identification of providers who meet the HHP standardsProvision of infrastructure to support HHPs in care coordinationCollecting and sharing member-level information regarding health care utilization and medicationsProviding quality outcome

Provider Type	Description
	<p>protocols to assess HHP effectiveness</p> <ul style="list-style-type: none"> 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)	<ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> Community Mental Health Services Program (Community Mental Health Center) Federally Qualified Health Center/Primary Care Safety Net Clinic Hospital based Physician Group Opioid Treatment Program Physician based Clinic Physician or Physician Practice Rural Health Clinics Substance Use Disorder Provider other than Opioid Treatment Program <ul style="list-style-type: none"> Tribal Health Center

Health Homes Providers

MEDICAID | Medicaid State Plan | Health Homes | MI2024MS0003O | MI-24-1501 | Opioid Health Home

Package Header

Package ID	MI2024MS0003O	SPA ID	MI-24-1501
Submission Type	Official	Initial Submission Date	7/18/2024
Approval Date	N/A	Effective Date	10/1/2024
Superseded SPA ID	MI-20-1501		
	System-Derived		

Reviewable Unit Instructions

- ☐ Teams of Health Care Professionals
- ☐ Health Teams

Health Homes Providers

MEDICAID | Medicaid State Plan | Health Homes | MI2024MS0003O | MI-24-1501 | Opioid Health Home

Package Header

Package ID	MI2024MS0003O	SPA ID	MI-24-1501
Submission Type	Official	Initial Submission Date	7/18/2024
Approval Date	N/A	Effective Date	10/1/2024
Superseded SPA ID	MI-20-1501		
	System-Derived		

Reviewable Unit Instructions

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 MOUD 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 MOUD. The following represents the care team requirement per 100 enrollees:

- Health Home Director (0.25 FTE)
- Behavioral Health Specialist (0.25 FTE)
- Nurse Care Manager (1.00 FTE)
- Peer Recovery Coach, Community Health Worker (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 or licensed practical nurse in Michigan with relevant experience

- Peer Recovery Coach, Community Health Worker
- 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 SUD-HH 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 SUD-HH 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
 - ii. 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 SUD-HH Program at the State defined rate.
7. The LE must be contracted with MDHHS to execute the enrollment, payment, and administration of the SUD-HH 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 SUD-HH becomes operational. PCMH application can be pending at the time of implementation. In the absence of accreditation from a national recognizing body (health home, PCMH, or integrated care), the LE may verify that an HHP meets standards to provide health home services parallel to those required for accreditation. The LE must establish and utilize a template for HHPs that aligns with SUDHH Partner Standards Document, SUDHH Handbook, SPA, and policy. MDHHS has the right to review all templates created by the LE quality assurance and compliance purposes.
 - 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 the LE contract with MDHHS, have priority access to treatment. Access timeliness standards and interim services requirements for these populations are provided below.

Name	Date Created	
SUDHH Provider Requirements and Expectations V1 (06. 2024)	6/26/2024 11:49 AM EDT	

Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | MI2024MS0003O | MI-24-1501 | Opioid Health Home

Package Header

Package ID	MI2024MS00030
Submission Type	Official
Approval Date	N/A
Superseded SPA ID	MI-20-1501
	System-Derived

SPA ID	MI-24-1501
Initial Submission Date	7/18/2024
Effective Date	10/1/2024

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 | MI2024MS0003O | MI-24-1501 | Opioid Health Home

Package Header

Package ID	MI2024MS0003O	SPA ID	MI-24-1501
Submission Type	Official	Initial Submission Date	7/18/2024
Approval Date	N/A	Effective Date	10/1/2024
Superseded SPA ID	MI-20-1501		
	System-Derived		

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 | MI2024MS0003O | MI-24-1501 | Opioid Health Home

Package Header

Package ID	MI2024MS0003O	SPA ID	MI-24-1501
Submission Type	Official	Initial Submission Date	7/18/2024
Approval Date	N/A	Effective Date	10/1/2024
Superseded SPA ID	MI-20-1501		
	System-Derived		

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 | MI2024MS0003O | MI-24-1501 | Opioid Health Home

Package Header

Package ID	MI2024MS0003O	SPA ID	MI-24-1501
Submission Type	Official	Initial Submission Date	7/18/2024
Approval Date	N/A	Effective Date	10/1/2024
Superseded SPA ID	MI-20-1501		
	System-Derived		

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	
SUDHH Payment Methodology V1 (06.2024)	6/26/2024 2:31 PM EDT	

Health Homes Services

MEDICAID | Medicaid State Plan | Health Homes | MI2024MS0003O | MI-24-1501 | Opioid Health Home

Package Header

Package ID	MI2024MS0003O	SPA ID	MI-24-1501
Submission Type	Official	Initial Submission Date	7/18/2024
Approval Date	N/A	Effective Date	10/1/2024
Superseded SPA ID	MI-20-1501		
	System-Derived		

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 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 SUDHH Primary Care Provider (must have appropriate licensure and/or certification from the State)

☒ Nurse Care Coordinators

Description

Nurse Care Manager (Coordinator) (e.g., RN, LPN)
*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

☐ Nurses

☐ Medical Specialists

☒ Physicians

☒ Physician's Assistants

☐ Pharmacists

☐ Social Workers

☐ Doctors of Chiropractic

☐ Licensed Complementary and alternative Medicine Practitioners

☐ Dietitians

☐ Nutritionists

☒ Other (specify)

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

Description

Physician, Nurse Practitioner, Physician's Assistant

*Serves as the SUDHH Primary Care Provider (must have appropriate licensure and/or certification from the State)

Description

Physician, Nurse Practitioner, Physician's Assistant

*Serves as the SUDHH Primary Care Provider (must have appropriate licensure and/or certification from the State)

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
Peer Recovery Coaches	Must obtain a peer certification from accredited body.
Health Home Partners	Any of the selected provider types above at the HHP.
Lead Entity	<ul style="list-style-type: none">Provides leadership for implementation and coordination of health home activitiesCoordinates all enrollment into the health home on behalf of providersCoordinates with LE care management staff and SUDHH providers to identify a beneficiary's optimal setting of careCoordinates and utilizes HIT with the SUDHH provider team to maximize care coordination and care managementServes as a liaison between the health homes site and MDHHS staff/contractorsChampions practice transformation based on health home principlesCoordinates all enrollment into the health home on behalf of providersDevelops and maintains working relationships with primary and specialty care providers including Community Mental Health Service Providers and inpatient facilitiesCollects and reports on data that permits an evaluation of increased coordination of care and chronic disease managementMonitors Health Home performance and leads quality improvement effortsDesigns and develops prevention and wellness initiatives, and referral trackingTraining and technical assistanceData management and reporting

Health Homes Services

MEDICAID | Medicaid State Plan | Health Homes | MI2024MS0003O | MI-24-1501 | Opioid Health Home

Package Header

Package ID	MI2024MS0003O	SPA ID	MI-24-1501
Submission Type	Official	Initial Submission Date	7/18/2024
Approval Date	N/A	Effective Date	10/1/2024
Superseded SPA ID	MI-20-1501		
	System-Derived		

Reviewable Unit Instructions

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 additions 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 or related degree)
*Screening/evaluation of individuals for mental health and substance use

- ☐ Nurse Practitioner
- ☒ Nurse Care Coordinators

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

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

Description

Nurse Care Manager (Coordinator) (e.g., RN, LPN)

- *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

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
Peer Recovery Coaches	Must obtain a peer certification from accredited body.
Health Home Partners	Any of the selected provider types above at the HHP.
Lead Entity	<ul style="list-style-type: none"> • 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 SUDHH providers to

Provider Type**Description**

identify a beneficiary's optimal setting of care

- Coordinates and utilizes HIT with the SUDHH 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 | MI2024MS0003O | MI-24-1501 | Opioid Health Home

Package Header

Package ID	MI2024MS0003O	SPA ID	MI-24-1501
Submission Type	Official	Initial Submission Date	7/18/2024
Approval Date	N/A	Effective Date	10/1/2024
Superseded SPA ID	MI-20-1501		
	System-Derived		

Reviewable Unit Instructions

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 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, LPN)

- *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
Peer Recovery Coaches	Must obtain a peer certification from accredited body.
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	<ul style="list-style-type: none"> 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 SUDHH providers to identify a beneficiary's optimal setting of care Coordinates and utilizes HIT with the SUDHH 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 | MI2024MS0003O | MI-24-1501 | Opioid Health Home

Package Header

Package ID	MI2024MS0003O	SPA ID	MI-24-1501
Submission Type	Official	Initial Submission Date	7/18/2024
Approval Date	N/A	Effective Date	10/1/2024
Superseded SPA ID	MI-20-1501		
	System-Derived		

Reviewable Unit Instructions

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

☒ Behavioral Health Professionals or Specialists

Description

Behavioral Health Provider (e.g., Case Worker or Addictions Counselor 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, LPN)

- *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
Peer Recovery Coaches	Must obtain a peer certification from accredited body.
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	<ul style="list-style-type: none">• 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 SUDHH providers to identify a beneficiary's optimal setting of care• Coordinates and utilizes HIT with the SUDHH 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 | MI2024MS0003O | MI-24-1501 | Opioid Health Home

Package Header

Package ID	MI2024MS0003O	SPA ID	MI-24-1501
Submission Type	Official	Initial Submission Date	7/18/2024
Approval Date	N/A	Effective Date	10/1/2024
Superseded SPA ID	MI-20-1501		
	System-Derived		

Reviewable Unit Instructions

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 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, LPN)
- *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
Peer Recovery Coaches	Must obtain a peer certification from accredited body.
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	<ul style="list-style-type: none"> 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 SUDHH providers to identify a beneficiary's optimal setting of care Coordinates and utilizes HIT with the SUDHH 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 | MI2024MS0003O | MI-24-1501 | Opioid Health Home

Package Header

Package ID	MI2024MS0003O	SPA ID	MI-24-1501
Submission Type	Official	Initial Submission Date	7/18/2024
Approval Date	N/A	Effective Date	10/1/2024
Superseded SPA ID	MI-20-1501		
	System-Derived		

Reviewable Unit Instructions

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 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, LPN)
*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
Peer Recovery Coaches	Must obtain a peer certification from accredited body.
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	<ul style="list-style-type: none"> 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 SUDHH providers to identify a beneficiary's optimal setting of care Coordinates and utilizes HIT with the SUDHH 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 | MI2024MS0003O | MI-24-1501 | Opioid Health Home

Package Header


Package ID	MI2024MS0003O	SPA ID	MI-24-1501
Submission Type	Official	Initial Submission Date	7/18/2024
Approval Date	N/A	Effective Date	10/1/2024
Superseded SPA ID	MI-20-1501		
	System-Derived		

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	
SUDHH Patient Flow V1 (06.2024)	6/26/2024 12:15 PM EDT	

PRA Disclosure Statement: Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) and (42 CFR 430.12); which sets forth the authority for the submittal and collection of state plans and plan amendment information in a format defined by CMS for the purpose of improving the state application and federal review processes, improve federal program management of Medicaid programs and Children's Health Insurance Program, and to standardize Medicaid program data which covers basic requirements, and individualized content that reflects the characteristics of the particular state's program. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to range from 1 hour to 80 hours per response (see below), including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

This view was generated on 7/18/2024 3:21 PM EDT

SUDHH 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)

The Health Home Director is responsible for but not limited to providing leadership for implementation and coordination of health home activities. Coordinates all enrollment and disenrollments into the health home on behalf of health home partners. Serves as the liaison between the health partners and MDHHS staff. Collects and reports on data evaluating increased coordination of care and chronic disease management for the health home. Monitors Health Home performance and leads quality improvement efforts through training and technical assistance.

Behavioral Health Specialist (e.g., Case Worker, Counselor, or Therapist related degree)

The Behavioral Health Specialist is responsible for but not limited to screening individuals for mental health and substance use disorders. Referring beneficiaries to a licensed mental health provider and/or licensed and certified SUD therapist as necessary. Conducts brief intervention for individuals' behavioral health needs. Focuses on population management. Works with patients to identify chronic behavior, discuss impact, develop improvement strategies and specific goal-directed interventions. Meets regularly with the care team to plan care and discuss cases and exchanges appropriate information with team members as part of the daily routine of the clinic.

Nurse Care Manager

The Nurse Care Manager (NCM) is responsible for but not limited to monitoring assessments and screenings to assure findings are integrated in the care plan. Meets regularly with the care team to plan care and discuss cases and exchanges appropriate information with team members. The NCM Communicates with medical providers, subspecialty providers including mental health and substance use service providers, long term care and hospitals regarding records including admission/discharge.

The NCM assists in managing the individual's full array of physical health needs, in addition to behavioral health care needs, taking a "whole person" approach.

- RNs and Licensed Practical Nurses (LPN) are qualified as NCMs.
- Experience working with SUD field is preferred.

Peer Recovery Coach

The Peer Recovery Coaches (PRC) is responsible for but not limited supporting a beneficiary by assisting and advocating for the beneficiaries they serve in achieving their needs, personal pursuits, and self-directed goals. The PRC will share their lived experiences to inspire hope, encourage change and assist to identify resources and supports that promote recovery. The PRC will meet regularly with the care team to plan care and discuss cases, exchange appropriate information with the care team.

- PRC can be state, CCAR, or MCBAP certified.
 - The state encourages LE/HHPs to assist PRCs to become state certified.

Community Health Worker

The Community Health Workers (CHW) is responsible for but not limited to serve as a liaison/link/intermediary between social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. The CHW will regularly meet with the care team to plan care and discuss cases, exchange appropriate information with the care team.

- CHW can be state certified or certified through another credentialed body.
 - The state encourages LE/HHPs to assist CHWs to become state certified.

Medical Consultant (i.e., primary care physician, physician's assistant, or nurse practitioner)

A Medical Consultant is responsible for but not limited to providing 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

A Psychiatric Consultant is responsible for communicating treatment methods and expert advice to a Behavioral Health Provider. The 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.

NOTE: Any provider could be assigned the "lead" for any patient based on their person- centered plan.

In addition to the above Provider Infrastructure Requirements, eligible HHPs should coordinate care with the following professions when appropriate:

- Dentist
- Dietician/Nutritionist
- Pharmacist
- Peer support specialist
- Diabetes educator
- School personnel
- Others as appropriate

MDHHS Opioid Health Home (SUDHH) Payment Methodology

Overview

MDHHS will provide a monthly case rate to the LE based on the number of SUDHH beneficiaries with at least one SUDHH 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

SUDHH 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 SUDHH per 100 enrollees:

Lead Entity (per 100 patients)

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

Rate Amounts

The SUDHH payment rates reflect a monthly case rate per SUDHH beneficiary with at least one proper and successful SUDHH service within a given month. The payment for SUDHH services is subject to recoupment from the PIHP if the beneficiary does not receive an SUDHH service during the calendar month. Rates will be effective on or after October 1, 2024. Rate information will be maintained on the MDHHS website at www.michigan.gov/SUDHH. 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.

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

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 in the health home handbook. If quality improvement benchmarks are not met by any of the HHPs within a given performance year, the funding will be distributed equally among regions that maintain a recoupment rate less than 45% during the performance year.

Metrics, Assessment, and Distribution

The methodology for metrics, specifications, and benchmarks will be effective October 1, 2024 and will be maintained on the MDHHS website: www.michigan.gov/SUDHH.

Substance Use Disorder Health Home (SUDHH) Patient Flow

Enrollee Identification and Assignment

Identification of Potential Enrollees

Substance Use Disorder Health Home (SUDHH) 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 SUDHH benefit. The selection of a health home provider is optional, the beneficiary may have other choices of health home providers, and the beneficiary may disenroll from the benefit at any time. Enrolling into the health home benefit does not restrict access to other providers nor does it limit access to other Medicaid benefits. Enrollment into health home is voluntary and the potential enrollee must agree to receive health home services and provide consent that is maintained in the enrollee's health record.

Lead Entity Identification of Potential Enrollees

Lead Entities will provide information about the SUDHH 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 SUDHH.

Provider Recommended Identification of Potential Enrollees

Health Home Partners are permitted to recommend potential enrollees for the SUDHH benefit via the WSA. SUDHH providers must provide documentation that indicates whether a potential SUDHH 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 SUDHH 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 Enrollment

Full enrollment into the SUDHH 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.


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 SUDHH 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.





Searching for that perfect item? Go to classifieds.mlive.com


Classified


**ANNOUNCEMENTS**
Bands/Music
Lost & Found
Personals


**MERCHANDISE**
Antiques
Appliances
Garage Sales


**FINANCIAL**
Investments
Stocks
Money to Loan


**PETS & FARMS**
Dirt & Gravel
Farm Equipment
Livestock & Feed

**RECREATION**
Boats
Campers
Snowmobiles

**TRANSPORTATION**
Cars
Trucks
Vans

**EMPLOYMENT**
Jobs
General Help
Services

**REAL ESTATE**
Homes for Sale
Apartment
Commercial

**BARGAIN CORNER**
Business Bargains
Items \$1,000 or
Less Wanted to Buy

**ANNOUNCEMENTS**
PUBLIC NOTICES

**ANNOUNCEMENTS**
PUBLIC NOTICES

**ANNOUNCEMENTS**
PUBLIC NOTICES

**ANNOUNCEMENTS**
PUBLIC NOTICES

Budget Hearing Notice
A public hearing will be held to review the 2024-2025 budget for Eagles Nest Academy. The meeting will be held at 6:00 pm on June 20th, 2024 at 5005 Cloverlawn Dr. Flint, MI 48504. A copy of the budget can be inspected at Eagles Nest Academy, 5005 Cloverlawn Dr. Flint, MI 48504 or via email request to: mcross@phalenacademies.org

Crown Castle is proposing to replace existing antenna and associated equipment on an existing 35.67-foot (39.67 feet overall) telecommunications pole at the following site: 702 Welch Blvd, Flint, Genesee County, MI 48505, Lat: 43-1-50.63, Long: -83-42-47.77. Crown Castle invites comments from any interested party on the impact of the proposed action on any districts, sites, buildings, structures or objects significant in American history, archaeology, engineering or culture that are listed or determined eligible for listing in the National Register of Historic Places and/or specific reason the proposed action may have a significant impact on the quality of the human environment. Specific information regarding the project is available by contacting Alaina S., a.decamposalles@trileaf.com, and 630-227-0202 during normal business hours. Comments must be received at 1821 Walden Office Square, Suite 500, Schaumburg, IL 60173 within 30 days of the date of this publication.

Crown Castle is proposing to replace an existing antenna and associated equipment on an existing 57.5-foot small cell telecommunications utility pole at the following site: 314 11th Ave, Flint, Genesee County, MI 48505, Lat: 43-1-38.03, Long: -83-42-13.28. Crown Castle invites comments from any interested party on the impact of the proposed action on any districts, sites, buildings, structures or objects significant in American history, archaeology, engineering or culture that are listed or determined eligible for listing in the National Register of Historic Places and/or specific reason the proposed action may have a significant impact on the quality of the human environment. Specific information regarding the project is available by contacting Alaina S., a.decamposalles@trileaf.com, and 630-227-0202 during normal business hours. Comments must be received at 1821 Walden Office Square, Suite 500, Schaumburg, IL 60173 within 30 days of the date of this publication.

Public Notice
Michigan Department of Health and Human Services
Behavioral and Physical Health and Aging Services Administration
Substance Use Disorder Health Home State Plan Amendment Requests

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) to expand the Opioid Health Home (OHH). The request includes a SPA and a corresponding alternative benefit plan (ABP) SPA.

The anticipated effective date for the SPAs is October 1,

2024.

This proposal of change will expand the OHH statewide and include two additional diagnoses. Currently, the benefit is limited to beneficiaries within Michigan's Prepaid Inpatient Health Plans (PIHP) Regions 1, 2, 4, 5, 6, 7, 8, 9, 10 with an opioid use disorder diagnosis. The expansion will include the addition of PIHP Region 3 (Allegan, Kent, Lake, Mason, Muskegon, Oceana, Ottawa) and additional diagnoses of alcohol use disorder and stimulant use disorder. The additional diagnoses will allow the current OHH to expand to a Substance Use Disorder Health Home (SUD-HH). The SPA will serve an additional estimated 2,000-5,000 beneficiaries once fully implemented. A region's PIHP will coordinate enrollment and care with selected providers.

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 SPAs is \$6.6 million per year.

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 sending an e-mail to MSADraftPolicy@michigan.gov or by submitting a request in writing to: MDHHS/Behavioral and Physical Health and Aging Services Administration, Program Policy Division, PO Box 30479, Lansing, MI 48909-7979 by June 30, 2024. A copy of the proposed SPAs will also be available for review at:

<https://www.michigan.gov/mdhhs/inside-mdhhs/budgetfinance/2547/state-plan-amendments>

Sealed bids will be received until 2:00 p.m. (EST), Monday, July 8, 2024, at the Genesee County Purchasing Department, 1101 Beach Street, Room 361, Flint, MI, 48502 for the Genesee County Jail Water Heater Replacement. Re-bid project as requested by the Genesee County Facility Operation Department.

A copy of the RFP #24-391 may be downloaded from the following site: Genesee County Purchasing Current Year Bids (geneseecountymi.gov), choose Current Bids and then click on the name of the RFP/ITB or contact the offices of the Genesee County Purchasing Department at (810) 257-3030.

ADVERTISEMENT FOR DIGITAL SIGN BIDS
SWARTZ CREEK COMMUNITY SCHOOLS - NEW MARY CRAPO COMMUNITY PARK
SWARTZ CREEK, MICHIGAN

SWARTZ CREEK COMMUNITY SCHOOLS will receive firm contractor bids for the new Mary Crapo Park Digital Sign, which is comprised of outfitting the masonry base with a two-way digital sign with decorative panels and logos, to be located at 8197 Miller Road, Swartz Creek, MI 48473.

The bidding documents consist of plans and

specifications as prepared by Richard Hunt Swartz Creek Community Schools and Plans by Signs by Crannie. Plan and bidding instructions will also be provided through Swartz Creek Community Schools postings on swartzcreek.org website, Bidnet, and Sigma. Interested parties with further questions can reach Richard Hunt, Director of Operations, for Swartz Creek Schools at rhunt@swcrk.org. The documents will be available on Thursday, June 6th, 2024.

Bids must be delivered no later than 2:00 p.m., EST, Wednesday, July 9th, 2024, to Swartz Creek Community School Offices located at 8354 Cappy Lane, Swartz Creek, MI 48473. Each proposal must be submitted, in duplicate, on the forms furnished and must be completed in full per the bidders' instructions. Each proposal shall be sealed in an opaque envelope and marked with the name of the bidder, the Mary Crapo Digital Signage being bid, and addressed to the attention of Swartz Creek Community Schools, 8354 Cappy Lane, Swartz Creek, MI 48473. Digital signage scope to be conducted in late Fall 2024 proceeding with completion of masonry work performed by others.

Request for Proposal Released 6/6/24 2:00 PM
Pre-Bid Walkthrough 6/12/24 11:00 AM
Bid Response Due 7/9/24 2:00 PM
Opening of Bids 7/9/24 2:05 PM
Awarding of Bid 7/17/24 Board Meeting

Swartz Creek Community Schools reserves the right to reject any and/or all bids in whole or in part and to waive any informality therein. Swartz Creek Community Schools reserves the right to accept that bid which in its opinion is in the best interest of the Owner.

FOR IMMEDIATE RELEASE:
June 6, 2024
CONTACT PERSON:
Jensen Sikora
Executive Assistant
(810) 249-2039

GLORIA COLES FLINT PUBLIC LIBRARY BOARD OF TRUSTEES MEETINGS + CALENDAR OF EVENTS

The Gloria Coles Flint Public Library has established regular Board of Trustee meeting dates through June 2025. Regular board meetings will be held at the Gloria Coles Flint Public Library (1026 E. Kearsley Street, Flint, MI 48503) in the Harris Room on Thursdays at 5:30pm (or as noted) on the following dates:

July 11, 2024 — Annual Meeting, immediately followed by Regular Meeting
August 1, 2024
September 12, 2024
October 3, 2024
November 7, 2024
December 5, 2024
January 9, 2025
February 6, 2025
March 6, 2025
April 3, 2025
May 1, 2025
June 5, 2025 — Public Budget Hearing at 5:00pm
June 5, 2025 — Regular Meeting at 5:30pm
June 26, 2025 — Final Budget Meeting at 5:30pm

Please contact Jensen Sikora at (810) 249-2039 for additional information.

NOTICE OF A PUBLIC HEARING ON PROPOSED 2024-2025 BUDGET

PLEASE TAKE NOTICE that on June 20, 2024 at 5:45 o'clock p.m., at 1020 West Coldwater Road, Flint, Michigan, the Board of Education of the Beecher Community School District will hold a public hearing to consider the District's proposed 2024-2025 budget.

The Board may not adopt its proposed 2024-2025 budget until after the public hearing. A copy of the proposed 2024-2025 budget including the proposed property tax millage rate is available for normal inspection during business hours at 1020 West Coldwater Road, Flint, Michigan.

The property tax millage rate proposed to be levied to support the proposed budget will be a subject of this hearing.

This notice is given by order of the Board of Education.

Soni Sparks, Secretary

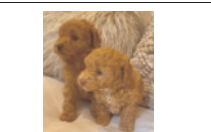


MERCHANDISE GARAGE SALES

Annual Subdivision Sale
Wicklow North/South
Irish Rd & 69, Friday and Saturday, June 14 & 15 8am-5pm. Furniture, toys, clothing, home goods, and more! Sponsored by Brian Abraham Realtor-Keller Williams First. Contact Brian @ BrianAbraham@kw.com or (810) 625-5321 for all of your real estate needs!



PETS & FARMS
AKC Poodles- Training started, UTD on shots. All Sizes & Ages available, Health tested parents, Allergy Friendly. Health guarantee. From \$500 & up. 810-252-3016



True Micro-Goldendoodle Puppies Ready for forever home 6-21. Vet health cert. Dewormed, shots. Mom wt. 14 lbs, Dad wt. 7 lbs.
1 Male \$2600 1 Female \$2900 with breeding rights. 303-907-0207 Traverse City, MI \$2600-\$2900 303-907-0207



A convenient list of local service providers

BUSINESS directory

To advertise your business in this directory call Ansaris Ali at 216-999-3810 or aali@advancelocal.com
MAKE SURE YOU MENTION TO YOUR SERVICE PROVIDER YOU SAW THEM HERE

BRICK, BLOCK & STONE
**BRICK MAN MASONRY & LANDSCAPING**
810-299-9610

CEMENT WORK
**PATTEE'S CONCRETE WORK**
Free Estimates
Flatwork • Footings
Basement Waterproofing
Specializing in Stamped Concrete
Eric Pattee 810.853.5488 Trevor Pattee 810.347.5120

CLEANING
**ELITE CLEANING systems**
DECK WASHING, STAINING & HOUSE WASHING
CONCRETE & BRICK PAVER AND GUTTER CLEANING
Licensed & Insured 810-893-1297

HANDYMAN SERVICES
Licensed & Insured #201142805
**JOSEPH SABO BUILDING CO.**
Home Improvement • Handyman Services • New Builds • Remodeling
Kitchens • Bathrooms • Basements • Roofing • Siding Windows
Doors • Pole Barns • Garages • Sheds
RESIDENTIAL HEATING & COOLING SYSTEMS
SNOW PLOWING
JOSEPH SABO Owner (810) 653-2905

HAULING
**JUNK REMOVAL CLEAN OUT**
Houses, Basements Garages, Yard, Gutters, Demo Sheds, Dog Houses, Antennas etc.
You call we haul! We do it all!
Free Estimates Call Paul's 810-938-4448

GUTTERS

HOME IMPROVEMENT AND REPAIR
**EDDY'S DRYWALL & PAINTING**
Residential Only
FREE ESTIMATES
Edgar Martinez (810) 299-9610

LAWN AND GARDEN
**RAD LANDSCAPE**
Spring/Fall Clean-Up, Junk Removal, Tree/Bush Trimming, Weeding, Mulch And All Of Your Garden Needs.
Call Russ 810-660-2150

PAINTING
**PAINTING**
Interior / Exterior.
Free Est. Licensed.
Call Jim, 810-686-8101

ROOFING & SIDING
**A Better ROOF For Less**
810.687.3599 • www.ABetterRoofForLess.com
Licensed & Insured • Storm Damage Specialists

SCRAPPING / RECYCLING
**Auto Scrap, Cash Buyer**
Free towing!
Call Russ : (810) 423-6191

WE BUY ALL CARS & TRUCKS
Not running? We can tow it! BIG \$\$\$
(810) 235-9166

**SUBSCRIBERS, CHECK OUT YOUR FREE eNewspaper**

DOWNLOAD THE APP TODAY!
Download on the App Store
GET IT ON Google Play

Full editions. Every Day.
Go to ENEWSFJ.MLIVE.COM TO ACTIVATE AND ENJOY!
 **THE FLINT JOURNAL**


Scan for easy access

Special Offer for Our Readers

15% OFF TOTAL PURCHASE*
* This offer is valid for homeowners over 18 years of age. The following persons are not eligible for this offer: employees of Leafguard or affiliated companies or entities, their immediate family members, previous participants in a Company in-home consultation within the past 12 months and all current and former Company customers. Previous/future purchases are not eligible for a discount or sale price adjustment. Sales tax does not qualify for discount. This offer cannot be combined with any other sale, promotion, discount, code, coupon and/or offer. This promotion has no cash value. Leafguard reserves the right to end any promotion at any time without notice. Offer ends 6/30/24.

SAY GOOD-BYE TO YOUR OLD GUTTER PROBLEMS

FINANCING AVAILABLE ASK FOR DETAILS!

- Leafguard® is guaranteed never to clog or we'll clean it for FREE*
- Seamless, one-piece system keeps out leaves, pine needles, and debris
- Eliminates the risk of falling off a ladder to clean clogged gutters
- Durable, all-weather tested system not a flimsy attachment



Call today for your FREE estimate and in-home demonstration.

**Leafguard**
Get it today. Protected for life.

**GOOD HOUSEKEEPING**
17 YEARS BACKED BY THE SEAL

CALL NOW 313-986-4432
SERVING THE STATE OF MICHIGAN

*Guaranteed not to clog for as long as you own your home, or we'll clean your gutters for free.



STATE OF MICHIGAN

GRETCHEN WHITMER
GOVERNOR

DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

ELIZABETH HERTEL
DIRECTOR

April 15, 2024

NAME
TITLE
ADDRESS
CITY STATE ZIP

Dear Tribal Chair and Health Director:

RE: Substance Use Disorder Health Home

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).

MDHHS is seeking approval from CMS to expand the opioid health home (OHH). This proposal of change will expand the OHH statewide and include two additional diagnoses. Currently the benefit is limited to beneficiaries within Michigan's Prepaid Inpatient Health Plans (PIHP) Regions 1, 2, 4, 5, 6, 7, 8, 9, 10 with an opioid use disorder diagnosis. The expansion will include the addition of PIHP Region 3 (Allegan, Kent, Lake, Mason, Muskegon, Oceana, Ottawa counties) and additional diagnoses of alcohol use disorder and stimulant use disorder. The additional diagnoses will allow the current OHH to expand to a Substance Use Disorder Health Home (SUD-HH). The SPA will serve an additional estimated 2,000-3,000 beneficiaries once fully implemented. A region's PIHP will coordinate enrollment and care with selected providers. Tribal Health Centers and Urban Health Centers that meet provider qualifications and standards are encouraged to participate and must adhere to the SPA requirements and standards. The anticipated effective date of this SPA is October 1, 2024.

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 517-512-4146, or via email at Elliott-EganL@michigan.gov. **Please provide all input by May 30, 2024.**

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.

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

Sincerely,



Meghan E. Groen, Director
Behavioral and Physical Health and Aging Services Administration

CC: Keri Toback, CMS
Nancy Grano, CMS
Chasity Dial, CEO, American Indian Health and Family Services of Southeastern Michigan
Asha Petoskey, Acting Area Director, Indian Health Service - Bemidji Area Office
Lorna Elliott-Egan, MDHHS

Distribution List for L 24-20
April 15, 2024

Ms. Whitney Gravelle, President, Bay Mills Indian Community
Ms. Audrey Breakie, Health Director, Bay Mills (Ellen Marshall Memorial Center)
Mr. David M. Arroyo, Chairman, Grand Traverse Band Ottawa & Chippewa Indians
Ms. Doris Winslow, Health Director, Grand Traverse Band Ottawa/Chippewa
Mr. Kenneth Meshigaud, Tribal Chairman, Hannahville Indian Community
Ms. G. Susie Meshigaud, Health Director, Hannahville Health Center
Ms. Doreen G. Blaker, Tribal President, Keweenaw Bay Indian Community
Ms. Deanna Foucault, 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. Phyllis Davis, Tribal Council Member, Match-E-Be-Nash-She-Wish Potawatomi
Ms. Mariah Austin, Tribal Council Member, 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
Ms. Rebecca Richards, Tribal Chairwoman, Pokagon Band of Potawatomi Indians
Ms. Priscilla Gatties, Interim Health Director, Pokagon Potawatomi Health Services
Mr. Tim Davis, Tribal Chief, Saginaw Chippewa Indian Tribe
Mrs. Karmen Fox, Executive Health Director, Nimkee Memorial Wellness Center
Mr. Austin Lowes, Tribal Chairperson, Sault Ste. Marie Tribe of Chippewa Indians
Mr. Leonid Chugunov, Health Director, Sault Ste. Marie Tribe of Chippewa Indians - Health Center

CC: Keri Toback, CMS
Nancy Grano, CMS
Chasity Dial, CEO, American Indian Health and Family Services of Southeastern Michigan
Asha Petoskey, Acting Area Director, Indian Health Service - Bemidji Area Office
Lorna Elliott-Egan, MDHHS