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**State/Territory Name: Michigan**

**State Plan Amendment (SPA)#: 25-1501**

This file contains the following documents in the order listed:

- 1) Approval Letter
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- 3) Approved SPA Pages

# MI - Submission Package - MI2025MS00030 - (MI-25-1501) - Health Homes

Summary Reviewable Units Versions Correspondence Log Analyst Notes **Approval Letter** RAI Transaction Logs News Related Actions

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
Medicaid and CHIP Operations Group  
Centers for Medicare & Medicaid Services  
601 E. 12th St., Room 355 (300)  
Kansas City, MO 64106



## Center for Medicaid & CHIP Services

May 15, 2026

Meghan E. Groen  
Chief Deputy Director, Behavioral and Physical Health and Aging Services  
Administration  
Michigan Department of Health and Human Services  
400 S Pine  
7th Floor  
Lansing, MI 48933-2250

Re: Approval of State Plan Amendment MI-25-1501 Opioid Health Home

Dear Meghan E. Groen,

On September 25, 2025, the Centers for Medicare and Medicaid Services (CMS) received Michigan State Plan Amendment (SPA) MI-25-1501 for Opioid Health Home to revise the current Substance Use Disorder Health Home (SUDHH) State Plan Amendment (SPA). This revision aims to add an addictionologist to the health home staffing structure along with adjusting the FTE to the Peer Recovery Coach and Community Health Worker line item. This update will reflect current roles and responsibilities in the model. MDHHS is planning to adjust the current Case Rate based on the added roles and responsibilities for the SUDHH.

We approve Michigan State Plan Amendment (SPA) MI-25-1501 with an effective date(s) of October 01, 2025.

If you have any questions regarding this amendment, please contact Christine Davidson at [christine.davidson@cms.hhs.gov](mailto:christine.davidson@cms.hhs.gov).

Sincerely,  
Nicole McKnight  
Acting Director, Division of Program  
Operations  
Center for Medicaid & CHIP Services

# MI - Submission Package - MI2025MS0003O - (MI-25-1501) - Health Homes

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## Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | MI2025MS0003O | MI-25-1501 | Opioid Health Home

CMS-10434 OMB 0938-1188

### Package Header

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| <b>Package ID</b>        | MI2025MS0003O | <b>SPA ID</b>                  | MI-25-1501 |
| <b>Submission Type</b>   | Official      | <b>Initial Submission Date</b> | 9/25/2025  |
| <b>Approval Date</b>     | 05/15/2026    | <b>Effective Date</b>          | N/A        |
| <b>Superseded SPA ID</b> | N/A           |                                |            |

### 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

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| <b>Superseded SPA ID</b> | N/A           |                                |            |

### SPA ID and Effective Date

**SPA ID** MI-25-1501

| Reviewable Unit                        | Proposed Effective Date | Superseded SPA ID |
|--|-------------------------|-------------------|
| 1945 Health Home Intro                 | 10/1/2025               | MI-24-1501        |
| 1945 Health Home Providers             | 10/1/2025               | MI-24-1501        |
| 1945 Health Home Payment Methodologies | 10/1/2025               | MI-24-1501        |

## Submission - Summary

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### Executive Summary

**Summary Description Including Goals and Objectives** The Michigan Department of Health & Human Services (MDHHS) is seeking approval from the Centers for Medicare and Medicaid Services to revise the current Substance Use Disorder Health Home (SUDHH) State Plan Amendment (SPA). This revision aims to add an addictionologist to the health home staffing structure along with adjusting the FTE to the Peer Recovery Coach and Community Health Worker line item. This update will reflect current roles and responsibilities in the model. MDHHS is planning to adjust the current Case Rate based on the added roles and responsibilities for the SUDHH.

### Federal Budget Impact and Statute/Regulation Citation

#### Federal Budget Impact

|        | Federal Fiscal Year | Amount    |
|--------|---------------------|-----------|
| First  | 2026                | \$1891100 |
| Second | 2027                | \$2094500 |

#### 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

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### Governor's Office Review

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

**Describe** Meghan E. Groen  
Chief Deputy Director  
Health Services

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.

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# MI - Submission Package - MI2025MS00030 - (MI-25-1501) - Health Homes

Summary Reviewable Units Versions Correspondence Log Analyst Notes Approval Letter RAI Transaction Logs News **Related Actions**

## 1945 Health Home Intro

MEDICAID | Medicaid State Plan | Health Homes | MI2025MS00030 | MI-25-1501 | Opioid Health Home

CMS-10434 OMB 0938-1188

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| <b>Superseded SPA ID</b> | MI-24-1501     |                                |            |
|                          | System-Derived |                                |            |

### Program Authority

1945 of the Social Security Act

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

#### Name of 1945 Health Home Program

Opioid Health Home

### Executive Summary

**Provide an executive summary of this Health Home 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 Medicare and Medicaid Services to revise the current Substance Use Disorder Health Home (SUDHH) State Plan Amendment (SPA). This revision aims to add an addictionologist to the health home staffing structure along with adjusting the FTE to the Peer Recovery Coach and Community Health Worker line item. This update will reflect current roles and responsibilities in the model. MDHHS is planning to adjust the current Case Rate based on the added roles and responsibilities for the SUDHH.

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 Home providers.
- The states provides assurance that it will not prevent individuals who are dually eligible for Medicare and Medicaid from receiving Health Home 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 Home providers.
- The state provides assurance that FMAP for 1945 Health Home 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 home 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.

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.

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# MI - Submission Package - MI2025MS0003O - (MI-25-1501) - Health Homes

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## 1945 Health Home Providers

MEDICAID | Medicaid State Plan | Health Homes | MI2025MS0003O | MI-25-1501 | Opioid Health Home

CMS-10434 OMB 0938-1188

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### Types of Health Home Providers

Designated Providers

**Indicate the Health Home 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"><li>• Be a regional entity as defined in Michigan's Mental Health Code (330.1204b).</li><li>• 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).</li><li>• Have authority to access Michigan Medicaid claims and encounter data for the OHH target population.</li><li>• Have authority to access Michigan's WSA and CareConnect360.</li><li>• Must have the capacity to evaluate, select, and support providers who meet the standards</li></ul> |

| Provider Type             | Description  |
|---------------------------|--|
|                           | <p>for HHPs, including:</p> <ul style="list-style-type: none"> <li>• Identification of providers who meet the HHP standards</li> <li>• Provision of infrastructure to support HHPs in care coordination</li> <li>• Collecting and sharing member-level information regarding health care utilization and medications</li> <li>• Providing quality outcome protocols to assess HHP effectiveness</li> <li>• Developing training and technical assistance activities that will support HHPs in effective delivery of HH services</li> <li>• Must maintain a network of providers that support the HHPs to service beneficiaries with an opioid use disorder.</li> </ul>  |
| Health Home Partner (HHP) | <ul style="list-style-type: none"> <li>• Enroll or be enrolled in Michigan Medicaid and agree to comply with all Michigan Medicaid program requirements.</li> <li>• 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"> <li>o Community Mental Health Services Program (Community Mental Health Center)</li> <li>o Federally Qualified Health Center/Primary Care Safety Net Clinic</li> <li>o Hospital based Physician Group</li> <li>o Opioid Treatment Program</li> <li>o Physician based Clinic</li> <li>o Physician or Physician Practice</li> <li>o Rural Health Clinics</li> <li>o Substance Use Disorder Provider other than Opioid Treatment Program</li> <li>o Tribal Health Center</li> </ul> </li> </ul> |

# 1945 Health Home Providers

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Teams of Health Care Professionals

Health Teams

# 1945 Health Home Providers

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|                          | System-Derived |                                |            |

## 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 (3.00-4.00 FTE)
- Medical Consultant (0.10 FTE)
- Addictionologist Medical Physician 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

#### Addictionologist Medical Physician Consultant

- Must be certified in addiction psychiatry or addiction medicine by a recognized board of the American Board of Medical Specialties, including the American Board of Psychiatry and Neurology or the American Board of Preventive Medicine or have held a prior certification by the American Board of Addiction Medicine. Additionally, received 30 hours of continuing medical education and training accredited by the Accrediting Council for Continuing Medical Education within 1 year after the date of hire in addiction psychiatry or addiction medicine through continuing medical education offered by the American Board of Medical Specialties, American Board of Preventative Medicine, American Society of Addiction Medicine, American Academy of Addiction Psychiatry, American Association for Treatment of Opioid Dependence, American Association of Osteopathic Addiction Medicine, the Michigan counterparts of these organizations, or other national or state programs acknowledged and accepted by the department.

#### 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 Home Providers

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

1. Provide quality-driven, cost-effective, culturally appropriate, and person- and family- centered Health Home 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 use disorder 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 Home Provider Standards

#### The state's requirements and expectations for Health Home 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
    1. Providing quality outcome protocols to assess HHP effectiveness
    - l) 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          |   |
|--|-----------------------|---|
| <a href="#">SUDHH Provider Requirements and Expectations V1 (06. 2025)</a> | 9/16/2025 3:21 PM EDT |  |

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## 1945 Health Home Payment Methodologies

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| <b>Submission Type</b>   | Official       | <b>Initial Submission Date</b> | 9/25/2025        |
| <b>Approval Date</b>     | 05/15/2026     | <b>Effective Date</b>          | <u>10/1/2025</u> |
| <b>Superseded SPA ID</b> | MI-24-1501     |                                |                  |
|                          | System-Derived |                                |                  |

### Payment Methodology

The State's Health Home 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**

See P4P section of the 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.

- 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)

# 1945 Health Home Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | MI2025MS0003O | MI-25-1501 | Opioid Health Home

## Package Header

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|                          | System-Derived |                                |            |

## 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

# 1945 Health Home Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | MI2025MS00030 | MI-25-1501 | Opioid Health Home

## Package Header

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| <b>Superseded SPA ID</b> | MI-24-1501     |                                |            |
|                          | System-Derived |                                |            |

## 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** Rate Development

##### Provider Type

Established in 2019, as the Opioid Health Home, the now approved Substance Use Disorder Health Home (SUDHH) is designed to support chronically ill Medicaid and Healthy Michigan Plan beneficiaries with a diagnosis of alcohol use disorder, stimulant use disorder, and or opioid use disorder. The program manages beneficiaries' conditions through an intensive level of care management and coordination.

Health home services provide integrated, person-centered, and comprehensive care to eligible beneficiaries, addressing the complexity of comorbid physical and behavioral health conditions. Michigan's health home model is comprised of a team, including a Lead Entity (LE) and contracted, Health Home Partners (HHPs). The LE is responsible for the payment and programmatic oversight of the health home model and HHPs must provide the six federally mandated core health home services which include: care management, care coordination, health promotion, transitional care, referral management.

##### Care Management PMPM Rate

###### Summary

SUDHH PMPM rates based on the current staffing structure were established in 2020. Consistent with 2020 rates, Enrollee utilization assumptions have not changed. A historical review of Medicaid beneficiaries with diagnosis code indicating Opioid Use Disorder was leveraged as the historical utilization base.

To support the program's continued success, MDHHS has developed revised SFY 2026 rates. The largest contributor to the case rate increase is the shift from 2019 salary benchmarks to estimated SFY 2026 staffing expenses. Additional contributors include the addition of the Addictionologist and increase staffing ratio for the Peer, Community Health Worker and Medical Assistant.

As described in the attachments (1) MDHHS BHH and SUDHH Case Rate Provider-Facing Memo 20250730 and (2) MDHHS BHH and SUDHH Case Rate Development 20250630, the SUDHH PMPM rate assumes a composite tier rate that reflects assumed utilization of different staffing assumptions to serve Intensive Acuity Tier and Moderate Acuity Tier beneficiaries. Assumed acuity distribution was developed by review of historical SUDHH beneficiary utilization patterns. As outlined in Figure 1 below, the composite SUDHH Case Rate is \$448.01.

FIGURE 1: Composite SUDHH Case Rate Development

| SUDHH acuity tiers       | ASSUMED ACUITY DISTRIBUTION | CASE RATE BY TIER | CASE RATE COMPONENT |
|--------------------------|-----------------------------|-------------------|---------------------|
| Low Acuity               | 17.43%                      | \$ 458.37         | \$ 79.76            |
| Moderate Acuity          | 60.73%                      | \$ 458.37         | \$ 278.23           |
| Intensive Acuity         | 21.84%                      | \$ 518.75         | \$ 113.61           |
| SUDHH Case Rate with P4P |                             |                   | \$ 471.59           |
| 5% P4P Withhold          |                             |                   | \$ 23.58            |
| SUDHH Case Rate          |                             |                   | \$448.01            |

##### Indirect Costs

The composite rate above incorporates an indirect service cost load of 15%. This aligns the indirect cost load with federal guidance surrounding the maximum allowed de minimis rate outlined in 2 CFR § 200.414(f).

##### Caseload

The composite SUDHH rate was developed with a caseload assumption of one hundred beneficiaries.

##### Rate Development: Staffing Assumptions and Fringe Benefits

Below, in Figure 2, are staffing costs used to develop the SUDHH to Intensive Acuity and Low and Moderate Acuity Tier rates. These rates were then blended into a composite rate using the utilization assumptions in Figure 1.

Salary amounts were determined through MDHHS's annual cost comparison work, which leverages annual provider-reported salary and wage survey and—for the SFY 2025 report—May 2025 Bureau of Labor Statistics data for Michigan.

This information was then trended by an independent actuary to mid-point SFY 2026 to arrive at the salary amounts provided in Figure 2.

The fringe rate, outlined in Figure 2, reflects 37.9% of the annual salaries and wages with estimated annual fringe benefit amounts rounded to the nearest thousand for each job position.

The rate development approach described above leverages annual MDHHS cost reporting along with trending and fringe benefits reviewed by an independent actuary. As such, the rate development approach supports efficient and economical rates, consistent with §1902(a)(30)(A), as well as rates sufficient to maintain provider enrollment and cost effective in comparison to other service delivery models. Additionally, this approach allows for ongoing rate monitoring and evaluation on an annual basis.

#### Acuity Tiers and Case Rate Build Up

The Intensive Acuity tier, outlined below in Figure 2, includes staffing costs for an additional 1.0 FTE than the Low and Moderate Acuity Tier. The FTEs are associated with Peer Recovery Coach/ Community Health Worker/Medical Assistant. Both tiers identify the addition of the Addictionologist Medical Physician Consultant.

FIGURE 2: Substance Use Disorder Health home case rate buildups by acuity level

| A. SUDHH LOW AND MODERATE ACUITY                                |      |            |            |            |
|---|------|------------|------------|------------|
|   | FTE  | SALARY     | FRINGE     | TOTAL      |
| Health Home Director  | 0.25 | \$ 106,000 | \$ 40,000  | \$ 36,500  |
| Nurse Care Manager  | 1.00 | \$ 93,000  | \$ 35,000  | \$ 128,000 |
| Behavioral Health Clinician/ Behavioral Health Specialist       | 0.25 | \$ 74,000  | \$ 28,000  | \$ 25,500  |
| Peer Recovery Coach/ Community Health Worker/ Medical Assistant | 3.00 | \$ 46,000  | \$ 17,000  | \$ 189,000 |
| Medical Consultant  | 0.10 | \$ 203,000 | \$ 77,000  | \$ 28,000  |
| Psychiatric Consultant  | 0.05 | \$ 360,000 | \$ 136,000 | \$ 24,800  |
| Addictionologist Medical Physician Consultant                   | 0.10 | \$ 337,000 | \$ 128,000 | \$ 46,500  |
| Total Staff   |      |            |            | 4.75       |
| Total Staff Cost  |      |            |            | \$ 478,300 |
| Indirect (15.0%)  |      |            |            | \$ 71,745  |
| Total Costs   |      |            |            | \$ 550,045 |
| Total Costs per 100 Beneficiaries per Month                     |      |            |            | \$ 458.37  |
| Caseload Efficiency   |      |            |            | 100.0%     |
| Total Costs per Encounter per Month with P4P                    |      |            |            | \$ 458.37  |
| B. SUDHH INTENSIVE ACUITY                                       |      |            |            |            |
|   | FTE  | SALARY     | FRINGE     | TOTAL      |
| Health Home Director  | 0.25 | \$ 106,000 | \$ 40,000  | \$ 36,500  |
| Nurse Care Manager  | 1.00 | \$ 93,000  | \$ 35,000  | \$ 128,000 |
| Behavioral Health Clinician/ Behavioral Health Specialist       | 0.25 | \$ 74,000  | \$ 28,000  | \$ 25,500  |
| Peer Recovery Coach/ Community Health Worker/ Medical Assistant | 4.00 | \$ 46,000  | \$ 17,000  | \$ 252,000 |
| Medical Consultant  | 0.10 | \$ 203,000 | \$ 77,000  | \$ 28,000  |
| Psychiatric Consultant  | 0.05 | \$ 360,000 | \$ 136,000 | \$ 24,800  |
| Addictionologist Medical Physician Consultant                   | 0.10 | \$ 337,000 | \$ 128,000 | \$ 46,500  |
| Total Staff   |      |            |            | 5.75       |
| Total Staff Cost  |      |            |            | \$ 541,300 |
| Indirect (15.0%)  |      |            |            | \$ 81,195  |
| Total Costs   |      |            |            | \$ 622,495 |
| Total Costs per 100 Beneficiaries per Month                     |      |            |            | \$ 518.75  |
| Caseload Efficiency   |      |            |            | 100.0%     |
| Total Costs per Encounter per Month with P4P                    |      |            |            | \$ 518.75  |

#### Unit(s) of Service

A unit of service is defined as one billable unit per service month. To be reimbursed for a billable unit of service, HHPs must provide one of the six required health home services. The PMPM rate will be paid for each unit of service. Once a patient has consented to receive services and has been enrolled in the health home program, the PMPM rate can be billed. The PMPM services are limited to non-clinical Health Home activities and will not duplicate services reimbursed under managed care contracts, targeted case management, or other Medicaid authorities.

#### Provider Payment

MDHHS provides a PMPM rate to the LE based on the number of enrolled beneficiaries. Contracted health home partners must deliver one of the six required health home services to receive payment from the LE. This monthly payment is subject to recoupment by the state from the LE if the beneficiary does not receive a health home service during the calendar month.

#### Service Documentation

HHPs must submit the SUDHH service encounter code in addition to any pertinent International Classification of Disease, Tenth Revision, Z codes (to indicate the many applicable social determinants of health) to the LE.

Payment for health home services is dependent on the submission of appropriate service encounter codes. Valid encounters must be submitted by HHPs to the LE within 90 days of providing a health home service to assure timely service verification. Health home staff must document services provided to the beneficiary in the beneficiary's care plan and within the billing notes.

#### Verification and Reconciliation of Encounters and Cost Data

MDHHS conducts ongoing reconciliation of SUDHH encounters using a six-month retrospective review to verify documented service delivery against submitted encounters. If this review determines that a beneficiary did not receive a health home service in a given calendar month, MDHHS initiates recoupment of the PMPM rate from the LE.

Additionally, SUDHH program costs are documented and tracked in the Financial Status Report (FSR) submitted annually by LEs. The SUDHH program team works closely with MDHHS Accounting at yearend to resolve any discrepancies identified in the FSR and to complete final yearend reconciliation.

#### Pay for Performance (P4P) Methodology

##### P4P Eligibility

MDHHS will administer pay for performance (P4P) incentive payments to SUDHH providers based on performance on three quality measures. The State selected these measures in collaboration with LEs and HHPs to reflect core elements of the SUDHH model and the needs of the target population. Measures were selected to identify two NCQA measures and one CMS measure with state specifications identified below. All HHPs who have been active in the SUDHH program for the entire performance year are eligible to receive P4P payments.

The following performance measures and weights will be used and are subject to change in future years to align with evolving best practices, federal guidance, state priorities, and metric specifications. All measures will be maintained in the SUDHH Handbook which is posted to the state's SUDHH website, <https://www.michigan.gov/mdhhs/assistance-programs/medicaid/substance-use-disorder-health-home>:

1. Follow-up after Emergency Department Visit for Alcohol or Other Drug Dependence (FUA-AD), Follow-up within 7 days after discharge- weighted 50 percent
2. Access to Preventive/Ambulatory Health Services (AAP)- weighted 30
3. Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries – weighted 20 percent

These measures are specific to the SUDHH program. They are not duplicative of other Medicaid managed care incentive payment arrangements administered by PHIPs.

##### P4P Benchmarks/Performance

Performance Measures specifications 1. and 2. can be reviewed on the Health Home Quality Reporting website, at <https://www.medicaid.gov/resources-for-states/medicaid-state-technical-assistance/health-home-information-resource-center/health-home-quality-reporting>.

Please note for measure 3, SUDHH beneficiaries must be enrolled in the SUDHH at the time of the ED event to be included in the numerator. In the denominator, the beneficiary must have been enrolled in SUDHH, in a PIHP benefit plan at any time in the year and not in spenddown. All SUDHH metrics encompass enrolled SUDHH beneficiaries which are determined eligible through CHAMPs verification of enrollment in the SUDHH Benefit Plan. Each Health Home Partner will be required to meet a Health Home ED utilization standard rate less than 400 per 1,000 beneficiaries, formula for measure 3 below. P4P allocation for each Health Home Partner with ED Utilization rate less than 400 = (Number of beneficiaries of Health Home Partner/Number of state total beneficiaries of Health Home Partners) X P4P.

Within six months of the end of the Performance Year (PY), MDHHS will notify the LE of P4P results. MDHHS will compare data in the PY by juxtaposing the LE's SUDHH Program metric performance against the performance for the entire state and PIHP Region for metrics 1 and 2. If the SUDHH Program metric performance exceeds the performance at the state and regional level, all P4P will be awarded for that given metric; if, however, the SUDHH Program metric only exceeds one comparative group but not the other (e.g., SUDHH Program metric performance exceeds the state performance, but not the regional performance), 75% of the P4P will be awarded for that given metric. If the LE does not meet either standard funds will be distributed to the LE who meet the metric. MDHHS will utilize this methodology for metric 1 and 2 for all subsequent PYs unless otherwise noted. Health Home Partners that do not meet the standard rate for metric 3 will not be awarded an allocation for measure 3 and funds will be redistributed to Health Home Partners that did meet the standard rate.

The State applies this scoring methodology uniformly across all eligible providers to ensure transparency, consistency, and equitable application of the P4P framework. FFP will only be claimed after benchmarks are met and providers have been paid.

##### P4P Timeline

Each subsequent fiscal year after the first year, in which the SUDHH SPA is in effect is defined as a Performance Year (PY). Within six months following the end of each PY, the State will evaluate the HHPs performance and notify LEs of their P4P determinations. LEs must distribute earned incentive payments to contracted HHPs within 30 calendar days of receiving payment from the State. LE must submit a P4P distribution plan to the State before receiving the incentive payment and distributing the funds to the HHPs.

If quality improvement benchmarks are not met by any of the regions within a given PY, the funding will be distributed equally among regions that maintain a recoupment rate of less than 45%. Subsequent PYs will operate in accordance with this structure.

If performance benchmarks are met, MDHHS will provide P4P monies to the LE for distribution. The LE may retain up to 5% of the P4P allotment. The LE must distribute the remainder of the P4P allotment to HHPs.

##### P4P Transparency/Consistency

The State ensures transparency and consistency in administering the P4P methodology through:

1. Uniform application of benchmarking and scoring across all LE regions using standardized measure specifications and consistent data validation procedures, including automated checks, numerator/denominator reconciliation, and provider appeal processes.
2. Clear payment flow requirements, whereby LEs must:
  - Pass through no less than 95 percent of P4P payments to HHPs;
  - Retain no more than 5 percent for allowable administrative activities directly tied to SUDHH operations;
  - Remit all P4P payments to HHPs within 30 calendar days of receipt.
3. Annual reporting, through which the State provides LEs with final P4P results, measure-level performance, payment

allocations, and calculation methodologies. Summary results are presented annually to all participating LEs.

4. Ongoing data oversight, including encounter validation, minimum data completeness standards, and required participation in technical assistance or corrective action processes as needed.

These provisions ensure the P4P methodology is transparent, equitable, and consistently applied across all LEs and HHPs.

#### Rebasing Rates

MDHHS will rebase rates at a minimum once every three years. Consistent with SFY 2026 rates, MDHHS will utilize an outside actuary to review salary and wage data, apply appropriate trending, and incorporate relevant program requirements, to establish rates that are cost effective, efficient, and sufficient to support quality services.

#### Managed Care Considerations

Payment policies have been developed to prevent duplication of care management activities and to coordinate payment for SUDHH services. MDHHS will also ensure compliance with applicable state and federal audit and documentation requirements.

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|                          | System-Derived |                                |            |

## Assurances

The State provides assurance that it will ensure non-duplication of payment for services similar to Health Home 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          |   |
|---|-----------------------|---|
| <a href="#">MDHHS BHH and SUDHH Case Rate Development 20250630</a>                | 2/26/2026 5:51 PM EST |    |
| <a href="#">MDHHS BHH and SUDHH Case Rate Provider-Facing Memo 20250730 (003)</a> | 2/26/2026 5:55 PM EST |  |

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