MSHN
Mid-State Health Network

Request for Interest (RFI) for Substance Use Disorder Health Homes (SUDHHs)

Purpose

This document outlines the Mid-State Health Network (MSHN) Prepaid Inpatient Health Plan's need to expand SUD Health Homes in the 21-county region, following the Michigan Department of Health and Human Services' (MDHHS) SUD Handbook.

MSHN is a regional entity, which was formed pursuant to 1974 P.A. 258, as amended, MCL §330.1204b, as a public governmental entity separate from the CMHSP Participants that established it. The CMHSP Participants formed Mid-State Health Network to serve as the prepaid inpatient health plan ("PIHP") for the twenty-one counties designated by the Michigan Department of Health and Human Services as Region 5. The CMHSP Participants include Bay-Arenac Behavioral Health Authority, Clinton-Eaton-Ingham Community Mental Health Authority, Community Mental Health for Central Michigan, Gratiot Integrated Health Network, Tuscola Behavioral Health Systems, Huron County Community Mental Health Authority, The Right Door for Hope, Recovery & Wellness, LifeWays Community Mental Health Authority, Montcalm Care Network, Newaygo County Community Mental Health Authority, Saginaw County Community Mental Health Authority, and Shiawassee Health & Wellness. Beginning January 1, 2014, MSHN entered a contract with the State of Michigan for Medicaid funding and entered subcontracts with the CMHSPs in its region for the provision of Mental Health, Substance Use Disorder, and Developmental Disabilities services.

Introduction to the Substance Use Disorder Health Home Service Model

Overview of the SUDHH

The Substance Use Disorder Health Home (SUDHH) 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 SUDHH functions as the central point of contact for directing and coordinating 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 SUDHH 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.

Michigan's SUDHH model is comprised of a team, including a Lead Entity (LE) and designated Health Home Partners (HHP). MSHN functions as the Lead Entity. Qualified providers function as Health Home Partners. Providers must meet the specific qualifications set forth in the State Plan Amendment, Medicaid Services Administration policy, the SUDHH Handbook and provide the six federally required core health home services. Michigan's SUDHHs must coordinate with other community-based organizations to manage the full breadth of beneficiary needs.

Diagnostic Criteria
Qualifying ICD-10 codes for alcohol, stimulant, and/or opioid substance use disorders. Qualifying beneficiaries must also be at risk of developing mental health conditions, asthma, diabetes, heart disease, BMI over 25 and/or COPD.

SUDHH Core Services
SUDHH services will provide integrated, person-centered, and comprehensive care to eligible beneficiaries to successfully address the complexity of comorbid physical and behavioral health conditions. The SUDHH must provide the following six core health home services as appropriate for each beneficiary:

- Comprehensive Care Management
- Care Coordination
- Health Promotion
- Comprehensive Transitional Care
- Individual and Family Support
- Referral to Community and Social Support Services

Finance Structure
MDHHS provides a monthly case rate to MSHN as the LE based on the number of SUDHH beneficiaries with at least one SUDHH service during a given month. In turn, MSHN reimburses the HHP at least 80% of the monthly case rate received from MDHHS if at least one SUDHH service was delivered/billed. HHPs must sign the Mid-State Substance Use Disorder Health Home Services and Responsibility Agreement to be a designated HHP and to receive payment (see attached). Finally, MDHHS provides a pay-for-performance (P4P) incentive that rewards providers based on program outcomes.

Expectations and General Information for Interested Providers

1. Interested provider must meet applicable Federal and State licensing standards in addition to Medicaid provider certification and enrollment requirements as one of the following:
    - Community Mental Health Services Program (Community Mental Health Center)
    - Federally Qualified Health Center/Primary Care Safety Net Clinic
    - Hospital based Physician Group
    - Physician based Clinic
    - Physician or Physician Practice
    - Rural Health Clinics
    - Substance Use Disorder Provider
    - Opioid Treatment Provider
    - Tribal Health Center
2. Interested providers must agree to the credentialing policies/procedures of MSHN to be a credentialed member of MSHN's SUD Provider Panel through a formal contractual agreement (for additional information, please see the MSHN Credentialing/Re-credentialing Policy).
3. Interested providers must have sufficient staff currently available and credentialed to be able to provide the services being sought, or in the alternative identify an expected timeframe of acquiring qualified staff.
4. Interested providers must have financial capacity to establish or expand existing service locations in the identified counties to provide the services being sought. For the purpose of FY26 SUDHH expansion MSHN will prioritize the following counties: Arenac, Clare, Eaton, Gladwin, Gratiot, Huron, Mecosta, Montcalm, Newaygo, Osceola, and Tuscola.
5. Interested providers have the capacity to be paneled with other third-party insurers, including but not limited to Medicare.
6. Interested providers must be willing to accept MSHN's Regional Reimbursement Rates for services rendered outside of SUD Health Home.
7. No start up funding will be offered by MSHN for the SUDHH initiative.

8. For additional information relative to becoming a SUD service provider with MSHN, please see the MSHN SUD Direct Service Procurement Policy.
9. The anticipated length of contract is the remainder of FY26 (1/1/2026– 9/30/2026) with the potential for renewal each fiscal year at MSHN's sole discretion.

Selection Process for New SUD Health Home Providers/Sites

MSHN maintains an open SUD provider panel and will consider contracting with interested SUDHH partners that meet the minimum requirements outlined in the MSHN SUD Service Provider Procurement Policy and the MDHHS Substance Use Disorder Health Home Handbook. If multiple interested providers meet the minimum requirements, MSHN may utilize the following additional criteria when necessary to prioritize certain providers for SUDHH expansion. Please refer to the MSHN Health Home Provider Policy for more information.

- Provider will expand or increase access to Substance Use treatment services in underserved area(s)
- Projected beneficiary enrollment and projected service utilization volume
- Provider operates an established SUD HH at a different site/location with a demonstrated history of success
- Provider holds accreditation from a nationally recognizing body specific to a health home, patient-centered medical home, or integrated care (NCQA, AAAHC, Joint Commission, CARF, etc.).

Submission of Interest Information

- Questions related to the FY26 SUDHH Request for Interest can be submitted and will be accepted until **5:00 P.M. on Friday, November 12, 2025.**
- All interested providers should complete and submit the SUD Health Home Statement of Interest Summary by **5:00 P.M. on Friday, November 28, 2025**.
- The submitted RFI is not binding, and a provider may withdraw their RFI at any time.
- This RFI process will be the only opportunity for FY26. Expansion will be reassessed for FY27.
- SUD Health Home Statement of Interest Summary and any subsequent questions should be submitted to:
  Leslie Thomas, MBA, CPA
  Chief Financial Officer
  Leslie.Thomas@midstatehealthnetwork.org

Resources

- Opioid/Substance Use Disorder Health Homes PowerPoint Presentation 9.19.24
- SUDHH Handbook
- MDHHS SUD HH Website
- SUD HH Brochure
- SUD HH Directory
- Health Home Provider (HHP) Application
- Contact Information for the Prepaid Inpatient Health Plans and Designated Substance Use Disorder Health Home Partners
- Health Home Encounter Codes and Rates for SUDHH

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SUD Health Home Statement of Interest Summary

Prospective Health Home / Provider Complete
Provider Information
Provider Name: Click or tap here to enter text.
Provider Main Address: Click or tap here to enter text.
Provider Web Address: Click or tap here to enter text.
Provider Main Contact: Click or tap here to enter text.
Main Contact Phone Number: Click or tap here to enter text.
Main Contact Email Address: Click or tap here to enter text.
New Health Home Site Information (If different from Provider Information)
Health Home Location Address: Click or tap here to enter text.
Health Home Location Primary Contact: Click or tap here to enter text.
Health Home Location Primary Contact Phone Number: Click or tap here to enter text.
Health Home Location Primary Contact Email Address: Click or tap here to enter text.
Provider Type: ☐ CCBHC ☐ CMHSP ☐ FQHC ☐ OTP ☐ OBOT ☐ Rural Health Clinic ☐ Tribal Health Center ☐ Other Click or tap here to enter text.
Counties to be served: ☐ Arenac ☐ Bay ☐ Clare ☐ Clinton ☐ Eaton ☐ Gladwin ☐ Gratiot ☐ Hillsdale ☐ Huron ☐ Ingham ☐ Ionia ☐ Isabella ☐ Jackson ☐ Mecosta ☐ Midland ☐ Montcalm ☐ Newaygo ☐ Osceola ☐ Saginaw ☐ Shiawassee ☐ Tuscola ☐ Other(s): Click or tap here to enter text.
Select accreditation(s) your agency possesses from a nationally recognized body specific to a health home, participant-centered medical home, or integrated care: ☐ AAAHC ☐ CARF ☐ Joint Commission ☐ NCQA ☐ URAC ☐ N/A ☐ Other: Click or tap here to enter text.
ASAM LOC Designation(s): Early Intervention ☐ 0.5 Outpatient ☐ 1.0 ☐ 2.1 Opioid Treatment Program ☐ Level 1 Partial Hospitalization ☐ 2.5 Residential ☐ 3.1 ☐ 3.3 ☐ 3.5 ☐ 3.7 Withdrawal Management ☐ 3.2 ☐ 3.7 ☐ No ASAM LOC Designation(s)
General Information
1. Provide a brief overview of your agency's current SUD service array/history. Click or tap here to enter text.
2. Provide a general, high-level narrative of how your agency would establish the requested services to support the Health Home programming, i.e. hire new staff, obtain physical space/location or modify an existing location, etc. Click or tap here to enter text.
3. Describe how your agency will expand or increase access to services in underserved area(s), to underserved populations, and/or to populations experiencing disparities in access, engagement, or outcomes. Include if your agency initially intends to focus on a specific subset population (adults/children, specific diagnoses, etc.) before expanding to include additional conditions/populations. Click or tap here to enter text.
4. Does your agency operate an established Health Home at a different site/location with a demonstrated history of success and commitment to expansion? ☐ Yes ☐ No

If yes, please provide details (i.e. location, year established, etc.) Click or tap here to enter text.
5. Following HH certification, what are the anticipated number of beneficiaries to be served? • 6-months post certification: Click or tap here to enter text. • 12-months post certification: Click or tap here to enter text.
6. Describe your agency's sustainability plan for the new SUDHH site(s): Click or tap here to enter text.

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SUD Health Home Frequently Asked Questions

Start Up Questions

Q: Where can resources/information on Health Homes be found?

A: Michigan's Integrated Health Homes for Medicaid Beneficiaries page on the MDHHS website houses information for the Substance Use Health Homes and Behavioral Health Home. For program specific information click on the respective link on the main page or visit www.michigan.gov/sudhh for SUDHH and www.michigan.gov/bhh for BHH. Consumer and provider resources are housed on each of the pages.

Q: Is the Health Home Partner Application Required before SUDHH services can begin?

A: Yes, the Health Home Partner Application must be completed and approved by MDHHS before services can begin. MSHN's Integrated Health Team will assist providers in completing and submitting the MDHHS-5745.

Q: In the absence of accreditation from a national recognizing body, the LE can certify that the HHP has met standards parallel to those required for accreditation. In that case, how should HHPs complete the accreditation portion?

A: The HHP should check "other" and write in the lead entity's name who is certifying them to participate in health homes.

Q: When MDHHS approves a Health Home Partner Application, will the LE receive a copy of it?

A: Yes, MDHHS will copy the lead entity on all approved HHP applications.

Q: Is the ASAM Continuum Assessment required for SUDHH HHPs who are SUD paneled providers?

A: Yes, the ASAM Continuum Assessment must be used for SUDHH HHPs who are SUD paneled providers. Other contracted providers through the SUDHH are not required to complete the assessment, the assessments used should be determined between LE and HHP.

Q: Can a LE contract with a HHP outside of their designated PIHP region for HH services?

A: Yes, a LE can contract outside of their PIHP region for HH services, but all beneficiaries must reside within that PIHP to be eligible for services.

Q: If an agency wanted multiple locations sites to be considered for the SUDHH opportunity, should the agency complete the RFI document for site or should the agency modify the RFI to list each location separately on the same RFI?

A: Please contact the Integrated Health Administrator with the number of site locations for a modified document to be sent to you.

Q: Does a Peer Recovery Coach have to be MDHHS certified to bill for SUDHH services?

A: The Peer Recovery Coach does not have to be MDHHS certified to bill for SUDHH services.

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

Eligibility & Enrollment

Q: What diagnoses qualifies a beneficiary to participate in SUDHH?

A: SUDHH Handbook, 1.3 Diagnostic Criteria: "Qualifying ICD-10 codes for alcohol, stimulant and opioid substance use disorders. Please see full list in appendix A. Qualifying SUD beneficiaries must also be at risk of developing mental health conditions, asthma, diabetes, heart disease, BMI over 25 and COPD."

Q: How can I assist a beneficiary to re-enroll in Medicaid?

A: Please use the link to MIBridges MDHHS- Tools and Resources (michigan.gov) to assist the beneficiary with enrollment.

Q: Can a beneficiary be enrolled in Behavioral Health Home and SUD Health Home?

A: No, beneficiaries cannot be enrolled in Behavioral Health Home (BHH), HHMICare (Health Home MI Care Team), ICO-MC (Integrated Care MI Health Link), or Hospice during the same month. SUD HH services can't be billed while a beneficiary is incarcerated or while receiving the TCM-INCAR benefit.

- Eligible beneficiaries include those enrolled in Medicaid, the Healthy Michigan Plan, Freedom to Work, Healthy Kids Expansion or MIChild who have a qualifying ICD-10 code diagnosis related to alcohol, stimulant or opioid use disorder.
- Beneficiaries can have dual Medicaid/Medicare coverage. A list of coexisting benefit plans can be found in Appendix B, all other plans are excluded while a beneficiary is enrolled in SUDHH.

Q: Can dual eligible beneficiaries (Medicaid/Medicare) that are enrolled in MI Health Link be enrolled in a Health Home?

A: Although dual eligible beneficiaries are eligible for health homes, those enrolled in MI Health Link are not eligible for health homes.

Q: Can SUDHH beneficiaries also be enrolled in CCBHC?

A: Yes, an individual receive services through a CCBHC and be enrolled/receive SUDHH services. Appendix B of the SUDHH Handbook lists coexisting benefits, including CCBHC.

Q: Is the MDHHS 5515 consent required for SUDHH beneficiaries?

A: Yes, the 5515-consent form must be signed upon enrollment in the WSA. HHPs should ensure beneficiaries have completed the document entirely before submitting to the LE.

Care Planning and Needs Assessment

Q: When does the Care Plan need to be updated?

A: The Care Plan should be updated at least every 6 months and resubmitted in the WSA. HHPs should be updating the Care Plan regularly as the goals of the beneficiary change.

Q: How do we determine if a beneficiary is at risk of developing mental health conditions, asthma, diabetes, heart disease, BMI over 25 and COPD?

A: If a beneficiary already has a risk factor identified ex: they have diabetes. The Peer/CHW/Nurse CM would be able to note they have a qualifying risk factor and enroll the beneficiary. The risk factor should be documented in the Health Home Needs Assessment and treatment/care plan.

- If a beneficiary doesn't have a risk factor identified the Physician or NCM (medical team) go through clinics screener and identify risk of medical conditions noted for program and it is documented in the treatment/care plan and the beneficiary is enrolled in the HH.

Q: Is the development of a care plan with the health home beneficiary a prerequisite for enrollment into the health home?

A. Developing the care plan is not a prerequisite for enrolling a beneficiary into the program in WSA. With that said, a care plan must be developed with both the beneficiary and care team after the beneficiary is enrolled. The HHP must send the care plan to the LE. The LE can determine the required mode in which the care plan is sent to the LE (via WSA, email, fax, etc.) and the timeframe in which the HHP must send the care plan to the LE.

- The care plan must be completed within 30 days of the beneficiary enrollment.

Q: Do the Nurse CM/Care Team and the beneficiary have to sign off on the care plan?

A: It is best practice to have the NCM/Care Team and beneficiary sign off on the care plan. Signing the care plan ensures the beneficiary understands their goals and gives the HHP receipt of who from the Care Team worked on creating the plan.

Q: Who can write and develop the Care Plan with the beneficiary?

A: Any member of the Care Team can work with the beneficiary on the development of the Care Plan as long as they have been appropriately trained on Care Plan development and motivational interviewing.

Encounters and Billing

Q: What benefit plans exclude a beneficiary to be eligible for Substance Use Disorder Health Homes?

A: Refer to the SUDHH Handbook for a comprehensive and up-to-date list. Generally speaking, a beneficiary cannot be enrolled in HHBH (Behavioral Health Home), HHMICare (Health Home MI Care Team), ICO-MC (Integrated Care MI Health Link), NH (Nursing Home), TCM-INCAR (Targeted Case Management for Incarceration) or Hospice at the same time as the HH. A beneficiary cannot be in spend down.

Q: What encounter code(s) can be submitted for health home services?

A: The S0280 code is the only "health home code". Claims should be submitted for each unique health home encounter; however, a provider will only be reimbursed for one monthly case rate. HHPs can bill Medicaid outside of the Health Home model for any services not related to the six core health home services.

Q: Does the HG modifier need to be submitted with each claim to the LE and encounter to the State?

A: Yes, the HG modifier must be submitted for each SUDHH claim/encounter.

Q: When should the TS modifier be used?

A: The TS modifier is used when a Health Home service is provided without the beneficiary in the room, i.e. telephone call with the beneficiary, team huddles, etc.

Q: When should the GT modifier be used?

A: The GT modifier should be used if a telemedicine service is being performed for treatment related services. There should not be an instance where an HHP would use both the TS and GT modifier together.

Q: Do Health Home Partners need to submit any documentation to the state?

A: No, the state will gather reports/metrics from the WSA and the Data Warehouse. Each PIHP may require HHPs to submit additional documentation or metrics. The HHP will submit claims to the PIHPs.

Q: Can health home services be provided outside of the office?

A: Yes, health home services can be provided out of the HHP provider site.

Q: Does the first HH visit have to be in-person?

A: Yes, all new SUDHH beneficiaries must have their first SUDHH visit in-person. Face-to face, telehealth, and direct messaging maybe utilized after the first HH visit.

Q: What is the definition of in-person vs face-to-face.

- In person: an encounter that must be completed with beneficiary and provider physically together in the same location and is not allowed through telehealth.
- Face-to-face: an encounter that can be either in person or using telehealth (simultaneous audio and visual technology).

Q: If the enrolled beneficiary is a child, can a staff member meet with the parent/guardian and still bill for the health home service?

A: Yes, if a core health home service is provided, such as Individual and Family Support, it can be billable as a health home service if the family member is an authorized representative of the child. It is recommended that the care team meets with the beneficiary as much as possible.

Q: Do HHPs have to change the billing process for treatment services?

A: No, the purpose of Health Homes is to provide comprehensive care coordination services on top of other Medicaid reimbursable services.

Q: Can a HHP bill a regular billable Medicaid Service and a Health Home Service on the same day?

A: Yes, a Medicaid Service and a Health Home Service can be billed on the same day if they are not duplicative to the Health Home Service provided that day. The Health Home Service should be "above and beyond" the regular Medicaid Service provided.

Q: Can a HHP bill an SUDHH encounter and a Targeted Case Management (TCM) encounter in the same month?

A: Yes, SUDHH and TCM can billed during the same month because both encounters are serving different needs for the beneficiary, except for TCM-INCAR.

Q: What happens if a beneficiary switches to a new provider in the same month?

A: The payment for a beneficiary will only be billed once per month. If the first provider has billed for services and the beneficiary moves to another provider, the second provider will not be reimbursed until next month when the beneficiary is enrolled in the WSA under the new organization.

Q: Can HH services be billed while a beneficiary is in residential or inpatient care?

A: Yes, SUDHH services can be billed while a beneficiary is in residential treatment or inpatient care, if appropriate. SUDHH LE and HHP need to ensure Medicaid billing is not

duplicated. For example, staff may provide care coordination without the beneficiary present, i.e. scheduling appointment or referral follow-up and tracking.

Q: Can beneficiaries receive services from Health Homes and CCBHC?

A: Yes, beneficiaries can be enrolled/assigned in both CCBHC and SUDHH programs. SUDHH should take lead on all care coordination activities.

Q: Can HHPs contract or create MOUs with other organizations to meet the HH staffing requirements?

A: Yes, health home partners can create MOUs or contract with other organizations to meet the staffing requirements for health homes.

Q: Do the care team's efforts to re-engage the person in SUDHH services count as a service? / If a beneficiary is unresponsive, can the HHP bill for outreach attempts?

A: No, the HHP cannot bill for outreach attempts for an unresponsive beneficiary. The care team's effort to re-engage a beneficiary does not fall into one of the core health home services, i.e. calling or texting the beneficiary to re-engage in services without response or answer.

Q: Should HHPs submit all encounters for a beneficiary even though payment is only associated with the first encounter submitted per month?

A: Yes, the HHP should submit all encounters per beneficiary per month.

Q: If an enrolled beneficiary is no longer or is not ready to receive MOUD or MAT, can the HHP still bill for the SUDHH benefit?

A: Yes, MOUD and MAT are not a requirement for the SUDHH benefit.

Quality Assurance & Quality Bonus Payments

Q: How will health home performance measures be reported to MDHHS?

A: All performance measures will be assessed using claims data in the data warehouse. LEs and HHPs will not need to send data to MDHHS.

Q: What can Pay-for-Performance funds be used for?

A: P4P funds must be reinvested into public behavioral health services.

Waiver Support Application (WSA)

Q: What is the WSA?

A: The Waiver Support Application (WSA) is the enrollment, maintenance, and management tool for the health home benefit. Beginning on October 1, 2020 both Lead Entities (LEs) and Health Home Partners (HHPs) who are approved will have access to the health home program in WSA.

- Lead Entities – Lead Entities will use the WSA to identify potential enrollees from MDHHS administrative claims data. LE's are also responsible for reviewing beneficiary information and required materials from health home partners during the provider recommended enrollment process as well as enrolling each beneficiary into the Health Home. LE's can also review region-specific reports.
- Health Home Partners – Health Home Partners will use the WSA to recommend potential health home enrollees to the LE. HHPs will confirm eligibility, diagnosis, and consent through the WSA for LEs to review. HHPs will have access to limited region-specific reports.

Q: How do I request access to the WSA?

A: All users must request access to the WSA by submitting the WSA Access Request Form. The WSA Access Request Form is in the Database Security Application (DSA). Both the WSA and the DSA are accessed through the State of Michigan (SOM) single sign-on portal, called MILogin. If you have completed any of the steps below in the past, you may not need to repeat them.

There are three steps that must be completed in order to be granted or maintain access to the WSA:

1. Create a MILogin account
2. Request access to the Database Security
3. Request access to the Waiver Support Application

Refer to the WSA Gaining Access Guide.

Q: Where do I find the WSA Training Documents?

A: You can find Training Documents in the WSA under the Training tab.

Q: What does a HHP have access to in the WSA?

A: Providers can access the WSA to request enrollment and disenroll of beneficiaries. Once the LE accepts a beneficiary into the WSA for SUDHH, the HHP will be able to see SUDHH enrollment totals and beneficiary information. HHPs do not access to make changes into the WSA, changes must be made by the LE.

Q: Are HHPs required to upload/attach documents in the WSA or is that optional (i.e. MDHHS-5515 form, care plan, needs assessment)?

A: HHPs can attach/upload documents in the WSA. MSHN requires the Initial Needs Assessment, Care Plan (initial, 6-month, and annual), and MDHHS-5515 (initial and annual) to be uploaded into the WSA.

Q: Can health home beneficiaries be auto-disenrolled from health homes via WSA?

A: No, beneficiaries must be manually disenrolled by the lead entity.

Q: Does Symmetry take into consideration Medicare and Medicaid claims?

A: No, Symmetry only includes Medicaid.

Q: What is the Case Assignment Date?

A: The Case Assignment Date is the date the LE assigns depending on when the beneficiary started HH services. This date is linked to the SUDHH payments.

Q: What if I submit the wrong Case Assignment Date in the WSA?

A: If you are a HHP, contact your LE to fix the case assignment date. LE reach out to the HH MDHHS contact to fix the Case Assignment Date error.

Q: Is there a timeframe for beneficiary inactivity before disenrollment is required?

A: Per the handbook, the HHP or LE must make at least three unsuccessful beneficiary contact attempts within three consecutive months for MDHHS to deem a beneficiary as unresponsive. The LE and MDHHS must maintain a list of disenrolled beneficiaries in the WSA. The HHP/LE must attempt to re-establish contact with these beneficiaries at least every six months after disenrollment, as applicable.

Q: What date do I enter for disenrollment for an unresponsive beneficiary?

A: Disenroll the beneficiary following the appropriate disenrollment prompt, for the end of the month after the last service date.

Additional Questions

Q: How does a beneficiary determine dental services coverage?

A: The beneficiary can go to myHealthPortal or contact Beneficiary Support through the Help Line at 1-800-642-3195 or beneficiarysupport@michigan.gov