MID-STATE HEALTH NETWORK

SUBSTANCE USE DISORDER SERVICES PROVIDER MANUAL

Effective Date: October 1, ~~2019~~2020

Approved by: Chief Executive Officer, ~~8.20.19~~
SUD Medical Director, ~~8.23.19~~

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Introduction

Welcome to the Mid-State Health Network (MSHN) substance use disorder (SUD) services provider manual. MSHN is pleased to be partnering with SUD prevention, treatment, and recovery support services providers that offer an array of services throughout MSHN's 21-county region. The purpose of this manual is to offer information and technical assistance regarding the requirements associated with provider contracted role(s). This manual is a referenced attachment to your contract for MSHN services and may be revised accordingly in response to changes in contract requirements and/or MSHN policies and procedures. MSHN will notify providers of effective changes. The most current version of the manual, along with a change log will be posted to the MSHN Website: Provider Network ~~→Provider Requirements~~→Substance Use Disorder→~~Contact & Rates~~Provider Manuals.

For the most current listing of MSHN staff, including contact information, visit the MSHN Website: Stakeholders → Contact

MSHN utilizes a 2-Year Strategic Plan, inclusive of the SUD Prevention, Treatment & Recovery provider system. The FY19-20 was approved by the MSHN board of directors in 2018. This plan focuses on the quadruple aim: Better Health, Better Care, Better Value, and Better Provider Systems and identifies current priorities for behavioral health services, including SUD within the region. MSHN is also charged with supported a Substance Use Disorder Strategic Plan for FY21-23 for Prevention, Treatment, and Recovery efforts for the region. Prevention efforts will be focused on reducing underage drinking, marijuana use, opioid prescription use, youth tobacco and nicotine use, and substance use in older adults. Treatment efforts will be focused on increasing accessibility of services (MAT, stimulant use treatment, WSS, jail-based services, and trauma-informed care), expanding penetration rates for adolescents, older adults and veterans/military families, and increasing cultural competence and reducing health disparities.

During the ~~current~~ COVID-19 State of Emergency; Federal and/or State policy or Executive Orders issued and in effect beginning on March 10, 2020, including any modifications of such Executive Orders or policies in relation to COVID-19, issued after that date, that provide different guidance or requirements than are currently identified and stated within the~~is~~ provider agreement and/or this manual and/or ~~PAYOR's~~MSHN's policies, procedures, or regional guidance the PROVIDER shall follow the federal and/or state direction and guidance as it relates to the COVID-19 State of Emergency. ~~-~~Please refer to the MSHN Coronavirus Disease webpage found HERE for further information.

Governing Authorities and Prepaid Inpatient Health Plan (PIHP) Requirements

MSHN is under contract with the Michigan Department of Health and Human Services (MDHHS), with all the associated obligations and requirements for the use of public funds. As one of the

10 PIHPs in Michigan, MSHN has provider network management obligations including but not limited to, assurance of overall federal, state, and other compliance mandates, regional service array adequacy, and ensuring provider competency expectations are met in both professional enhancement and service delivery areas.

Key references for SUD services are on the MSHN website: Provider Network→Provider Resources→Provider Resources and include:

- MSHN SUD Prevention Provider contract
- MSHN SUD Treatment Provider contract
- MSHN & MDHHS Contract, Attachment P.II.B.A., Substance Use Disorder Policy Manual
- MDHHS Office of Recovery Oriented Systems of Care (OROSC) policies & advisories
- LARA Licensing, Certification, Training
- Medicaid Provider Manual, Chapter: Mental Health/Substance Abuse
- SAMHSA mental and substance use disorders
- MDHHS Provider Qualifications Chart
- Medicaid Services Administration (MSA) Bulletins

Providers are expected to adhere to all standards, requirements, and legal obligations contained in these referenced MDHHS guidance and requirement documents applicable to the specific services being purchased and provided. For efficiency, MSHN will highlight but will not duplicate, in entirety, the information found in the above-mentioned references. Providers are responsible for understanding, demonstrated through service delivery, the content pertinent to the scope of work identified in contract. MSHN will make every effort to inform SUD providers about policy, procedure, or other requirement change(s).

For convenience, MSHN has policies and procedures posted on the MSHN website: Provider Network→Provider Requirements→Policies and Procedures and include: Applicable MSHN policies and procedures for SUD providers include, but are not limited to:

- Advance Directives
- Behavioral Health Recovery Oriented Systems of Care
- Background Checks
- Breach Notification
- Compliance and Program Integrity
- Confidentiality and Notice of Privacy
- Conflict of Interest Policy
- Consent to Share Information
- Consumer Satisfaction
- Credentialing and Re-Credentialing Policy
- Credentialing and Recredentialing ~~-: Background Checks and Primary Source Verification~~Licensed Independent Practitioners
- ~~Credentialing: Monitoring~~

~~Credentialing: Suspension and Revocation~~

- Critical Incidents
- Cultural Competency
- Customer Service (Policy and Procedure)
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- Michigan Mission Based Performance Indicator System
- MSHN's Compliance and Program Integrity
- Monitoring and Oversight
- Non-Licensed Provider Qualifications
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- Provider Appeal Procedure
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- Recipient Rights for Substance Use Disorder Recipients
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- Service Philosophy, Access System
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MSHN's governing Board of Directors (BOD) includes representation from each of the 12 Community Mental Health Service Programs (CMHSP) in the region. The BOD has policy and fiduciary responsibilities for all contracts with MDHHS including SUD administration and services. Additionally, and as required by statute, the MSHN PIHP region has a SUD Oversight Policy Board (OPB), whose members represent each of the 21 counties in the region. The OPB is an advisory to the BOD and serves as the authority for approving use of Public Act 2 funds.

In 2018, MSHN established the SUD Provider Advisory Committee. This cross-function group is charged with serving in an advisory capacity to offer input to MSHN regarding SUD policies, procedures, strategic planning, monitoring and oversight processes, to assist MSHN with establishing and pursuing state and federal legislative, policy and regulatory goals, and to support MSHN's focus on evidence-based, best practice service and delivery to persons served.

The list of these board members can be found on the MSHN website: Stakeholders→Boards & Councils, along with a calendar of regional meetings.

MSHN welcomes the opportunity to enhance SUD partnerships and appreciates feedback regarding SUD services. Please contact MSHN staff or a member of the SUD Provider Advisory Committee to share knowledge, concerns and/or expertise.

Definitions

Medicaid Abuse refers to practices that are inconsistent with sound fiscal, business or medical practices and result in an unnecessary cost to the payor, or in reimbursement for services that are not medically necessary or fail to meet professionally recognized standards for healthcare.

Admission is that point in an individual's relationship with an organized treatment service when the intake process has been completed and the individual is determined eligible to receive services of the treatment program.

Amount refers to the number of units (e.g., 25 15-minute units of community living supports) of service identified in the individual plan of service or treatment plan to be provided.

AMS refers to the Access Management System which is required by the Michigan Department of Health and Human Services (MDHHS) to screen, authorize, refer and provide follow-up services.

Appeal: A review at the local level by a PIHP of an Adverse Benefit Determination, as defined above. 42 CFR 438.400.

ASAM refers to the American Society for Addiction Medicine. It is the medical association for Addictionist~~ddictionologists~~. The members developed the patient placement criteria, the most recent of which is *The ASAM Patient Placement Criteria*, *3rd Edition*.

ASI refers to the Addiction Severity Index, a semi structured interview designed to address seven potential problem areas in clients with substance use disorders and to determine level of care.

Assessment includes those procedures by which a qualified clinician evaluates an individual's strengths, areas identified for growth, problems, and needs to establish a SUD diagnoses and determine priorities so that a treatment plan can be developed.

Breach- is an impermissible use or disclosure under the HIPAA Privacy Rule that compromises the security or privacy of the protected health information.

Care Coordination means a set of activities designed to ensure needed, appropriate and cost-effective care for beneficiaries. As a component of overall care management, care coordination activities focus on ensuring timely information, communication, and collaboration across a care team and between Responsible Plans. Major priorities for care coordination in the context of a care management plan include:

- Outreach and contacts/communication to support patient engagement,
- Conducting screening, record review, and documentation as part of Evaluation and Assessment,
- Tracking and facilitating follow-up on lab tests and referrals,
- Care Planning,
- Managing transitions of care activities to support continuity of care,

- Address social supports and making linkages to services addressing housing, food, etc., and
- Monitoring, Reporting and Documentation.

Case Management refers to a substance use disorder case management program that coordinates, plans, provides, evaluates and monitors services or recovery from a variety of resources on behalf of and in collaboration with a client who has a substance use disorder. A substance use disorder case management program offers these services through designated staff working in collaboration with the substance use disorder treatment team and as guided by medical necessity and the individualized treatment planning process.

CMHSP Participant refers to one of the twelve member Community Mental Health Services Program (CMHSP) participant in the Mid-State Health Network.

Continued Service Criteria is when, in the process of client assessment, certain problems and priorities are identified as justifying admission to a particular level of care. Continued Service Criteria describe the degree of resolution of those problems and priorities and indicate the intensity of services needed. The level of function and clinical severity of a client's status in each of the six assessment dimensions of ASAM is considered in determining the need for continued service.

Continuum of Care refers to an integrated network of treatment services and modalities, designed so that an individual's changing needs will be met as that individual moves through the treatment and recovery process.

Co-Occurring Disorders are concurrent substance-related and mental health disorders. Use of the term carries no implication as to which disorder is primary and which secondary, which disorder occurred first, or whether one disorder caused the other.

Cultural Competency is defined as a set of values, behaviors, attitudes, and practices within a system, organization, and program or among individuals and which enables them to work effectively cross culturally. It refers to the ability to honor and respect the beliefs (religious or otherwise), language, interpersonal styles and behaviors of individuals and families receiving services, as well as staff who are providing such services. Cultural competence is a dynamic, ongoing, developmental process that requires a long-term commitment and is achieved over time.

Discharge Summary is the written summary of the client's treatment episode. The elements of a discharge summary include description of the treatment received, its duration, a rating scale of the clinician's perception of investment by the client, a client self-rating score, description of the treatment and non-treatment goals attained while the client was in treatment, and detail those goals not accomplished with a brief statement as to why.

Discharge/Transfer Criteria is when, in the process of treatment, certain problems and priorities indicate a different level of care, a different provider, or discharge from treatment may be necessary. The level of functioning and clinical severity of a client's status in each of the six ASAM dimensions is considered in determining the need for discharge or transfer.

DSM-V refers to the *Diagnostic and Statistical Manual of Mental Disorders (5th Edition)*, developed by the American Psychiatric Association (APA). It is the standard classification of mental health disorders used by mental health professionals in the United States. It is intended to be used in SUD clinical settings by clinicians for determining behavioral health diagnoses that are part of the assessment and inform development of an individualized treatment plan with the medically necessary level of care.

Duration refers to the length of time (e.g., three weeks, six months) it is expected that a service identified in the individual plan of service or treatment plan will be provided.

Early Intervention is a specifically focused treatment program including stage-based intervention for individuals with substance use disorders as identified through a screening or assessment process including individuals who may not meet the threshold of abuse or dependence. (The ASAM Criteria, 3rd Edition Level .05 Early Intervention)

Encounter is used for billing purposes related to treatment services, recovery support, and early intervention services to indicate a measure of time spent providing a service with a consumer.

Episode of Care is the period of service between the beginning of a treatment service for a drug or alcohol problem and the termination of services for the prescribed treatment plan. The first event in this episode is an admission and the last event is a discharge. Any change in service and/or provider during a treatment episode should be reported as a discharge, with transfer given as the reason for termination. For reporting purposes, "completion of treatment" is defined as completion of all planned treatment for the current treatment episode.

Fraud refers to an intentional deception or misrepresentation by a person with the knowledge the deception could result in unauthorized benefit to him/herself or some other person. Includes any act that constitutes fraud under applicable Federal or State law.

Grievance: A Consumer's expression of dissatisfaction about service issues, other than an Adverse Benefit Determination. Possible subjects for grievances include, but are not limited to, quality of care or services provided, aspects of interpersonal relationships between a service provider and the consumer, failure to respect the Consumer's rights regardless of whether remedial action is requested, or an Consumer's dispute regarding an extension of time proposed by the PIHP to make a service authorized decision. 42 CFR 438.400.

Grievance and Appeal System: The processes implemented to handle Appeals of Adverse Benefit Determinations and Grievances, as well as the processes to collect and track information about them. 42 CFR 438.400.

Health Care Eligibility/Benefit Inquiry (270) is used to inquire about the health care eligibility and benefits associated with a subscriber or dependent.

Health Care Eligibility/Benefit Response (271) is used to respond to a request inquiry about the health care eligibility and benefits associated with a subscriber or dependent.

HMP refers to Healthy Michigan Plan, Michigan's Medicaid expansion program which became effective on April 1, 2014, to serve newly enrolled persons. HMP expanded the array of services available for persons with substance use disorders in need of treatment.

Individualized Treatment is treatment designed to meet a particular client's needs, guided by an individualized treatment plan that is informed by the individual client's assessment and his/her particular strengths, needs, wishes, and diagnostic areas.

Intensity of Service is the scope, type, and frequency of staff interventions and other services (such as consultation, referral or support services) provided during treatment at a particular level of care.

Interim Service(s) are provisional service(s) provided while client is waiting for an appropriate level of care. Please see the specific procedure for priority populations for additional information.

Length of Service is the number of days (for residential care) or units/visits/encounters (for outpatient care) of service provided to a client, from admission to discharge, at a particular level of care.

Level of Care, as part of the ASAM, refers to a discrete intensity of clinical and environmental support services bundled or linked together and available in a variety of settings.

Level of Function is an individual's relative degree of health and freedom from specific signs and symptoms of a mental or substance-related disorder, which determine whether the individual requires treatment.

Level of Service, as part of the ASAM, this term refers to broad categories of patient placement, which encompass a range of clinical services from early intervention to high-intensity residential services.

MAPS is the acronym for Michigan's Automated Prescription System. It is a web-based service to monitor prescriptions for individuals in Michigan. The website is MAPS.

MDHHS refers to the Michigan Department of Health and Human Services (MDHHS).

Medicaid Health Plans (MHPs) are insurance companies who contract with the State to provide coverage for the physical health care and mild-moderate behavioral health care benefits of Medicaid enrollees.

Medical Necessity means determination that a specific service is medically (clinically) appropriate and necessary to meet a client's treatment needs, consistent with the client's diagnosis, symptoms and functional impairments and consistent with clinical Standards of Care.

Michigan Prevention Data System (MPDS) is the State's web-based data system that captures all direct funded prevention services and specific recovery-based services and community out-reach services.

Non-urgent cases are those clients screened for substance use disorder services but who do not require urgent (immediate) services.

Peer Support/Recovery Supports are programs designed to support and promote recovery and prevent relapse through supportive services that result in the knowledge and skills necessary for an individual's recovery. Peer Recovery programs are designed and delivered primarily by individuals in recovery and offer social, emotional, and/or educational supportive services to help prevent relapse and promote recovery.

Program is a generalized term for an organized system of services designed to address the treatment needs of clients.

Readiness to Change refers to an individual's emotional and cognitive awareness of the need to change, coupled with a commitment to change. Dimension 4 of the ASAM-PPC, "Readiness to Change", describes the individual's degree of awareness of the relationship between his or her substance use and/or mental health problems and the adverse consequences, as well as the presence of specific readiness to change personal patterns.

Recognize, Understand, and Apply is the distinction that the criteria made between an individual's ability to *recognize* an addiction problem, *understand* the implications of alcohol and other drug use on the individual's life, and *apply* coping and other recovery skills in his/her life to limit or prevent further alcohol or other drug use. The distinction is in the difference between an intellectual awareness and more superficial acknowledgement of a problem (recognition) and a more productive awareness of the ramifications of the problems for one's life (understanding); and the ability to achieve behavior change through the integration of coping and other relapse prevention skills (application).

Recovery means a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential. SAMHSA states Recovery is built on access to evidence-based clinical treatment and recovery support services for all populations.

RAS-The Recovery Assessment Scale (RAS) was developed as an outcome ~~measaure~~measure for program evaluations. Based on a process model of recovery, the RAS attempts to assess aspects of recovery with a special focus on hope and self-determination.

RSA-R means Recovery Self-Assessment Revised. It is a validated scale designed to gauge the degree to which programs implement recovery-oriented practices. It is a self-reflective tool designed to identify strengths and target areas of improvement as agencies and systems strive to offer recovery-oriented care. There are three versions designed for different population groups.

Reporting Requirements: The PIHP shall collect required reports as identified in provider contracts. Refer to the contract for a list of report due dates and point of contact. Reporting requirements are subject to changes based on state and federal requirements.

REMI stands for the Regional Electronic Medical Information (REMI) system. REMI is the web-based managed care information system used by MSHN implemented on February 1, 2018. REMI replaced CareNet for collection of state and federal data elements, PIHP performance indicators, utilization management (authorization of services), and reimbursement.

RISC means Recovery and Integrated Services Collaborative, a regional effort to embed recovery-oriented systems of care (principles and practices) throughout the service provider network. Collaborative efforts of substance use and mental health providers and comprised of prevention providers, treatment providers, community members, and individuals in recovery.

ROSC refers to Recovery Oriented System of Care which describes a paradigm shift from an acute model of treatment to a care model that views SUD as a chronic illness. A ROSC is a coordinated network of community-based services and supports that is person-centered and builds over a period of months and/or years on the strengths and resilience of individuals, families, and communities to achieve abstinence and improved health, wellness, and quality of life for those with or at risk of alcohol and drug problems.

SAMHSA stands for Substance Abuse and Mental Health Services Administration. It is the federal agency which oversees the funding to the states for substance use disorder and mental health services. It is a department within the U. S. Department of Health and Human Services.

SAPT stands for Substance Abuse, Prevention, and Treatment grant sometimes called a "block" grant. It is the community grant funding from SAMHSA for substance use disorder treatment and prevention services in the 50 states.

Scope of service is the parameters within which the service will be provided, including: Who (e.g., professional, paraprofessional, aide supervised by a professional); how (e.g., face-to-face, telephone, taxi or bus, group or individual); and where (e.g., community setting, office, beneficiary's home).

Sentinel Event An unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase or 'risk thereof' includes any process variation for which a reoccurrence would carry a significant change of serious adverse outcome.

Stages of Change means assessing an individual's readiness to act on new healthier behavior while providing strategies or processes of change to guide the individual to action and maintenance. Stages of Change include precontemplation, contemplation, preparation, action, and maintenance.

State Fair Hearing: Impartial state level review of a Medicaid Consumer's appeal of an adverse benefit determination presided over by a MDHHS Administrative Law Judge. Also referred to as "Administrative Hearing". The State Fair Hearing Process is set forth in detail in Subpart E of 42 CFR Part 431.

Support Services are those readily available to the program through affiliation, contract or because of their availability to the community at large (for example, 911 emergency response

services). They are used to provide services beyond the capacity of the staff of the program on a routine basis or to augment the services provided by the staff.

Transfer is the movement of the client from one level of service to another or from one provider to another within the continuum of care.

Treatment is the application of planned procedures to identify and change patterns of behavior that are maladaptive, destructive and/or injurious to health; or to restore appropriate levels of physical, psychological and/or social functioning.

Urgent cases are those clients screened for substance use disorder services (i.e. pregnant women) and must be offered treatment within 24 hours.

Waste refers to overutilization of services, or other practices that result in unnecessary costs. Generally not considered caused by criminally negligent actions, but rather the misuse of resources.

CUSTOMER SERVICE AND RECIPIENT RIGHTS

Customer Service

Customer Service is a function that operates to enhance the relationship between the individual and the provider. This includes orienting new individuals to the services and benefits available including how to access them, helping individuals with all problems and questions regarding benefits, handling individual complaints and grievances in an effective and efficient manner, and tracking and reporting patterns of problem areas for the organization. This requires a system that will be available to assist at the time the individual has a need for help and being able to help on the first contact in most situations. Customer Service is an important aspect of assuring that persons needing SUD treatment have information about how to access and/or be assessed for SUD treatment, as well as other relevant community resources to meet potential client and other community representatives or citizens' informational needs. Customer Services is responsible to provide support and resources to meet client and provider needs, including but not limited to resource information and referrals. MSHN will assist providers to meet any special needs of any consumers, including but not limited to those who have hearing or vision impairments, those who need written or oral interpreter services, those who have limited English language proficiency, or clients who need any other special accommodation to receive needed SUD treatment.

Each provider is expected to designate a staff member to provide Customer Service for the organization and Customer Service staffing should be sufficient to meet the needs of the consumers engaged in services. Customer Service staff shall assist consumers with questions, accessing the local resolution processes, filing grievances and appeals, Medicaid Fair Hearings information, and coordinating, as appropriate, with the Recipient Rights Advisor. Providers shall ensure the ways to contact Customer Service via phone and mail are sufficiently displayed and provided to consumers. Telephone calls to Customer Service shall be answered by a live voice during business hours, telephone menus are not acceptable. A variety of alternatives may be employed to triage high volumes of calls as long as each call receives a response within one business day. The hours which Customer Service operates and the process for accessing information from Customer Service outside those hours shall be publicized. MSHN Customer Services is available Monday – Friday, 8:00 am to 5:00 pm to assist consumers and providers with questions, complaints/grievances assistance, local appeals requests, Medicaid Fair Hearings information, and SUD Recipient Rights support. Calls should be directed to MSHN Customer Service at (844) 405-3094.

Customer Service is required to ensure that consumers are offered a Customer Handbook when they first enter services and the most current handbook version annually thereafter. Providers are required to use the MSHN developed standardized notice templates which can be downloaded for use from the MSHN website: Provider Network→Provider Requirements→ Substance Use Disorder→Forms. Providers must maintain records for appeals and grievances which includes (at minimum) the following information: the name of the person for whom the appeal or grievance was filed, a general description of the reason for the appeal or grievance, date received, date of each review, date of resolution, resolution details of the appeal or grievance, and the recordkeeping must be accurately maintained in a manner accessible to MSHN and available upon request.

Recipients Rights for Substance Use Disorder Services

MSHN adheres to the 1978 PA 368, as amended, Administrative Rules for Substance Use Disorder Programs in Michigan, sections R325.1301 to R325.1399 regarding Recipient Rights.

Clients have the right to know about the services they are receiving, to make a complaint about a possible violation to those rights and expect a resolution. The recipient rights process establishes a method which, if a client believes his or her rights have been violated, there is a known procedure to follow to process the complaint. Each SUD program shall designate one staff member to function as the program rights advisor by the program director. The rights advisor shall:

- Complete the required Recipient Rights Advisor trainings.
- Receive and investigate all recipient rights complaints. ~~independent of interference or reprisal from program administration.~~
- Communicate directly with the MSHN Rights Consultant, when necessary.

The Licensing and Regulatory Affairs (LARA) Rights of Recipients poster ~~should~~ must be displayed in a public place and a copy provided to consumers upon admission. The Recipient Rights poster ~~will~~should indicate the program's designated rights advisor's name and telephone number, along with the MSHN Regional Rights Consultant's information. Additional brochures, rights information, and posters are available at the LARA Resources and the MDHHS Resources websites. ~~The Recipient Rights poster will indicate the program's designated rights advisor's name and telephone number, along with the MSHN Regional Rights Consultant's information.~~

The Regional Rights Consultant for MSHN is:
Dan Dedloff, Customer Service & Rights Specialist
Office: 517-657-3011 | Fax: 517-253-7552 | Toll-Free 844-405-3094
Dan.Dedloff@midstatehealthnetwork.org

COMPLIANCE

Providers will be subject to contract compliance actions and performance improvement plans from MSHN when contract expectations are not met or maintained. Contract actions can take many forms, including but not limited to corrective action plans, repayment of funds, suspension of referrals, monetary or non-monetary sanctions or contract termination. The selection, nature, extent, duration and other particulars of any initiated compliance or enforcement actions are at the sole discretion of MSHN. Providers will be offered opportunity to correct non-compliance wherever reasonable, and sanctions will be issued in writing, commensurate with the level of non-compliance.

In addition, Providers are required to report all suspected fraud and abuse to the MSHN Compliance Officer prior to completing any investigation or taking any action. The report will be submitted using the Office of Inspector General Fraud Referral Form which can be downloaded for use from the MSHN website: Provider Network→Provider Requirements→ Substance Use Disorder→Forms. Providers will cooperate fully with investigations involving MSHN, the Michigan Department of Health and Human Services Office of Inspector General and/or the Department of Attorney General.

Provider staff with firsthand knowledge of activities or omissions that may violate applicable laws and regulations (not involving suspected fraud or abuse) are required to report such wrongdoing to the MSHN Compliance Officer or to the Provider Compliance Officer. The Provider Compliance Officer will review reported violations to determine the need to report to the MSHN Compliance Officer. The review will be based on but not limited to: external party involvement, Medicaid recipient services, practices and/or system-wide process applicability.

The Provider (CEO)/Executive Director(ED) and/or designee, shall inform, in writing, the MSHN Chief Executive Officer (CEO) of any material notice to, inquiry from, or investigation by any Federal, State, or local human services, fiscal, regulatory, investigatory (excluding Recipient Rights related to non-PIHP activities), prosecutory, judicial, or law enforcement agency or protection and/or advocacy organization regarding the rights, safety, or care of a recipient of Medicaid services. The Provider CEO/ED shall inform, in writing, the MSHN CEO immediately of any subsequent findings, recommendations, and results of such notices, inquiries, or investigations.

In addition, providers are expected to communicate any issues regarding non-compliance in a timely manner so MSHN can assist with developing and/or supporting appropriate responses.

~~Any matters involving potential fraud and abuse will be reported immediately to the MSHN Compliance Officer, without the provider taking any further action or investigation.~~

The Compliance Officer for MSHN is:
Kim Zimmerman, Director of Compliance, Customer Service & Quality
Office: 517-657-3018 | Fax: 517-253-7552
kim.zimmerman@midstatehealthnetwork.org

Confidentiality, ~~&~~ Privacy & Release of Information

MSHN contracted SUD treatment providers shall comply with the Federal Drug and Alcohol Confidentiality Law (42 CFR, Part 2) and the Health Insurance Portability and Accountability Act (HIPAA) of 1996 – Privacy Standards (45 CFR Parts 160 and 164). MSHN requires provider compliance with all federal and state confidentiality and privacy laws.

42 CFR Part 2 – Federal Drug and Alcohol Confidentiality Law **-** 42 U.S.C. Section 290dd-3, 290ee-3 for Federal laws and 42 C.F.R. Part 2 for the Code of Federal Regulations is the law that protects client records and status within the context of SUD treatment. Generally, the program may not acknowledge to anyone outside the program that a client attends a program, or disclose any information identifying a client as an alcohol or drug abuser without a written signed release unless:

- The disclosure is allowed by a special court order; or
- The disclosure is made to medical personnel in a medical emergency;
- The disclosure is made to qualified personnel for research, audit, or program evaluation;

Violation of the Federal law and regulations by a program is a crime. Suspected violations may be reported to the United States Attorney in the district where the violation occurs. SUD Providers are mandated reporters of suspected child abuse or neglect and thus federal law and regulations do *not* protect any information about suspected child abuse or neglect from being reported under state law to appropriate state or local authorities. For additional information, see here: Mandated Reporting of Abuse/Neglect.

45 CFR Parts 160 and 164 – HIPAA Privacy **-** In conjunction with the protections under 42 U.S.C. and 42 CFR, all clients have all their personal health records protected under HIPAA, 45 CFR. The client record contains information that under HIPAA is called Protected Health Information or PHI.

The Privacy Rule defines PHI as individually identifiable health information, held or maintained by a covered entity or its business associates acting for the covered entity that is transmitted or maintained in any form or medium (including the individually identifiable health information of non-U.S. citizens). This includes identifiable demographic and other information relating to the past, present, or future physical or mental health or condition of an individual, or the provision or payment of health care to an individual that is created or received by a health care provider, health plan, employer, or health care clearinghouse.

Some elements that are considered PHI include, but are not limited to: name, address (including street address, city, county, zip code and equivalent geocodes), name of relatives, name of employer, all dates (including birth, death, date of service, admission, discharge, etc.), telephone numbers, fax number, social security number, health plan beneficiary number, account numbers, certificate/license number, any vehicle or other device serial number, web Universal Resource Locator (URL), Internet Protocol (IP) address number, finger or voice prints, and photographic images.

Release of Information- Substance Use Disorder (SUD) Providers are required to obtain consents to share information regarding alcohol and substance use services and treatment. The consent form is to be utilized for all electronic and non-electronic Health Information Exchange

environments. Providers are required to utilize, accept and honor the MDHHS standard release form that was created by MDHHS under Public Act 129 of 2014 (DCH-3927 Consent to Share Behavioral Health Information for Care Coordination Purposes).

The ~~Confidentialitly &~~ Privacy Officer for MSHN is:
Kim Zimmerman, Director of Compliance, Customer Service & Quality
Office: 517-657-3018 | Fax: 517-253-7552
kim.zimmerman@midstatehealthnetwork.org

BREACH NOTIFICATION

Mid-State Health Network contracted substance use disorder providers must provide notification following the discovery of a breach of unsecured protected health information in accordance with 45 CFR 164.400-414 (notification in the case of breach of unsecured protected health information).
The notification shall be sent to the privacy officer and/or security officer at Mid-State Health Network immediately following the discovery of a breach of unsecured protected health information as outlined in the Business Associate's Agreement and Breach Notification Procedure.

Forest Goodrich, Chief Information Officer, Security Officer
Office: 517-253-7549 | Fax: 517-253-7552
forest.goodrich@midstatehealthnetwork.org

Documentation & Records

MSHN adheres to MDHHS's General Schedule #20 – Community Mental Health Services Programs' Record Retention and Disposal Schedule, located at: MDHHS Records Disposal.

All services, such as, assessments, treatment planning, referrals, progress notes, discharge planning and all other content relative to service delivery must be properly documented in REMI as well as the provider's SUD treatment/medical record by properly credentialed clinicians and linked to an individualized treatment plan. All progress notes must be signed and any clinicians under a professional development plan must have notes co-signed by a properly credentialed and authorized supervisor.

All records are subject to audit by MDHHS or MSHN, including event verification as required for federal Medicaid compliance. MSHN and providers could also be subject to federal audit relative to the use of Medicaid funds. Secure storing of records must meet requirements for privacy, security and retention, including any electronic records.

Destruction of records needs to follow the policy and retention and disposal schedule listed above. Disposal must be properly executed with cross-cut shredding or other such proper disposal under the supervision of an authorized person. Requests for client records from legal contacts or other entities as well as Freedom of Information (FOIA) requests should be coordinated with MSHN prior to release.

Reporting Requirements & Delinquency Procedure

Mid-State Health Network (MSHN) is required to submit Prevention and Treatment data and financial reports to the Michigan Department of Health and Human Services (MDHHS) on a monthly, quarterly and annual basis. MSHN also establishes region-specific deadlines for operational reports like annual plans and program budgets. MSHN's ability to meet the deadlines required by MDHHS and regional deadlines for provider network oversight is dependent upon all contracted prevention and treatment providers complying with report submission due dates on a consistent basis.

All data and finance reports and budgets regarding prevention and treatment are due to MSHN on the designated due dates. Annually, providers will be given the due dates for submission of all required reports and budgets for the fiscal year. The document entitled, "Reporting Requirements for MSHN SUD Providers", is included as an attachment to the MSHN Provider Contract and includes dates of submission and designated MSHN staff contact person(s) or locations for submission of each report. Programs are responsible for timely submission of these reports and budgets on or prior to these due dates.

Thirty (30) days prior to the report due date, MSHN staff will send SUD treatment and prevention providers email reminders with the report title, the due date, and email address for submission. A follow-up reminder email will be sent seven (7) days prior to the due date as well. Treatment and prevention providers are expected to submit the required report(s) by the deadline.

Please refer to the Delinquency Procedure for SUD Providers for details.

QUALITY IMPROVEMENT

Mid-State Health Network (MSHN) is ~~SHN~~ responsible for ensuring the responsibilities of the Quality Management Program are outlined in the Quality Assessment and Performance Improvement Plan (QAPIP) as required by Michigan Department of Health and Human Services. The purpose of the MSHN QAPIP is to establish a system for monitoring, evaluating, and improving quality and safety for those we serve. ~~monitors the overall quality and improvement of the PIHP through the Quality Management Program. The PIHP responsibilities are outlined in the .~~ The scope of MSHN's Quality Management Program ~~APIP program~~ is inclusive of all CMHSP Participants, the Substance Use Disorder Providers and their respective provider networks. Performance monitoring covers all important organizational functions and aspects of care and service delivery systems. Performance monitoring is accomplished through a combination of well-organized and documented activities. MSHN delegates to its providers responsibility for timely access to treatment, effectiveness of treatment, consumer safety, and consumer feedback. ~~retained, contracted and delegated activities. Where performance monitoring activities are contracted or delegated, MSHN assures monitoring of reliability and compliance.~~

Annual Consumer~~lient~~ Satisfaction Surveys

All MSHN providers shall conduct ~~client~~ consumer satisfaction surveys of persons receiving MSHN funded treatment at least once a year. MSHN will provide the survey tool and will compile the findings and results of the consumer~~lient~~ satisfaction surveys for all providers, and will make the findings and results, by provider, available to the public. Consumers~~lients~~ may be active consumers~~lients~~ or having been discharged up to 12 months prior to their participation in the survey. Surveys may be conducted by mail, telephone, or face-to-face. The information obtained through the consumer~~lient~~ satisfaction survey process should be used in the development of a Performance Improvement plan which incorporates evaluation outcomes, utilizing data to make program changes, and identifies how services are impacted by the program's goals and objectives.

Recovery ~~Self~~-Assessment

All MSHN Providers shall participate in an assessment of the organization's recovery environment. ~~the Recovery Self-Assessment. (RSA).~~ The Recovery Assessment Scale ~~RSA-R~~ is a validated assessment~~scale~~ designed to gauge the degree to which programs implement recovery-oriented practices. It is a self-reflective tool designed to identify strengths and target areas of improvement as agencies and systems strive to offer recovery-oriented care. This includes the completion of a~~the~~ self-assessment for administrators, providers and implementation of an ~~the~~ assessment with persons in recovery. Provider further agrees to provide data requested by MSHN in order to comply with the MDHHS data submission requirements related to the recovery measure.~~RSA- Performance Indicators~~

Michigan Mission Based Performance Indicator System (MMBPIS)~~s~~

MSHN Treatment Providers are contractually responsible to meet and document in REMI the timeliness standards for Medicaid and Healthy Michigan Plan in accordance with the most current Michigan Mission-Based Performance Indicator System PIHP Reporting Codebook, in which there are two~~three~~ (2~~3~~) timeliness performance indicators as listed below:

- ~~Indicator 2:~~ The percentage of new persons during the quarter receiving a face-to-face service for treatment or supports within 14 calendar days of a non-emergency request for service for persons with Substance Use Disorders.~~assessment with a professional within 14 calendar days of a non-emergency request for service (by five sub-populations: MI-adults, MI-children, DD-adults, DD-children, and (P~~p~~ersons with Substance Use Disorders). FY21 Baseline Data Collection. No Standard.~~ Standard = 95%~~
- ~~Indicator 3: Percentage of new persons during the quarter starting any needed on-going service within 14 days of a non-emergent face-to-face assessment with a professional ((by five sub-populations: MI-adults, MI-children, DD-adults, DD-children, and persons with Substance Use Disorders). Standard = 95% within 14 days~~
- Indicator 4b: The percentage of discharges from a sub-acute Detox unit during the quarter that were seen for follow-up care within 7 days. Standard=95%.

Sentinel Events

MSHN Treatment Providers agree to review all required critical incidents as identified by MDHHS to determine if a sentinel event has occurred.

The following events should be reviewed to determine if the event meets the requirement for a sentinel event:

- Death of a recipient
- Accidents requiring emergency room visits and/or admissions to a hospital
- Arrest or conviction of recipients
- Serious challenging behaviors
- Medication errors
- Administration of Narcan

A sentinel event must be identified within 3 business days of the incident occurring. A root cause analysis must commence within 2 business days of the identification of a sentinel event. ~~requiring a root cause analysis.~~ ~~Sentinel events are to be reported as indicated in the reporting requirements.~~ All sentinel events require the completion of a root cause analysis to determine any contributing factors and determine if actions are required to prevent recurrence of the sentinel event. Critical Incidents and Sentinel events are to be reported as indicated in the reporting requirements. Technical assistance may be provided by contacting MSHN's Quality Manager. Visit the MSHN website: Provider Network → Provider Requirements → Substance Use Disorder for more information about reporting requirements.

The Quality Manager for MSHN is:
Sandy Gettel, Quality Manager
Office: 517-220-2422 | Fax: 517-253-7552
Sandy.Gettel@midstatehealthnetwork.org

PROVIDER NETWORK MANAGEMENT

Organizational Credentialing and Recredentialing

Substance Use Disorder providers must complete the agency credentialing process in order to join MSHN's provider panel. Recredentialing must be conducted at least every two years. Providers seeking to join MSHN's provider panel must demonstrate the following minimum qualifications:

- **License:** a current unrestricted, unconditional license to practice substance use disorder treatment or prevention services in the State of Michigan, issued by LARA;
- **Accreditation** (treatment programs only): Current accreditation from a national body approved by the State of Michigan;
- **Certification** (if applicable): Current certifications to provide specialized services as required by the State of Michigan;
- **ASAM Level of Care Designation (treatment programs only)**: Approved by the State of Michigan;
- **Insurance**: Current malpractice insurance and professional liability insurance in the amount required by MSHN (minimum $1,000,000 per occurrence and $3,000,000 aggregate);
- **Willing to accept** all Medicaid/Healthy Michigan clients residing in MSHN's 21-county region; and
- **Provider staff must meet provider qualifications** as defined by the State of Michigan.

Delegation of Rendering Provider Credentialing and Recredentialing

MSHN requires organizational providers to credential and re-credential, and conduct primary source verification, and monitor licensure/certification expiration dates of their direct employed and contracted rendering providers in accordance with the MSHN's credentialing/recredentialing policies and procedures, which conforms to the *MDHHS credentialing and recredentialing processes (Attachment P 7.1.1)*.

SUD treatment rendering providers must meet qualifications as outlined in the *PIHP/CMHSP Provider Qualifications Chart*. Upon hire, and upon obtaining new or advanced credentials, the *REMI Multiple User Activation/Deactivation form* must be used to provide MSHN with rendering provider credentials. Organizational Providers will not be paid for claims where provider qualifications are not met. Refer to the REMI Help document titled *CPT Codes – NPI, Time, and Modifier Information* for a complete listing of codes which require specific credentials or NPI. MSHN monitors compliance with credentialing and recredentialing processes as part of the Quality Assurance and Performance Improvement site reviews.

SUD treatment and prevention provider staff cannot provide services if they are not certified or do not have a registered a development plan with MCBAP. SUD treatment and prevention providers may request temporary privileging for staff members who are not certified or have not registered a development plan with MCBAP but are in the process of obtaining certification or a registered development plan. If temporary privileging is granted, it shall expire 120 days after the MSHN decision effective date. Master's level interns will also need to complete a Temporary Privileging Form.

Once the temporary privileging has been approved by MSHN, the provider can submit a REMI User Activation form. Once MCBAP approves the certification or development plan, a revised REMI User activation form will need to be submitted by the provider with updated expiration dates.

Visit the MSHN website: Provider Requirements → Substance Use Disorder for more information about credentialing and provider qualifications. Provider qualifications and supervision requirements are also outlined in the Medicaid Managed Specialty Supports and Services Program Manual available on the Provider Requirements section of the webpage.

Quality Assurance and Performance Improvement

The Quality Assurance and Performance Improvement team (QAPI) is responsible for conducting ~~annual~~ periodic Quality Assurance reviews for activities related to provider performance and compliance monitoring and ensuring successful monitoring processes are in place as well as continued monitoring of corrective action plan implementation. Reviews include site and desk reviews for purposes of evaluating providers in areas of administration and clinical performance and compliance. MSHN supports reciprocity, and where appropriate, may accept the results of an audit conducted by another ~~PIHP~~qualified entity. Copies of standards are available on the MSHN webpage: Provider Requirements → Substance Use Disorder→Quality Assurance and Performance Improvement.

For more information or to contact the QAPI team email QAPI@midstatehealthnetwork.org.

~~General Business Requirements~~

~~Providers are responsible to ensure all provision of services are in compliance with local municipality and state and federal business requirements, including business records, reporting, and adherence to all relevant statutes. Providers must be in compliance with all applicable standards and expectations from the most current *MDHHS Substance Use Disorder Services (SUDS) Program Audit Guidelines,* which include single financial audit requirements for providers in receipt of federal funds above a $750,000 level in a fiscal year.~~

Capacity

The treatment provider will notify MSHN in the event there are any capacity limitations and/or any inability to accept new referrals. It is also the provider's responsibility to notify MSHN of any change in occupancy or service capacity relevant to their MSHN contract scope of work for SUD services. MSHN may elect to seek or add providers to the regional panel to meet existing or new needs of consumers at any time. All providers are required to submit the monthly Capacity Waitlist Report, regardless of the status.

Providers may be interested in MSHN's publication, *Assessment of Network Adequacy*.
Visit the MSHN website: Provider Network → Provider Requirements → Community Mental Health Service Participants for more information.

Notification of Termination/Closure

If a provider is ending its service contract with MSHN ~~or is closing a program for any reason~~, due to contract termination or provider closure, the provider must notify MSHN ~~and its clients~~ of their intent to close as soon as possible but no less than 30 days before the contract termination/closure of the program. Also, each provider must make a good faith effort to give

written notice of termination, within 15 days from the provider's notice to MSHN, to each client who receivesd his or her services from, or was seen on a regular basis by, the provider. The written notification to Eeach client, as coordinated with the responsible MSHN contact, mustwill be notified in writing ofcontain:

- Date of closure..
- Directions regarding obtaining continued treatment.
- Process for transferring their records to a new provider.
- The need for a signed release of information prior to the transfer of records.
- In the event of provider closure:
    - Where their records will be transferred.
    - How to obtain information from their records after closure.
- Procedure for transferring their records.
- The need for a signed release of information prior to the transfer of records.

The provider terminating/closing provider will notify provide MSHN ofUM Department (UM@midstatehealthnetwork.org) and MSHN Customer Services (dan.dedloff@midstatehealthnetwork.org) a list which includes open consumers and consumers who were recently closed within the past 60 days from the date of the notice of termination for the purpose of transfer/discharge planning. the client's needs and choices through MSHN will work closely with the terminating/closing provider through weekly reviews and/or REMI, and MSHN may ask the provider to assist each the client with their transfer to another treatment provider or termination from treatment. The MSHN Contract Specialist and/or Director of Provider Network Management will provide additional instructions to assist the provider during the termination/closure process.

Providers who offer SUD services must have a mechanism to notify clients in a reasonable manner regarding unexpected program or site closure, such as due to inclement weather, building damage, etc.

Employee Confidentiality

MSHN will protect the confidentiality of the SUD treatment service clients and their records as provided by law. Every contracted/sub-contracted program staff member involved in MSHN funded work is expected to read and abide by the provisions of the MSHN standards of conduct for confidentiality and privacy. Contracted/Sub-Contracted Providers are required to use and accept the standard release form that was created by MDHHS under Public Act 129 of 2014.

- Every staff member will sign an employee confidentiality and/or privacy statement at time of employment;
- A signed copy of the statement will be placed in the staff personnel file;
- A review of the confidentiality policy will be provided annually to the staff; and,
- A new, signed confidentiality/privacy form will be obtained from each staff member annually.

Training and Continuing Education

MSHN providers are expected to maintain and stay up-to-date on all trainings required by their licensure and/or accreditation. All contracted/subcontracted providers are responsible to ensure that staff members involved in direct service delivery meet and maintain all training and

continuing education requirements as outlined in the MSHN Regional Minimum Training Requirements. Refer to MSHN Contract for regional training requirements for treatment and prevention provider staff or the MSHN website: Provider Resources → Provider Trainings for a complete listing of required trainings and frequency.

Communicable Disease: MSHN adheres to requirements for communicable disease as described in the OROSC Prevention *Policy #2: Addressing Communicable Disease Issues in the Substance Abuse Service Network.* All MSHN funded treatment programs must have a procedure in place for all clients entering their programs for treatment stating individuals will be appropriately screened for risk of Tuberculosis, Hepatitis B and C, Sexually Transmitted Infections (STIs and HIV).

All funded programs will meet state reporting requirements while adhering to federal and state confidentiality requirements, including 42 CFR Part 2 and Confidentiality of HIV/AIDS Information. Health education and risk reduction education for at-risk clients must be provided at the treatment provider's site or referred to the local public health department. Follow-up must be monitored and documented in the client's record. TB Tine Tests may be read by trained staff. Such training is to be documented and readily available for review.

It is important for all staff working in a substance use disorder program to have at least a minimum knowledge of communicable disease. Knowledge standards are expected to be consistent with the roles and responsibilities of program and clinical staff. Minimum standards are listed in the OROSC Policy under Minimum Knowledge Standards for Substance Abuse Professionals – Communicable Disease Related. Appropriate training for new staff is to be completed within the first three (3) months of hire with updated training every two (2) years thereafter.

All trainings required for treatment and prevention providers are available through ~~pproved training can be located on~~ Improving Mi Practices, a free training platform. In addition, there are a variety of other trainings that may benefit your agency and staff. Agencies may create agency accounts and associate staff members to the agency for easy d~~D~~ocumentation and tracking of completion of initial training and annual refreshers. Staff members are able to access their training transcript as well. ~~is to be kept in each employee's record as well as documentation of updated training.~~

MSHN will monitor compliance with MSHN Regional Training Requirement with review of employee training records during annual quality assurance site review ~~and is subject to ad-hoc review at any time~~.

Please contact ~~the~~ Carolyn Tiffany~~Watters~~, Director of Provider Network Management Systems or Kyle Jaskulka, Contract Specialist –for questions and feedback related to amendments and service agreements, credentialing and re-credentialing processes, the network provider directory, provider communication systems, the provider, appeal process, network expansion, and the site review process.

TREATMENT SERVICES

MSHN's Treatment Specialists are available to assist treatment providers with questions pertaining to treatment programming. Treatment Specialists can assist with activities, such as new program proposals, program enhancement, development of women's specialty services (WSS) designation/enhancement, training needs related to treatment, and community collaboration efforts. Please contact the treatment specialist assigned to support your agency~~in your part of the region~~ to address any needs or concerns or call (517) 253-7525.

Trisha Thrush:	trisha.thrush@midstatehealthnetwork.org
~~Jeanne Diver:~~	
Rebecca Emmenecker:	rebecca.emmenecker@midstatehealthnetwork.org
Sherrie Donnelly:	sherrie.donnelly@midstatehealthnetwork.org
Shannon Myers:	shannon.myers@midstatehealthnetwork.org

General Expectations: Providers should refer to the Michigan Medicaid Manual for complete descriptions of treatment services along with all relevant MDHHS and MSHN policies and references noted in this manual. Treatment services requirements and expectations are also outlined in the MDHHS/OROSC policies ~~referenced in this manual are~~ located here: OROSC policies & advisories. MSHN offers additional guidance below:

~~FASD Screenings:~~

~~FASD prevention should be a part of all substance use disorder treatment programs that serve women, regardless of whether or not they are a designated Women's Specialty provider. Providing education on the risks of drinking during pregnancy along with FASD screening and detection are easily incorporated into the treatment regimes. It is also recommended that programs who serve men with children provide FASD prevention information.~~

Annual Plans

The MSHN treatment team's annual planning process is utilized to help support communication and collaboration among MSHN staff and the provider network, as well as provide discussions around planning and service ~~expansion~~development for the SUD treatment providers. Annual plans provide an opportunity for the SUD provider to share feedback on their experiences and needs with providing SUD services, as well as to request technical assistance from MSHN, as needed. The annual planning process also allows the MSHN treatment team to share information with providers in a one-on-one venue and discuss the SUD providers programs/services in their communities. Annual plans are completed ~~one time per year,~~ usually in spring/summer for the subsequent fiscal year that begins in October.

Auricular Acupunture

Auricular acupuncture is a commonly practiced technique involving the stimulation of specific points on the ear. The National Acupuncture Detoxification Association (NADA)-standardized 3- to 5-point ear acupuncture protocol, has evolved into the most widely implemented acupuncture-assisted protocol, not only for substance abuse, but also for broad behavioral health applications. Mid State Health Network accepts and promotes the use of auricular acupuncture to assist individuals with substance use disorders in overcoming cravings, anxiety, sleep disturbances, triggers for use, and other issues related to recovery from substances.

Biopsychosocial Assessment

General Assessment Guidance: Under the current 1115 Waiver agreement The Michigan Department of Health and Human Services (MDHHS) requires a standardized assessment for individuals with substance use disorders. Minimum requirements for a standardized (research-based, tested and validated) assessment is one that is multi-dimensional, provides a Diagnostic and Statistical Manual based diagnosis, an ASAM level of care placement output and be validated for the age of the consumer. Currently the Global Appraisal of Individual Needs (GAIN) is approved for use while other options are researched. Per MDHHS, only the GAIN I-Core or other approved Centers for Medicare and Medicaid Services (CMS) ASAM-compliant assessment will be allowed after September 30, 2021.

Per MDHHS guidance, the following licenses/credentials are required for clinicians who conduct an SUD assessment: Licensed Psychologist (LP), Limited License Psychologist (LLP), Time Limited Licensed Psychologist (TLLP), Licensed Professional Counselor (LPC), Limited License Professional Counselor (LLPC), Licensed Marriage and Family Therapist (LMFT), Limited Licensed Marriage and Family Therapist (LLMFT), Licensed Master's Social Worker (LMSW) and Limited License Master's Social Worker (LLMSW).

MDHHS is considering a proposed alternative to the GAIN I-Core described above from Michigan's PIHPS. The publication of this provider manual will predate the MDHHS decision. Therefore, MSHN will issue a supplement to the provider manual with pertinent guidance on the assessment chosen for implementation.

Jan Maino, SUD Assessment Coordinator
Jannifer.Maino@midstatehealthnetwork.org
517-252-7673

Co-Occurring Mental Health and Substance Abuse Disorders

Dual Diagnosis Capable (i.e. co-occurring capable) refers to an ASAM category of addiction treatment programs that accommodate individuals with mental health disorders that are mild to moderate in severity. These programs address co-occurring disorders (COD) in treatment of individuals and is reflected in organizational policies, procedures, assessment, and programming.

- Providers are expected to screen all consumers for co-occurring mental health and substance use disorders, at the point of access and throughout treatment.
- Provider will provide continuous, comprehensive and individualized services to individuals with substance use and mental health disorders in a coordinated or integrated manner.
- MSHN provider programs will demonstrate competency in the provision of services for those who have co-occurring conditions.

- Acknowledging the high rate of co-occurrence of mental health and SUD symptoms, all MSHN providers are expected to be co-occurring capable. It is the expectation of MSHN that all providers will complete the Dual Diagnosis Capability in Addiction Treatment (DDCAT) self-scoring assessment, and provide supporting documentation for each indicator. Providers will develop and implement DDCAT goals annually, and provide feedback on progress of achieving those goals during the subsequent years annual planning process.. Further information on the DDCAT process may be obtained from the MSHN Treatment team.

Cultural Competency

The Federal Register provides National Standards for Culturally and Linguistically Appropriate Services. It is critical that MSHN provider network members strive toward cultural competency for all persons from diverse cultural backgrounds in our communities who need to access SUD treatment and prevention services. Cultural response includes removing barriers and embracing differences, in order to offer safe and caring environments for all who are in need of services.

Cultural competency can be defined as a set of values, behaviors, attitudes, and practices within a system, organization, and program, or among individuals which enables them to work effectively cross-culturally. Further, it refers to the ability to honor and respect the beliefs (including religious), language, interpersonal styles and behaviors of individuals and families receiving services, as well as staff who are providing such services. Cultural competence is a dynamic, ongoing, developmental process that requires a long-term commitment and is achieved over time, according to the National Center for Cultural Competency.

It is the expectation that each SUD prevention/treatment provider will have applicable policies and training of staff relative to cultural competency and available to MSHN for review, including governance and practitioners providing treatment. MSHN expects that providers will demonstrate training competencies to support a diverse population of clients served and seek to establish a diverse workforce to meet client needs. MSHN will endorse a variety of methods to help ensure cultural competency, including recognition in the regional strategic plan and other support as indicated.

Assessment tools and/or methods used must be culturally sensitive, reliable, and validated, whenever possible, for use with racial and ethnic minorities. Service/support/treatment plans and discharge plans must incorporate the natural supports and strengths specific to the racial and ethnic background of the client, family, community, faith-based, and self-help resources. Prevention, education and outreach efforts will include linkages with racial, ethnic, and cultural organizations throughout the community.

Discharge Planning

MSHN requires that effective discharge planning will be provided for clients, and that follow-up services meet contractual and regulatory requirements.

Discharge planning is considered an integral part of SUD treatment. Consideration of the continuum of care and long-term recovery needs of the client will be considered at every step of treatment planning. Discharge planning provides improvements to the quality of care and improves outcomes and controls cost, by assuring coordination and collaboration with mental health, SUD and other health providers to fully address the needs of the client. It is critical

that all providers and organizations serving a client act together to develop an integrated health aftercare plan and then implement this ongoing aftercare plan in an environment that eliminates barriers and duplication of services.

Discharge Planning will occur according to best practices and the provider organizations' admission and discharge policies:

- A review of a client's discharge plan for all levels of care will be completed to ensure that appropriate follow-up care is arranged for those ending treatment.
- A written discharge plan will be prepared to ensure continuity of service and will be distributed to parties involved to carry out the plan.
- The MSHN contracted provider network will ensure that all clients are appropriately discharged from their care, including entering a discharge into REMI.
- Aftercare services are incorporated into the treatment plan, and needs are identified and addressed in the discharge plan.
- Follow up SUD treatment services from a detox and or residential facility will be completed not more than seven (7) days after discharge.
- Consumer satisfaction surveys should be distributed to the clients at discharge.

Evidence-Based Practices

MSHN requires all SUD treatment providers to document and provide evidence-based programs for their services. Treatment providers must demonstrate knowledge and competencies in practice relevant to service provision. Each provider is monitored at least annually with regular site visits to verify that the evidence-based programs are being provided and that staff and clinicians have the requisite training and qualifications for the practices in which they are engaging clients. Evidence-based practices may include motivational interviewing, trauma-informed care and positive behavioral supports. Recognizing the stages of change for persons recovering from SUD is an important component of evidence-based service provision. Providers should take steps to ensure fidelity to evidence-practice models, including sustaining fidelity when valid models and/or program staffing changes occur, which may require new training or credentials in maintaining integrity of clinical service provision. MSHN reserves the right to endorse evidence-based practices in use by funded provider programs.

Gambling Disorder Protocol

Gambling disorders (GD) frequently are co-occurring with substance use disorders. Nationally representative samples suggest more than half of all individuals with a GD have co-occurring mood, anxiety or substance use disorders. Additional evidence suggests that problem gamblers with co-occurring mood and anxiety disorders use gambling as a way to cope with symptoms of those disorders. Additional evidence shows that, at least among consumers of substance abuse treatment, rates of gambling problems are quite high.

Gambling Disorder Screening: At designated times, during the course of providing treatment, MSHN contracted SUD Treatment providers will be prompted by the REMI system to administer a gambling disorder screening, assessment, and referral:

During Admissions process:

1. Administer the three-question GD screen, the NODS-CLiP.

2. Results of the NODS-CLiP screen must be documented and made available to MSHN in a format to be provided by MSHN.
3. If the screen is positive for GD, PROVIDER will administer the 9-question NODS-SA assessment. The assessment outcome must be documented and made available to MSHN in a format to be provided by MSHN with either a "rule out" of GD or a diagnosis of gambling disorder.

During Treatment Planning process and ongoing during treatment:

1. If there is a GD diagnosis, PROVIDER shall add a goal to the treatment plan regarding the GD diagnosis.
2. Provider shall make a referral to the Gambling Disorder Helpline.
3. Progress notes following a referral to the Helpline should document ongoing check-in regarding GD with the consumer to encourage follow-through with the Helpline and to discuss parallels and differences in their addictions to gambling and to substances.

At Discharge:

1. At discharge, providers need to report the following to MSHN: "If a GD diagnosis was identified at admission: 1) Was a GD goal added to the TX plan? 2) Was consumer referred to the GD Help-Line?" 3) If consumer was transferred to a different provider/LOC, did coordination of care include submission of the treatment plan with GD goal(s) to the next provider?"

Group Therapy

According to SAMHSA TIP 41, *Substance Abuse Treatment: Group Therapy*, group therapy is therapeutic for treating substance use disorders and reducing isolation. Groups organized around therapeutic goals provide insight and guidance, enable individuals to observe others' recovery and create a culture that supports healing and recovery.

TIP 41 introduces five group models that are used in substance use disorder treatment: psycho-educational, skills development, cognitive-behavioral, support, and interpersonal process.

1. Psychoeducational groups educate clients about substance abuse;
2. Skills development groups cultivate skills needed to attain and sustain abstinence;
3. Cognitive-behavioral groups alter thoughts and actions leading to substance abuse;
4. Support groups provide a forum to share pragmatic information about maintaining abstinence and managing day-to-day, chemical-free life; and
5. Interpersonal process groups delve into major developmental issues that contribute to addiction or interfere with recovery. TIP 41 reflects that resources, training and theoretical orientation of group leaders, and the needs and desires of clients is to be considered when determining the most appropriate group model. The challenge is matching the individual to the group model for maximum benefit.

Outpatient Treatment Continuum of Services Treatment Policy #9 defines the minimum in group therapy as face-to-face interventions with three or more clients, which includes therapeutic interventions/counseling. MSHN recommends no more than 12 members to a therapeutic group and 15 members to an educational and/or didactic group to allow

participants to feel heard and understood, for the leader to know each of them, and for members to feel a sense of connection and belonging to the group. The exception to the caps is for 1) skills development groups where 8-10 members is recommended to allow members to practice new skills and 2) Cognitive-Behavior groups which should be 3-10 members. Please note, if the provider is utilizing an evidence-based practice curriculum they will want to follow the guidelines of the number of participants allowed per group to follow the fidelity of the model.

Therapeutic Yoga: Yoga is not a replacement for a program of addiction recovery, but an adjunct. The word Yoga means "union," according to the Hazelden Betty Ford Institute article, Yoga and Addiction Recovery. By focusing on and controlling breath through yoga, the mind-body system relaxes and moves toward healing, recovery, and wholeness, which is lost in active addiction. Yoga helps prevent relapse, reduce withdrawal symptoms and drug cravings, and provide a healthy outlet to cope with potential triggers and daily life stressors. According to the Office of Recovery Oriented Systems of Care (OROSC), when yoga is offered as a therapeutic practice and the development of an appropriate coping mechanism to help prevent relapse, this practice is allowed. The treatment plan is to reflect the therapeutic intervention for every client that participates in therapeutic yoga. The focus of the group is to be comprised mostly of therapeutic verbal conversation and processing; not just yoga itself. It is preferred that an instructor with trauma experience or qualifications provides the therapeutic yoga, however, if one cannot be found, a staff person is able to participate along with the yoga instructor and talk to participants about times when yoga may be helpful, used as a coping mechanism, de-stressing mechanism, sharing the experience with their kids, etc. If therapeutic yoga is provided in residential treatment, it is bundled into the per diem. If therapeutic yoga is provided in an outpatient service, it could be coded as 90853 or H0005, depending on the credentials of the counselor/therapist who is co-facilitating.

Individualized Treatment Planning

Per Treatment Policy #6, there are two key requirements of individualized treatment plans. First, to be individualized, "treatment and recovery planning requires [the provider's] understanding that each client is unique and each plan must be developed based on the individual needs, goals, desires, and strengths of each client." Second, client participation and engagement in the treatment planning process is critical: "Treatment and recovery plans must be a product of the client's active involvement and informed agreement. Direct client involvement in establishing the goals and expectations for treatment is required to ensure appropriate level of care determination, identify true and realistic needs, and increase the client's motivation to participate in treatment." Individualized treatment planning should also utilize S.M.A.R.T. (Specific, Measurable, Attainable, Reasonable, and Time-bound) goals and objectives, with appropriately identified amount, scope, and duration for each.

MSHN's expectation for Treatment Plan timelines are as follows:

Outpatient: Initial treatment plan will be completed by the third (3rd) session with the client. Periodic Review of outpatient treatment plans should be within 90 days, but for more intensive services (e.g. IOP) and/or based on higher intensity client needs, more frequent reviews are required.

Residential/Withdrawal Management: Initial treatment plans are due within three (3) days of the initiation of treatment services (3 calendar days or 72 hours, not 3 business days). Periodic review of residential/withdrawal management treatment plans should take place every seven (7) days for residential/withdrawal management services.

Integrated Coordination of Care

MSHN expects providers will collaborate and coordinate services with other care providers as appropriate after completing a comprehensive assessment of needs. MSHN also expects SUD treatment providers to coordinate care with a consumer's previous and current behavioral health treatment providers. Coordination of care should include the consumer's primary care physician (PCP) and if the consumer does not have one, efforts should be made to link the consumer to a PCP wherever possible. Providers should maintain documentation of coordination of care between other behavioral health care providers and physical health care providers.

Coordination of care is expected to occur with every client and will be comprehensive and based on the client's individual needs. It may include, but is not limited to; legal, dental, transportation, education, employment, and any other areas of need.

Jail-Based Services

This section applies to providers whose service delivery extends to providing SUD treatment in a jail setting.

Jail-based SUD treatment can be an important aspect for an individual's rehabilitation process and with that in mind, MSHN will authorize, when available, SUD treatment services to those who meet eligibility criteria.

However, providing SUD treatment services within the jail setting has barriers and complications relating specifically to it being provided in the jail. The provider has no control over client availability and knowledge of the actual release due to the jail's capacity. With MSHN's understanding of the barriers and complications involved, the following guidelines should be utilized when providing services to incarcerated clients:

- The SUD treatment provider will assess the client when the client presents for services and begin the process of developing a treatment plan for post-jail. Jail-based services are based on the individual's medical necessity for SUD services.
- Each client will have an individual assessment, treatment plan, and intake completed (there will be no "group intakes").
- All clients receiving services while incarcerated will have a referral made to a SUD provider in their respective county of residence, with an appointment date and time that is scheduled close to the next business day following their release date. Since there will be a possibility of clients being released early, clients are to have all the necessary referral information as soon as possible to be able to schedule an appointment themselves after early release.
- It is an expectation of MSHN if clients are released from jail early, every attempt will be made by the provider of jail-based services to contact the clients to help ensure a successful transition to their community SUD treatment provider is made. The attempts to contact the client should be documented in the clients file.

- The provider of jail-based services will secure a release to both the receiving provider and the client's home region, if not MSHN.
- All appointment dates and times will be documented in the REMI system for each client in his/her discharge summary. A note will be made in the discharge note section of the discharge summary in REMI stating if the client was released early.
- The provider of jail-based services will ensure that each client that receives any jail-based services will have documentation in REMI for the services.

Medication Assisted Treatment (MAT)

MSHN adheres to requirements described in all OROSC policies related to MAT. Detail regarding the state and federal regulations and MSHN's expectations regarding MAT are in Appendix C of this manual. Licensure as an Outpatient-Methadone program is required as well as a State determination of appropriate ASAM Level(s).

Medication Assisted Treatment (MAT) is a standard of care that is broadly recognized as an essential pillar in any comprehensive approach to the national opioid addiction and overdose epidemic. MSHN seeks to ensure that no consumer is denied access to or pressured to reject the full-service array of evidence-based and potentially life-saving treatment options, including MAT, that are determined to be medically necessary for the individualized needs of that consumer.

Following the recommendations by SAMHSA, the Centers for Disease Control and Prevention (CDC), the ASAM, the National Institute for Drug Abuse (NIDA*), MDDHS's OROSC Treatment Policies #5 and #6*, and other state and national directives, MSHN requires of its substance use disorder (SUD) Treatment Provider Network that no MSHN client is denied access to or pressured to reject the full service array of evidence-based and potentially life-saving treatment options, including Medication Assisted Treatment (MAT), that are determined to be medically necessary for the individualized needs of that client. Per SAMHSA, exclusion of clients who are on MAT may be a violation of the Americans with Disabilities Act (ADA) and/or the Rehabilitation Act of 1973. Please reference the SAMHSA brochure here called "Know Your Rights: Rights for Individuals on Medication-Assisted Treatment."

MSHN-contracted SUD treatment providers are expected to adopt a MAT-inclusive treatment philosophy in which 1) the provider demonstrates willingness to serve all eligible treatment-seeking individuals, including those who are using MAT as part of their individual recovery plan at any stage of treatment or level of care, and without precondition or pressure to adopt an accelerated tapering schedule and/or a mandated period of abstinence, 2) the provider develops policies that prohibit disparaging, delegitimizing, and/or stigmatizing of MAT either with individual clients or in the public domain.

MSHN adheres to the *MDHHS Medication Assisted Treatment Guidelines for Opioid Use Disorders.* It is a MSHN expectation that each medication assisted treatment (MAT) provider offers all medication approved and available for Opioid Use Disorders (OUD).

Abstinence-Based (AB) Providers: In the interest of consumer choice, MSHN will contract with Abstinence-Based providers who ~~offer~~adhere to written policies and procedures stating the following:

- If a prospective client, at the point of access, expresses his/her preference for an abstinence-based treatment approach, the access worker will obtain a signed "MSHN Informed Consent" form (See Appendix E) that attests that the client was informed in an objective and non-judgmental way about other treatment options including MAT, and attest that the client is choosing an abstinence-based provider from an informed perspective. This includes the client's acknowledgement of receipt of MSHN's informational handout/grid titled "Recovery Pathways for Opioid Use Disorder." (See Appendix F).
- When a client already on MAT (or considering MAT) is seeking treatment services (counseling, case management, recovery supports, and/or transitional housing) at the point of access to an AB facility, access staff a) will be accepting and non-judgmental towards MAT as a choice, b) will not pressure the client to make a different choice, and c) will work with that client to do a "warm handoff" to another provider who can provide those ancillary services while the client pursues his or her chosen recovery pathway that includes MAT.
- Providers' policies will include language that prohibits delegitimizing, and/or stigmatizing of MAT (e.g. using either oral or written language that frames MAT as "substituting one addiction for another") either verbally with individual clients, in written materials for clients or for public consumption, or in the public domain.

A consensus statement in support of inclusion was endorsed by all ten PIHP's on November 1, 2017.

Performance Enhancement Plan (PEP)

A MSHN treatment team Performance Enhancement Plan (PEP) is a supportive measure to offer a provider more intensive technical assistance and monitoring to address quality, performance, outcomes, and compliance issues. The Performance Enhancement Plan is typically developed and implemented by the MSHN Treatment Team in partnership with the MSHN Utilization Management Team, QAPI Team, and Quality/Compliance Team. The focus of the PEP is to offer proscriptive direction to the provider of steps to be taken to address the quality and compliance issues in concrete and measurable approaches. Utilization of the PEP is considered on an individualized basis per provider, but could be for any/all of the following:

- Repeat findings and ongoing issues documented in the MSHN QAPI Site Review process
- Repeat and ongoing issues with implementation of quality and compliance standards
- Repeat and ongoing issues with implementing provided technical assistance into practice
- Customer Service or Recipient Rights complaints that warrant further monitoring and oversight
- The need for increased monitoring and technical assistance to stabilize a program

The timeline of monitoring for a PEP can include a variety of touch points depending on the individualized needs of the provider and the reasons for the implementation of the PEP. For occurrences when a need for a PEP is more immediate to address the health and safety needs of individuals in services, there may be an implementation and review period of monitoring every 30 days. Other PEPs may warrant time for attention and implementation of technical assistance or other resources and will be reviewed no more than 90 days out from implementation or progress review. Performance Enhancement Plans continue to be

implemented and monitored until the items within the plan reach the measurable standards outlined, and no further needs for assistance have been identified by MSHN or the provider.

Depending on the circumstances which warranted the implementation of the PEP, MSHN can engage contract non-compliance action as outlined in Section VI.I Contract Remedies and Sanctions of the FY21 contract and in this provider manual. These steps may include, at the sole discretion of MSHN, but are not limited to, implementing a full new admissions hold or placing a cap on program admissions, and communication/collaboration with LARA and/or other accrediting bodies.

Prohibition on Provision of Hypodermic Needles

Providers will assure that no federal or state funds will be used to provide consumers with hypodermic needles or syringes enabling such consumers to use illegal drugs.

Project ASSERT & SBIRT Programs

For agencies who engage in Project ASSERT (Alcohol & Substance Abuse Services, Education, & Referral to Treatment) or SBIRT (Screening, Brief Intervention, & Referral to Treatment) programs in their communities, the provider will now be required to support data collection and data entry of encounters into the MSHN REMI system. Providers should utilize the H0002 Brief Screen code for authorization and reimbursement for the initial face-to-face screening contact they have with an individual. The H0002 code is an encounter code that is utilized to report peer recovery coach interactions with individuals when the focus of the encounter is screening, brief intervention, and referral to treatment services. For providers to utilize the H0002 code, the peer recovery coach supporting Project ASSERT or SBIRT activities must be appropriately trained according to Medicaid guidelines and be either CCAR trained or State Certified. Following the initial face-to-face screening encounter, peer recovery coaches conducting Project ASSERT & SBIRT will continue efforts to follow-up with the individual over the course of the next 30-90 days. Follow-up phone calls that do not result in a face-to-face encounter would not be reported in REMI, but through an alternate outcome reporting process. Utilization of the H0002 code does not require an admissions record or BHTEDS data for submission. Any follow-up that is not face to face will utilize a separate outcome reporting process for submission to the treatment team for review.

Recovery Oriented Systems of Care

ROSC Participation: MSHN will continue leading the journey of transformational system change to build a better, more Recovery Oriented Systems of Care (ROSC) in the region. This systems change will be inclusive and a long-term process that will entail changes not only for providerss of services and supports but for all parts of the system including fiscal, policy, regulatory and administrative strategies. MSHN wants to ensure that this process represents a broad range of stakeholder viewpoints.

a. Providers will act consistent with collaboration and cooperation of efforts in order to effect positive change in communities/counties.

b. Providers support a process of community change that engages critical thinking and collaboration with community partners.

c. Providers support a continuum of improved health and functioning in which there are a variety of diverse roles for all involved to provide input. These roles include prevention and treatment PROVIDERS, peer support specialists, community-based support services, and others.

Therefore, all provider partners shall engage in this process; shall participate and provide input in the development of Recovery Oriented Systems of Care (ROSC) for the region and at local/county levels.

MSHN asks that provider partners identify a minimum of one representative to participate in MSHN-convened ROSC meetings. Participation can be defined as in person, by phone, videoconference, or connection through email list-serve.

Telemedicine

Telemedicine is the use of telecommunication technology to connect a patient with a health care professional in a different location. MDHHS requires a real time (synchronous) interactive system at both the originating and distant site, allowing instantaneous interaction between the patient and health care professional via the telecommunication system. Telemedicine should be used primarily when travel is prohibitive for the beneficiary or there is an imminent health risk justifying immediate medical need for services. MSHN does not support asynchronous (store and forward) telemedicine practices for this population. Providers must ensure the privacy of the beneficiary and the security of any information shared via telemedicine. The technology used must meet the needs for audio and visual compliance in accordance with current regulations and industry standards. Providers must have a contract with or be authorized by MSHN in order to provide allowable services via telemedicine. Refer to Section 17 of the Medicaid Provider Manual for more information on telemedicine. Refer to the PIHP/CMHSP Encounter Reporting document for a list of allowable telemedicine services codes and modifier requirements.

~~Please refer to the MSHN Coronavirus Disease FAQ Document found for further information on Telemedicine during the pandemic.~~

Transfer

Transfer is the movement of the client ~~post discharge~~ from one level-of-care service "to another level of care, program, provider, or facility." There is to be follow-up communication between the provider that is transferring the individual to another level of care, program, provider, or facility and the provider receiving the individual to ensure the individual timely reaches its referral destination for admission. Timely admission is defined according to MDHHS requirements. The provider receiving the individual is to notify the provider making the transfer referral when the individual being transferred is admitted, is a no show, or schedules another admission appointment. Such notification is to be made as agreed upon between the two programs, providers, or facilities and to keep within requirements.

Trauma Informed Care

A trauma-informed approach to behavioral health care shifts away from the view of "What's wrong with this person?" to a more holistic view of "What *happened* to this person?" This becomes the foundation on which to begin a healing recovery process. Employing a trauma-

informed approach creates a place of safety and mutual respect where a person's whole history can be considered. This enables trauma survivors and providers to work together to find the best avenues for healing and wellness. A program, organization, or system that is trauma-informed follows SAMHSA's four "Rs" by:

- *Realizing* the widespread impact of trauma and understands potential paths for recovery
- *Recognizing* the signs and symptoms of trauma in clients, families, staff, and others involved with the system
- *Responding* with fully integrated knowledge about trauma into policies, procedures, and practices
- Resisting *re-traumatization*

Acknowledging the high rate of trauma experienced by clients served, MSHN providers are expected to be trauma informed and to provide trauma informed care. It is the expectation of MSHN that all providers will complete the Trauma Informed Organizational Survey. Providers will develop and implement Trauma Informed goals annually, and provide feedback on progress of achieving those goals during the subsequent years annual planning process. Further information on the Trauma Informed Organizational Survey may be obtained from the MSHN Treatment team.

Trauma-Specific Services

Prevention, intervention, or treatment services that address traumatic stress as well as any co-occurring disorders that developed during or after trauma. SAMHSA's six principles of a trauma-informed approach and trauma-specific interventions are designed specifically to address the consequences of trauma and to facilitate healing. These principles include:

- *Safety*—Throughout the organization, staff and clients should feel physically and psychologically safe.
- *Trustworthiness and transparency*—Organizational operations and decisions are conducted with transparency and the goal of building and maintaining trust among staff, clients, and family members.
- *Peer support and mutual self-help*—Both are seen as integral to the organizational and service delivery approach and are understood as key vehicles for building trust, establishing safety, and empowerment.
- *Collaboration and mutuality*—There is true partnering between staff and clients and among organizational staff from direct care staff to administrators.
- *Empowerment, voice, and choice*—Throughout the organization, and among the clients served, individuals' strengths are recognized, built on, and validated, and new skills developed as necessary.
- *Cultural, historical, and gender issues*—The organization actively moves past cultural stereotypes and biases, considers language and cultural considerations in providing support, offers gender-responsive services, leverages the healing value of traditional cultural and peer connections, and recognizes and addresses historical trauma.

In addition to trauma-informed care, promoting recovery and resilience for those who have experienced traumatic events involves developing and implementing supports that specifically consider the event and trauma experienced. It also means examining ways to reduce re-

traumatization. Consistent with SAMHSA's working definition of recovery, trauma-informed services and supports build on consumer and family choice, empowerment, and collaboration.

Providers shall develop a trauma-informed system for all ages and across the services spectrum and shall ensure that the following essential elements are provided:

I. Adoption of trauma informed culture: values, principles and development of a trauma informed system of care ensuring safety and preventing re-traumatization:
   - Providers will ensure that all staff, including direct care staff, are trained/has ongoing training in trauma informed care.
   - Policies and procedures shall ensure a trauma informed system of care is supported and that the policies address trauma issues, re-traumatization and secondary trauma of staff.

II. Engagement in organizational self-assessment of trauma informed care

III. Adoption of approaches that prevent and address secondary trauma of staff:
   - Providers will adopt approaches that prevent and address secondary traumatic stress of all staff, including, but not limited to:
     i. Opportunity for supervision
     ii. Trauma-specific incident debriefing
     iii. Training
     iv. Self-care
     v. Other organizational support (e.g., employee assistance program).

IV. Screening for trauma exposure and related symptoms for each population:
   - Providers shall use a culturally competent, standardized and validated screening tool appropriate for each population during the intake process and other points as clinically appropriate.

V. Trauma-specific assessment for each population:
   - Providers shall use a culturally competent, standardized and validated assessment instrument appropriate for each population. Trauma assessment is administered based on the outcome of the trauma screening.

VI. Trauma-specific services for each population using evidence-based practice(s) (EBPs); or evidence informed practice(s) are provided in addition to EBPs:
   - Providers shall use evidence-based trauma specific services for each population in sufficient capacity to meet the need. The services are delivered within a trauma informed environment.

VII. Providers shall join with other community organizations to support the development of a trauma informed community that promotes behavioral health and reduces the likelihood of mental illness and substance use disorders:
   - Providers shall join with community organizations, agencies, community collaboratives (i.e., MPCBs) and community coalitions (i.e., Substance Abuse Coalitions, Child Abuse and Neglect Councils, Great Start Collaboratives, neighborhood coalitions, etc.) to support the development of a trauma informed community that promotes healthy environments for children, adults and their families.
   - Education on recovery and the reduction of stigma are approaches supported in a trauma informed community.
   - Substance abuse prevention programming is provided using a SAMHSA approved, evidence based and trauma informed approach.

(Medicaid Managed Specialty Supports and Services Program FY20 Amendment #1, MDHHS Trauma Policy, Attachment 7.10.6.1)

Veteran Services

MSHN ~~has~~employs a Veteran Navigator whose role is to facilitate access to services for incoming clients who currently or in the past served in one of the branches of the U.S. Military and their families. Upon identification of a client who is serving or has served in the U.S. Armed Forces, the client should be given contact information of how to reach the Veteran Navigator:

Michael Scott, Veterans Navigator
Michael.Scott@midstatehealthnetwork.org
517.483.2742

MSHN's Veteran Navigator is available as a resource to network providers if they have questions regarding a client's eligibility for services. The Veteran Navigator is also available to present Military Cultural Competency trainings to network providers to help improve access for this population. This training will help providers to better understand the unique barriers that veterans and military personnel face when accessing services. Call or email our Veteran Navigator if you would like to schedule a training for your organization.

Please also refer to Appendix B, *Veteran's Eligibility Technical Requirement*, for full documentation on determining service coordination options for Veterans in the MSHN region. MSHN expects veterans, service members, and military families within its 21 counties to be able to access SUD services. Providers should note that a client's service in the military does not automatically mean they receive Veteran's Affairs (VA) benefits. Providers should, however, work with clients to ensure VA benefits are used as primary insurance, *if available*.

Warm Transfer

Warm transfer is a process to ensure a caller is connected to a live representative at another location to best provide an answer to the access to treatment requests of the caller. It entails allowing the caller to express his/her situation and circumstances to determine as not urgent or emergent and then warm transferring the call. Emphasis is on engaging the individual to create a bond and ensure a safety check. This requires open communication and ~~teamwork;~~teamwork, avoiding communication breakdown.

Once the caller's situation is determined to be non-urgent or non-emergent, the representative receiving the call is to ask the caller if it is okay to transfer him/her and explains the reasoning for the transfer. This allows the caller to understand he/she is not just being passed off to someone else but builds trust with a positive experience for the caller. The representative receiving the call connects the caller to a live representative to assist the individual in explaining what the individual is seeking. Warm transfer means an individual caller encounters no telephone "trees," and is not put on hold or sent to voicemail until he/she has spoken to a live representative from the access system.

"For non-emergent calls, a person's time on-hold awaiting a screening must not exceed three minutes without being offered an option for callback or talking with a non-professional in the

interim." If the caller's situation is a crisis or emergent, the caller is immediately transferred to a qualified practitioner without requiring the individual to call back."

Transfer

Transfer is the movement of the client post discharge from one level-of-care service "to another level of care, program, provider, or facility." There is to be follow-up communication between the provider that is transferring the individual to another level of care, program, provider, or facility and the provider receiving the individual to ensure the individual timely reaches its referral destination for admission. Timely admission is defined according to MDHHS requirements. The provider receiving the individual is to notify the provider making the transfer referral when the individual being transferred is admitted, is a no show, or schedules another admission appointment. Such notification is to be made as agreed upon between the two programs, providers, or facilities and to keep within requirements.

Group Therapy

According to SAMHSA TIP 41, *Substance Abuse Treatment: Group Therapy*, group therapy is therapeutic for treating substance use disorders and reducing isolation. Groups organized around therapeutic goals provide insight and guidance, enable individuals to observe others' recovery and create a culture that supports healing and recovery.

TIP 41 introduces five group models that are used in substance use disorder treatment: psycho-educational, skills development, cognitive-behavioral, support, and interpersonal process.

1. Psychoeducational groups educate clients about substance abuse;
2. Skills development groups cultivate skills needed to attain and sustain abstinence; cultivate skills needed to attain and sustain abstinence;
3. Cognitive-behavioral groups alter thoughts and actions leading to substance abuse;
4. Support groups provide a forum to share pragmatic information about maintaining abstinence and managing day-to-day, chemical-free life; and
5. Interpersonal process groups delve into major developmental issues that contribute to addiction or interfere with recovery. TIP 41 reflects that resources, training and theoretical orientation of group leaders, and the needs and desires of clients is to be considered when determining the most appropriate group model. The challenge is matching the individual to the group model for maximum benefit.

Outpatient Treatment Continuum of Services Treatment Policy #9 defines the minimum in group therapy as face-to-face interventions with three or more clients, which includes therapeutic interventions/counseling. MSHN recommends no more than 15 members to a group to allow participants to feel heard and understood, for the leader to know each of them, and for members to feel a sense of connection and belonging to the group. The exception to the cap of 15 members is for skills development groups where 8-10 members is recommended to allow members to practice new skills and Cognitive-Behavior groups which should be 3-10 members.

Therapeutic Yoga: Yoga is not a replacement for a program of addiction recovery, but an adjunct. The word Yoga means "union", according to the Hazelden Betty Ford Institute article, Yoga and Addiction Recovery. By focusing on and controlling breath through yoga, the mind-body system relaxes and moves toward healing, recovery, and wholeness, which is lost in active addiction. Yoga helps prevent relapse, reduce withdrawal symptoms and drug cravings, and

provide a healthy outlet to cope with potential triggers and daily life stressors. According to the Office of Recovery Oriented Systems of Care (OROSC), when yoga is offered as a therapeutic practice and the development of an appropriate coping mechanism to help prevent relapse, this practice is allowed. The treatment plan is to reflect the therapeutic intervention for every client that participates in therapeutic yoga. The focus of the group is to be comprised mostly of therapeutic verbal conversation and processing; not just yoga itself. It is preferred that an instructor with trauma experience or qualifications provides the therapeutic yoga, however, if one cannot be found, a staff person is able to participate along with the yoga instructor and talk to participants about times when yoga may be helpful, used as a coping mechanism, de-stressing mechanism, sharing the experience with their kids, etc. If therapeutic yoga is provided in residential treatment, it is bundled into the per diem. If therapeutic yoga is provided in an outpatient service, it could be coded as 90853 or H0005, depending on the credentials of the counselor/therapist who is co-facilitating.

Individualized Treatment Planning

Per Treatment Policy #6, there are two key requirements of individualized treatment plans. First, to be individualized, "treatment and recovery planning requires [the provider's] understanding that each client is unique and each plan must be developed based on the individual needs, goals, desires, and strengths of each client." Second, client participation and engagement in the treatment planning process is critical: "Treatment and recovery plans must be a product of the client's active involvement and informed agreement. Direct client involvement in establishing the goals and expectations for treatment is required to ensure appropriate level of care determination, identify true and realistic needs, and increase the client's motivation to participate in treatment."

MSHN's expectation for Treatment Plan timelines are as follows:

Outpatient: initial treatment plan will be completed by the third (3rd) session with the client. Periodic Review of outpatient treatment plans should be within 90 days, but for more intensive services (e.g. IOP) and/or based on higher intensity client needs, more frequent reviews are required.

Residential/Withdrawal Management: Initial Treatment Plans are due within three (3) days of the initiation of treatment services (3 calendar days or 72 hours, not 3 business days). Periodic review of residential/withdrawal management treatment plans should take place every seven (7) days for residential/withdrawal management services.

Evidence-Based Practices

MSHN requires all SUD treatment providers to document and provide evidence-based programs for their services. Treatment providers must demonstrate knowledge and competencies in practice relevant to service provision. Each provider is monitored at least annually with regular site visits to verify that the evidence-based programs are being provided and that staff and clinicians have the requisite training and qualifications for the practices in which they are engaging clients. Evidence-based practices may include motivational interviewing, trauma-informed care and positive behavioral supports. Recognizing the stages of change for persons recovering from SUD is an important component of evidence-based service provision. Providers should take steps to ensure fidelity to evidence-practice models, including sustaining fidelity when valid models and/or program staffing changes occur, which may require new training or

credentials in maintaining integrity of clinical service provision. MSHN reserves the right to endorse evidence-based practices in use by funded provider programs.

Co-Occurring Mental Health and Substance Abuse Disorders

Dual Diagnosis Capable (i.e. co-occurring capable) refers to an ASAM category of addiction treatment programs that accommodate individuals with mental health disorders that are mild to moderate in severity. These programs address co-occurring disorders (COD) in policies, procedures, assessment, and programming.

- Providers are expected to screen all consumers for co-occurring mental health and substance use disorders, at the point of access and throughout treatment.
- MSHN will provide continuous, comprehensive and individualized services to individuals with substance use and mental health disorders in a coordinated or integrated manner.
- MSHN provider programs will demonstrate competency in the provision of services for those who have co-occurring conditions.
- Acknowledging the high rate of co-occurrence of mental health and SUD symptoms, MSHN providers are expected to be co-occurring capable. It is the expectation of MSHN that all providers will complete the Dual Diagnosis Capability in Addiction Treatment (DDCAT) self-scoring assessment, and provide supporting documentation for each indicator. Providers will develop and submit DDCAT goals annually. Further information on the DDCAT process may be obtained from the MSHN Treatment team.

Trauma Informed Care

A trauma-informed approach to behavioral health care shifts away from the view of "What's wrong with this person?" to a more holistic view of "What *happened* to this person?" This becomes the foundation on which to begin a healing recovery process. Employing a trauma-informed approach creates a place of safety and mutual respect where a person's whole history can be considered. This enables trauma survivors and providers to work together to find the best avenues for healing and wellness. A program, organization, or system that is trauma-informed follows SAMHSA's four "Rs" by:

- *Realizing* the widespread impact of trauma and understands potential paths for recovery
- *Recognizing* the signs and symptoms of trauma in clients, families, staff, and others involved with the system
- *Responding* with fully integrated knowledge about trauma into policies, procedures, and practices
- Resisting *re-traumatization*

Acknowledging the high rate of trauma experienced by clients served, MSHN providers are expected to be trauma informed and to provide trauma informed care. It is the expectation of MSHN that all providers will complete the Trauma Informed Organizational Survey. Providers will develop and submit Trauma Informed goals annually. Further information on the Trauma Informed Organizational Survey may be obtained from the MSHN Treatment team.

Trauma-specific services

Prevention, intervention, or treatment services that address traumatic stress as well as any co-occurring disorders that developed during or after trauma. SAMHSA's six principles of a trauma-

informed approach and trauma-specific interventions are designed specifically to address the consequences of trauma and to facilitate healing. These principles include:

- *Safety*—Throughout the organization, staff and clients should feel physically and psychologically safe.
- *Trustworthiness and transparency*—Organizational operations and decisions are conducted with transparency and the goal of building and maintaining trust among staff, clients, and family members.
- *Peer support and mutual self-help*—Both are seen as integral to the organizational and service delivery approach and are understood as key vehicles for building trust, establishing safety, and empowerment.
- *Collaboration and mutuality*—There is true partnering between staff and clients and among organizational staff from direct care staff to administrators.
- *Empowerment, voice, and choice*—Throughout the organization, and among the clients served, individuals' strengths are recognized, built on, and validated, and new skills developed as necessary.
- *Cultural, historical, and gender issues*—The organization actively moves past cultural stereotypes and biases, considers language and cultural considerations in providing support, offers gender-responsive services, leverages the healing value of traditional cultural and peer connections, and recognizes and addresses historical trauma.

In addition to trauma-informed care, promoting recovery and resilience for those who have experienced traumatic events involves developing and implementing supports that specifically consider the event and trauma experienced. It also means examining ways to reduce re-traumatization. Consistent with SAMHSA's working definition of recovery, trauma-informed services and supports build on consumer and family choice, empowerment, and collaboration.

Providers shall develop a trauma-informed system for all ages and across the services spectrum and shall ensure that the following essential elements are provided:

- Adoption of trauma informed culture: values, principles and development of a trauma informed system of care ensuring safety and preventing re-traumatization:
  - The PIHP will develop and support a Quality Improvement committee with representatives from children, adult, SUD, I/DD services and consumers. The committee's primary focus is to ensure the building and maintaining of trauma informed care within the PIHP's direct service operations and its network providers.
  - Providers will ensure that all staff, including direct care staff, are trained/has ongoing training in trauma informed care.
  - Policies and procedures shall ensure a trauma informed system of care is supported and that the policies address trauma issues, re-traumatization and secondary trauma of staff.
- Engagement in organizational self-assessment of trauma informed care:
  - The PIHP Quality Improvement committee conducts an organizational self-assessment to evaluate the extent to which current agency's policies are trauma-informed, identify organizational strengths and barriers, including an environmental scan to ensure that the environment/building(s) do(es) not re-traumatize. To be updated every three years.

- Adoption of approaches that prevent and address secondary trauma of staff (See Exhibit A):
  - Providers will adopt approaches that prevent and address secondary traumatic stress of all staff, including, but not limited to:
  - Opportunity for supervision
  - Trauma-specific incident debriefing
  - Training
  - Self-care
  - Other organizational support (e.g., employee assistance program).
- Screening for trauma exposure and related symptoms for each population:
  - Providers shall use a culturally competent, standardized and validated screening tool appropriate for each population during the intake process and other points as clinically appropriate.
- Trauma-specific assessment for each population:
  - Providers shall use a culturally competent, standardized and validated assessment instrument appropriate for each population. Trauma assessment is administered based on the outcome of the trauma screening.
- Trauma-specific services for each population using evidence based practice(s) (EBPs); or evidence informed practice(s) are provided in addition to EBPs:
  - Providers shall use evidence-based trauma specific services for each population in sufficient capacity to meet the need. The services are delivered within a trauma informed environment.
- Network providers shall join with other community organizations to support the development of a trauma informed community that promotes behavioral health and reduces the likelihood of mental illness and substance use disorders:
  - Providers shall join with community organizations, agencies, community collaboratives (i.e., MPCBs) and community coalitions (i.e., Substance Abuse Coalitions, Child Abuse and Neglect Councils, Great Start Collaboratives, neighborhood coalitions, etc.) to support the development of a trauma informed community that promotes healthy environments for children, adults and their families.

  - Education on recovery and the reduction of stigma are approaches supported in a trauma informed community.
  - Substance abuse prevention programming is provided using a SAMHSA approved, evidence based and trauma informed approach.

(Medicaid Managed Specialty Supports and Services Program FY20 Amendment #1, MDHHS Trauma Policy, Attachment 7.10.6.1)

Cultural Competency

The Federal Register provides National Standards for Culturally and Linguistically Appropriate Services. It is critical that MSHN provider network members strive toward cultural competency for all persons from diverse cultural backgrounds in our communities who need to access SUD treatment and prevention services. Cultural response includes removing barriers and embracing differences, in order to offer safe and caring environments for all who are in need of services.

Cultural competency can be defined as a set of values, behaviors, attitudes, and practices within a system, organization, and program, or among individuals which enables them to work effectively cross-culturally. Further, it refers to the ability to honor and respect the beliefs (including religious), language, interpersonal styles and behaviors of individuals and families receiving services, as well as staff who are providing such services. Cultural competence is a dynamic, ongoing, developmental process that requires a long-term commitment and is achieved over time, according to the National Center for Cultural Competency.

It is the expectation that each SUD prevention/treatment provider will have applicable policies and training of staff relative to cultural competency and available to MSHN for review, including governance and practitioners providing treatment. MSHN expects that providers will demonstrate training competencies to support a diverse population of clients served and seek to establish a diverse workforce to meet client needs. MSHN will endorse a variety of methods to help ensure cultural competency, including recognition in the regional strategic plan and other support as indicated.

Assessment tools and/or methods used must be culturally sensitive, reliable, and validated, whenever possible, for use with racial and ethnic minorities. Service/support/treatment plans and discharge plans must incorporate the natural supports and strengths specific to the racial and ethnic background of the client, family, community, faith-based, and self-help resources. Prevention, education and outreach efforts will include linkages with racial, ethnic, and cultural organizations throughout the community

Prohibition on Provision of Hypodermic Needles

Providers will assure that no federal or state funds will be used to provide consumers with hypodermic needles or syringes enabling such consumers to use illegal drugs.

Integrated Coordination of Care

MSHN expects providers will collaborate and coordinate services with other care providers as appropriate after completing a comprehensive assessment of needs.

MSHN also expects SUD treatment providers to coordinate care with a consumer's previous and current behavioral health treatment providers. Coordination of care should include the consumer's primary care physician (PCP) and if the consumer does not have one, efforts should be made to link the consumer to a PCP wherever possible. Providers should maintain documentation of coordination of care between other behavioral health care providers and physical health care providers.

Coordination of care is expected to occur with every client and will be comprehensive and based on the client's individual needs. It may include, but is not limited to; legal, dental, transportation, education, employment, and any other areas of need.

Early Intervention – Treatment (ASAM Level 0.5)

MSHN adheres to the recommendations as described in the OROSC *Treatment Technical Advisory #09: Early Intervention.* Licensure as an Early Intervention program is required as well as a State determination of appropriate ASAM Level(s).

The ASAM Criteria; 3rd Edition defines Early Intervention as "an organized service that may be delivered in a wide variety of settings. Early intervention services are designed to explore and address problems or risk factors that appear to be related to substance use and addiction behavior, and to help the individual recognize the harmful consequences of high risk substance use and/or addictive behavior."

Early Intervention services should be short-term and may indicate a need for the individual to enter a new level of care. Early intervention services may be provided in individual or group modalities, and may be office or community based.

Outpatient Services (ASAM Levels 1 and 2)

MSHN adheres to the requirements as described in OROSC's *Treatment Policy #09: Outpatient Treatment Continuum of Services.* Licensure as an Outpatient program is required as well as a State determination of appropriate ASAM Level(s).

Outpatient and Intensive Outpatient SUD treatment services are organized levels of care which may be delivered in a wide variety of settings where addiction treatment staff provide professionally-directed screening, evaluation, treatment, and ongoing recovery and disease management services.

Such services are provided in regularly scheduled sessions of:

- Outpatient: Fewer than nine contact hours per week of structured programming for adults, and fewer than six hours per week for adolescents.
- Intensive Outpatient: Nine to nineteen hours of structured programming for adults, and six to nineteen hours for adolescents.

The services follow a defined set of policies and procedures or clinical protocols. Individual, couple, group, and family therapy are common modalities appropriate for SUD outpatient care. Outpatient treatment is the level of care with the least amount of restriction, so it is important that clients are able to maintain a degree of safety outside of services.

Case Management

MSHN adheres to the requirements as described in OROSC's *Treatment Policy #08: Substance Abuse Case Management Program Requirements.* Licensure as an Outpatient program is required with a Case Management designation.

Case Management (CM) services are those services which will assist clients in gaining access to needed medical, social, educational/vocational and other services. CM services can help establish a stronger foundation for a client's long-term recovery for those who have addictive disorders by assuring they have access to all needed services. For complete guidance on case management services, please see Appendix D and Appendix E.

Recovery Oriented Systems of Care

ROSC Participation: MSHN will continue leading the journey of transformational system change to build a better, more Recovery Oriented Systems of Care (ROSC) in the region. This systems change will be inclusive and a long-term process that will entail changes not only for PROVIDERs of services and supports but for all parts of the system including fiscal, policy,

regulatory and administrative strategies. MSHN wants to ensure that this process represents a broad range of stakeholder viewpoints.

a. Providers will act consistent with collaboration and cooperation of efforts in order to effect positive change in communities/counties.

b. Providers support a process of community change that engages critical thinking and collaboration with community partners.

c. Providers support a continuum of improved health and functioning in which there are a variety of diverse roles for all involved to provide input. These roles include prevention and treatment PROVIDERS, peer support specialists, community-based support services, and others.

Therefore, all PROVIDER partners shall engage in this process; shall participate and provide input in the development of Recovery Oriented Systems of Care (ROSC) for the region and at local/county levels.

MSHN asks that PROVIDER partner identify a minimum of one representative to participate in MSHN-convened ROSC meetings. Participation can be defined as in person, by phone, videoconference, or connection through email list-serve.

Peer Recovery/Recovery Support Services

MSHN adheres to the recommendations described in OROSC's *Treatment Technical Advisory #7: Peer Recovery/Recovery Supports* and MSA Bulletin 17-45. Licensure as an Outpatient program is required with a Peer Recovery designation, or a CAIT license with a Peer Recovery designation.

Recovery support services will be available to all qualifying clients entering SUD treatment services. This does not necessarily mean every provider in the network has to have a direct-operated peer recovery/recovery support services component.

Peer recovery/recovery support services do not include therapy or other clinical services, ongoing transportation to regular appointments, and/or participation in activities that might jeopardize the coach's own recovery.

Persons employed to provide peer recovery/recovery support services as a Qualified Peer Specialist must meet requirements as outlined in the Medical Services Bulletin MSA 17-45, effective January 1, 2018, in order to bill under Medicaid and/or Healthy Michigan. Persons not meeting the requirements of the MSA-17-45, may still be billable for services to Block Grant or PA2 funding sources.

For group treatment services:

- Didactic/educational groups shall not exceed 15 individuals.

Note: MSHN highly discourages agencies/organizations from hiring or assigning staff to dual roles – either therapists as recovery coaches or recovery coaches in a therapeutic role. This

can be very confusing for both client and recovery coach and can diminish the role of peer recovery/recovery support services.

Withdrawal Management/Detoxification (ASAM Level 3.2-WM and 3.7-WM)

MSHN adheres to the recommendations described in OROSC's *Treatment Policy #13: Withdrawal Management Continuum of Services.* Licensure as a Withdrawal Management program is required.

Sub-acute withdrawal management is part of a continuum of care for substance use disorders and does not constitute the end goal in the treatment process. The withdrawal management process consists of three essential components: evaluation, stabilization, and fostering client readiness for, and entry into, treatment. A withdrawal management process that does not incorporate all three components is considered incomplete and will not be meeting MSHN expectations for this service.

- Sub-acute withdrawal management will be authorized as part of a planned SUD treatment episode, with the clinical pathway detailed in the authorization of services and explained to the client prior to admission into detoxification services.
- The sub-acute withdrawal management provider will facilitate and obtain follow up for the client's transfer to the next level of care.
    - Follow up involves the communication between the sub-acute withdrawal management provider and the provider receiving the individual to ensure the individual is timely admitted to its referral destination. Timely is defined according to the MDHHS requirement whereby the individual is admitted to the provider receiving the individual post discharge from a sub-acute withdrawal management provider within the required number of calendar days.
    - The provider receiving the individual is to notify the sub-acute withdrawal management provider when the individual being transferred is admitted, is a no show, or schedules another admission appointment.
- The sub-acute withdrawal management provider is to provide a safe withdrawal from the drug(s) of dependence.
- The sub-acute withdrawal management is to be provided in a supportive environment, with caring staff, sensitivity to cultural issues, confidentiality, and selection of appropriate withdrawal management medication (if needed) in order to be sure that the withdrawal is humane and protects the client's dignity.
- The sub-acute withdrawal management provider is to prepare the client for ongoing treatment of his/her SUD by emphasizing withdrawal management as one phase of SUD treatment, not a treatment modality by itself. Withdrawal management is an opportunity to offer clients information and to motivate them for longer term treatment.

Pregnant Women in Detox: Pregnant women (IDU or not) need to be offered admission into withdrawal management services within twenty-four (24) hours after the initial screening. It is **highly recommended** pregnant women whose primary drug(s) of choice are alcohol, benzodiazepines, and/or barbiturates (Sedatives-Hypnotics) be referred to an acute care medical hospital where the stress of withdrawal on the pregnancy will be appropriately monitored until her need for withdrawal management while pregnant is no longer needed.

REQUIREMENT: All clients entering residential withdrawal management must be tested for TB upon admission. With respect to clients who exhibit symptoms of active TB, policies and procedures must be in place to avoid a potential spread of the disease. These policies and procedures must be consistent with the Centers for Disease Control (CDC) guidelines and/or communicable disease best practice.

Medication Assisted Treatment (MAT)

MSHN adheres to requirements described in all OROSC policies related to MAT. Detail regarding the state and federal regulations and MSHN's expectations regarding MAT are in Appendix C of this manual. Licensure as an Outpatient-Methadone program is required as well as a State determination of appropriate ASAM Level(s).

Medication Assisted Treatment (MAT) is a standard of care that is broadly recognized as an essential pillar in any comprehensive approach to the national opioid addiction and overdose epidemic. MSHN seeks to ensure that no consumer is denied access to or pressured to reject the full-service array of evidence-based and potentially life-saving treatment options, including MAT, that are determined to be medically necessary for the individualized needs of that consumer.

Following the recommendations by SAMHSA, the Centers for Disease Control and Prevention (CDC), the ASAM, the National Institute for Drug Abuse (NIDA*), MDDHS's OROSC Treatment Policies #5 and #6*, and other state and national directives, MSHN requires of its substance use disorder (SUD) Treatment Provider Network that no MSHN client is denied access to or pressured to reject the full service array of evidence-based and potentially life-saving treatment options, including Medication Assisted Treatment (MAT), that are determined to be medically necessary for the individualized needs of that client. Per SAMHSA, exclusion of clients who are on MAT may be a violation of the Americans with Disabilities Act (ADA) and/or the Rehabilitation Act of 1973. Please reference the SAMHSA brochure here called "Know Your Rights: Rights for Individuals on Medication-Assisted Treatment."

MSHN-contracted SUD treatment providers are expected to adopt a MAT-inclusive treatment philosophy in which 1) the provider demonstrates willingness to serve all eligible treatment-seeking individuals, including those who are using MAT as part of their individual recovery plan at any stage of treatment or level of care, and without precondition or pressure to adopt an accelerated tapering schedule and/or a mandated period of abstinence, 2) the provider develops policies that prohibit disparaging, delegitimizing, and/or stigmatizing of MAT either with individual clients or in the public domain.

MSHN adheres to the *MDHHS Medication Assisted Treatment Guidelines for Opioid Use Disorders.* It is a MSHN expectation that each medication assisted treatment (MAT) provider offers all medication approved and available for Opioid Use Disorders (OUD).

Abstinence-Based (AB) Providers: In the interest of consumer choice, MSHN will contract with Abstinence-Based providers who offer written policies and procedures stating the following:

- If a prospective client, at the point of access, expresses his/her preference for an abstinence-based treatment approach, the access worker will obtain a signed "MSHN Informed Consent" form (See Appendix E) that attests that the client was informed in an

objective and non-judgmental way about other treatment options including MAT, and attest that the client is choosing an abstinence-based provider from an informed perspective. This includes the client's acknowledgement of receipt of MSHN's informational handout/grid titled "Recovery Pathways for Opioid Use Disorder." (See Appendix F).

- When a client already on MAT (or considering MAT) is seeking treatment services (counseling, case management, recovery supports, and/or transitional housing) at the point of access to an AB facility, access staff a) will be accepting and non-judgmental towards MAT as a choice, b) will not pressure the client to make a different choice, and c) will work with that client to do a "warm handoff" to another provider who can provide those ancillary services while the client pursues his or her chosen recovery pathway that includes MAT.
- Providers' policies will include language that prohibits delegitimizing, and/or stigmatizing of MAT (e.g. using either oral or written language that frames MAT as "substituting one addiction for another") either verbally with individual clients, in written materials for clients or for public consumption, or in the public domain.

A consensus statement in support of inclusion was endorsed by all ten PIHP's on November 1, 2017.

For group treatment services:

- Therapeutic groups shall not exceed 12 individuals.
- Didactic/educational groups shall not exceed 15 individuals.

Residential Services (ASAM Level 3)

MSHN adheres to the requirements of *BHDDA Treatment Policy #10: Residential Treatment Continuum of Services*. Licensure as a residential program is required as well as a State determination of appropriate ASAM Level(s).

Residential services are no longer delineated between "short-term" and "long-term" residential, but reflect the current ASAM Levels of 3.1 Clinically Managed Low-Intensity Residential Services, 3.3 Clinically Managed Population-Specific Residential Services, 3.5 Clinically Managed High-Intensity Residential Services, and 3.7 Medically Monitored High-Intensity Inpatient Services. Each MSHN residential services provider is expected to have a specific destination for one (or more) of these levels from the Michigan BHDDA. MSHN is expected to have the capacity to provide a residential continuum that will meet the needs of clients at ASAM Levels 3.1, 3.3, 3.5, and 3.7.

In addition to the requirements of *BHDDA Treatment Policy #10: Residential Treatment Continuum of Services* MSHN maintains the following expectations of its contracted residential treatment providers:

- Utilize screening and assessment practices designed to connect individuals seeking residential treatment to the appropriate ASAM level of care for their needs, not simply seeking a "first available" admission date. ** NOTE: MDHHS maintains a current database of state-approved ASAM designations for SUD providers on their website, located here.*

- If a potential client contacts a residential provider for services but that residential provider is not designated to provide the ASAM level of care the person needs, it is the provider's responsibility to actively assist the person with a referral to a different provider that offers the correct level of care. A "referral" is defined as a warm handoff, whenever possible, not just providing the individual with phone numbers to call.

- Providers are expected to offer treatment that is flexibly staged with variable length of stay. Length of stay should always be determined by individual client need, medical necessity, and ASAM criteria, **not** pre-determined time frames ("21-Day program", "30-Day program", "Long-term" treatment, etc). Flexibly staged treatment adapts with the changing needs of the client such as increasing/decreasing the number of treatment hours per week and matching treatment modalities to the client's unique needs. Flexibly staged treatment is client care driven as opposed to agency process driven.

- Additionally, length of stay should not be driven by funding expectations. MSHN uses concurrent and retrospective utilization practices with regard to residential treatment services; residential services are not pre-authorized. Treatment providers should not discharge clients in the event a re-authorization request has not been reviewed or approved by the MSHN utilization management department. Providers should ensure that their own prospective (i.e. eligibility) practices are sounds in determining appropriate level of care to ensure that authorization requests are reviewed without any problems.

- Residential treatment providers should actively assist clients with continuing care planning and are expected to coordinate care with the continuing care provider. This includes but is not limited to: assist the client with scheduling the first appointment following discharge from residential treatment, secure a signed release of information and send the residential discharge summary to the identified continuing care provider.

- In the event that a client is absent from treatment for more than 24 hours, a note needs to be generated in REMI.

- Staff providing direct clinical services within a residential program need to be appropriately credentialed and licensed based on the services they provide.

Recovery Housing

Per the *MDHHS Technical Advisory #11: Recovery Housing*, recovery housing providers must have a CAIT license. *MDHHS Technical Advisory #11* can be found on the MSHN Website: Provider Network→Provider Resources→Provider Resources. Recovery housing providers are also expected to follow the standards outlined in the National Alliance for Recovery Residences (NARR) – Domains, Core Principles, and Standards document found here. MSHN requires providers to obtain and maintain certification from Michigan Association of Recovery Residences (MARR).

MSHN's Recovery Housing technical requirement is available in Appendix F of this manual.

Women's Specialty Services

MSHN adheres to the requirements and recommendations made by OROSC in the following Treatment Policies and Treatment Technical Advisory: *Treatment Policy #11: Fetal Alcohol*

Spectrum Disorders; Treatment Policy #12: Women's Treatment Services; and, Technical Advisory #8: Enhanced Women's Services.

Women's Specialty Services (WSS) may only be provided by providers that are designated as gender-responsive by MDHHS or as gender-competent by MSHN. Approved WSS providers must meet standard panel eligibility requirements in compliance with *MDHHS Treatment Policy #12: Women's Treatment Services*. Approved Enhanced WSS providers must meet standard panel eligibility requirements in compliance with *MDHHS Technical Advisory #8: Enhanced Women's Services.*

Federal requirements are contained in 45 CFR (Part 96), section 96.124.

Additionally, WSS is to be gender competent. Gender competence can be a characteristic of anything from individual knowledge and skills, to teaching, learning and practice environments, literature and policy. Wherever present, gender competence promotes equality in treatment and outcomes for men and women.

Providers must have policies/procedures in place that require additional training for communicable disease screening, referral, and treatment.

Providers must have policies/procedures in place that require appropriate methods for neo-natal substance use exposure screening and referral.

Jail-Based Services

This section applies to providers whose service delivery extends to providing SUD treatment in a jail setting.

Jail-based SUD treatment can be an important aspect for an individual's rehabilitation process and with that in mind, MSHN will provide, when available, SUD treatment services to those who meet eligibility criteria.

However, providing SUD treatment services within the jail setting has barriers and complications relating specifically to it being provided in the jail. The provider has no control over client availability and knowledge of the actual release due to the jail's capacity. With MSHN's understanding of the barriers and complications involved, the following guidelines should be utilized when providing services to incarcerated clients:

- The SUD treatment provider will assess the client when the client presents for services and begin the process of developing a treatment plan for post-jail. Jail-based services are based on the individual's medical necessity for SUD services.
- Each client will have an individual assessment, treatment plan, and intake completed (there will be no "group intakes").
- All clients receiving services while incarcerated will have a referral made to a SUD provider in their respective county of residence, with an appointment date and time that is scheduled close to the next business day following their release date. Since there will be a possibility of clients being released early, clients are to have all the necessary referral information as soon as possible to be able to schedule an appointment themselves after early release.

- It is an expectation of MSHN if clients are released from jail early, every attempt will be made by the provider of jail-based services to contact the clients to help ensure a successful transition to their community SUD treatment provider is made. The attempts to contact the client should be documented in the clients file.
- The provider of jail-based services will secure a release to both the receiving provider and the client's home region, if not MSHN.
- All appointment dates and times will be documented in the REMI system for each client in his/her discharge summary. A note will be made in the discharge note section of the discharge summary in REMI stating if the client was released early.
- The provider of jail-based services will ensure that each client that receives any jail-based services will have documentation in REMI for the services.

For group treatment services:

- Therapeutic groups shall not exceed 12 individuals.
- Didactic/educational groups shall not exceed 15 individuals.

Discharge Planning

MSHN requires that effective discharge planning will be provided for clients, and that follow-up services meet contractual and regulatory requirements.

Discharge Planning is considered an integral part of SUD treatment. Consideration of the continuum of care and long-term recovery needs of the client will be considered at every step of treatment planning. Discharge planning provides improvements to the quality of care and improves outcomes and controls cost, by assuring coordination and collaboration with mental health, SUD and other health providers to fully address the needs of the client. It is critical that all providers and organizations serving a client act together to develop an integrated health aftercare plan and then implement this ongoing aftercare plan in an environment that eliminates barriers and duplication of services.

Discharge Planning will occur according to best practices and the provider organizations' admission and discharge policies:

- A review of a client's discharge plan for all levels of care will be completed to ensure that appropriate follow-up care is arranged for those ending treatment.
- A written discharge plan will be prepared to ensure continuity of service and will be distributed to parties involved to carry out the plan.
- The MSHN contracted provider network will ensure that all clients are appropriately discharged from their care, including entering a discharge into REMI.
- Aftercare services are incorporated into the treatment plan, and needs are identified and addressed in the discharge plan.
- Follow up SUD treatment services from a detox and or residential facility will be completed not more than seven (7) days after discharge.
- Consumer satisfaction surveys should be distributed to the clients at discharge.

Veteran Services

MSHN has a Veteran Navigator whose role is to facilitate access to services for incoming clients who currently or in the past served in one of the branches of the U.S. Military. Upon

identification of a client who is serving or has served in the U.S. Armed Forces, the client should be given contact information of how to reach the Veteran Navigator:

Michael Scott, Veterans Navigator
Michael.Scott@midstatehealthnetwork.org
517.483.2742

Please also refer to Appendix B, *Veteran's Eligibility Technical Requirement*, for full documentation on determining service coordination options for Veterans in the MSHN region. MSHN expects veterans, service members, and military families within its 21 counties to be able to access SUD services. Providers should note that a client's service in the military does not automatically mean they receive Veteran's Affairs (VA) benefits. Providers should, however, work with clients to ensure VA benefits are used as primary insurance, *if available*.

Gambling Disorder Protocol

Gambling disorders (GD) frequently are co-occurring with substance use disorders. Nationally representative samples suggest more than half of all individuals with a GD have co-occurring mood, anxiety or substance use disorders. Additional evidence suggests that problem gamblers with co-occurring mood and anxiety disorders use gambling as a way to cope with symptoms of those disorders. Additional evidence shows that, at least among consumers of substance abuse treatment, rates of gambling problems are quite high.

Gambling Disorder Screening: At designated times, during the course of providing treatment, MSHN contracted SUD Treatment providers will be prompted by the REMI system to administer a gambling disorder screening, assessment, and referral:

During Admissions process:

1. Administer the three-question GD screen, the NODS-CLiP.
2. Results of the NODS-CLiP screen must be documented and made available to MSHN in a format to be provided by MSHN.
3. If the screen is positive for GD, PROVIDER will administer the 9-question NODS-SA assessment. The assessment outcome must be documented and made available to MSHN in a format to be provided by MSHN with either a "rule out" of GD or a diagnosis of gambling disorder.

During Treatment Planning process and ongoing during treatment:

1. If there is a GD diagnosis, PROVIDER shall add a goal to the treatment plan regarding the GD diagnosis.
2. Provider shall make a referral to the Gambling Disorder Helpline.
3. Progress notes following a referral to the Helpline should document reflect ongoing check-in regarding GD with the consumer to encourage follow-through with the Helpline and to discuss parallels and differences in their addictions to gambling and to substances.

At Discharge:

1. At discharge, providers need to report the following to MSHN: "If a GD diagnosis was identified at admission: 1) Was a GD goal added to the TX plan? 2) Was consumer

referred to the GD Help-Line?" 3) If consumer was transferred to a different provider/LOC, did coordination of care include submission of the treatment plan with GD goal(s) to the next provider?"

Transportation

MSHN strives to reduce transportation barriers to accessing SUD treatment and recovery services, using the best quality, consumer-friendly, cost-efficient means possible. Transportation services are not a guaranteed benefit and are limited by the availability of Substance Abuse Block Grant funding during each fiscal year. Transportation needs must be identified during the screening and assessment process and clearly documented within the consumer's individualized treatment plan. If transportation needs arise during the course of a treatment episode, documentation of the need must be included in the consumer chart (i.e.: progress note, treatment plan review, recovery , etc.) and it must be included on an amended treatment or recovery plan. The treatment or recovery plan must include goals related to helping the consumer reduce barriers to transportation, and must promote consumer self-sufficiency and empowerment.

MSHN's Transportation Technical Requirement is available in Appendix G of this manual.

REMI

All treatment providers contracted for MSHN SUD services must use the internet-based information system known as REMI, a product of PCE. REMI is the mechanism for the provider network members to request authorization for SUD services for clients who meet admission criteria. REMI also serves as a central location for collecting and analyzing data. MSHN has established authorized provider access to REMI and offer a common REMI platform for provider use in the region.

For providers needing to activate or deactivate users in REMI, the forms are located on MSHN's website: Provider Network → Provider Requirements → Substance Use Disorder.

Mid-State Health Network expects deactivation notices will occur immediately following the completion of employment for any staff utilizing REMI.

In all cases the treatment provider is responsible for entering demographic, financial, insurance, admission/discharge, and authorization data into the REMI system. REMI includes screening, level of care determination, assessment, treatment, and demographic information for all clients served.

The provider is responsible for the hardware and software requirements of:

- Commercial Internet Service Provider
- Internet Explorer 9.0 or higher
- Internet browser
- Windows 7 or higher based on operating system

Please contact inquiries@midstatehealthnetwork.org for the following specific REMI issues:

- User access, user deactivation, and user password reset
- A service was billed and the user cannot get the service added/accepted into REMI

- To add clinicians to the REMI Clinician list (for billing purposes)

Telemedicine

Telemedicine is the use of telecommunication technology to connect a patient with a health care professional in a different location. MDHHS requires a real time interactive system at both the originating and distant site, allowing instantaneous interaction between the patient and health care professional via the telecommunication system. Telemedicine should be used primarily when travel is prohibitive for the beneficiary or there is an imminent health risk justifying immediate medical need for services. Providers must ensure the privacy of the beneficiary and the security of any information shared via telemedicine. The technology used must meet the needs for audio and visual compliance in accordance with current regulations and industry standards. Providers must have a contract with or be authorized by MSHN in order to provide allowable services via telemedicine. Refer to Section 17 of the Medicaid Provider Manual for more information on telemedicine. Refer to the PIHP/CMHSP Encounter Reporting document for a list of allowable telemedicine services codes and modifier requirements.

Please refer to MSHN Coronavirus Disease FAQ Document found HERE for further information on Telemedicine during the pandemic.

Global Appraisal of Individual Needs (GAIN) Assessment

The Global Appraisal of Individual Needs (GAIN) is a standardized assessment for use with individuals with substance use disorders. The Michigan Department of Health and Human Services (MDHHS) has chosen the GAIN I-Core assessment as part of their application to the federal government for the 1115 waiver. Per the FY20 PIHP contract with MDHHS and the approval of the 1115 waiver MSHN will provide resources and training to providers to ensure full implementation by October 1, 2020.

MSHN will offer GAIN certification training to clinicians in the SUD provider network (in-region) by certified Local Trainers. The current MDHHS guidance requires that only master's level clinicians with professional licenses are appropriate to administer the assessment to clients as the GAIN results in a diagnosis. Per MDHHS guidance, the following licenses meet the standard for credential for GAIN I CORE certification: Licensed Psychologist (LP), Limited License Psychologist (LLP), Time Limited Licensed Psychologist (TLLP), Licensed Professional Counselor (LPC), Limited License Professional Counselor (LLPC), Licensed Marriage and Family Therapist (LMFT), Limited Licensed Marriage and Family Therapist (LLMFT), Licensed Master's Social Worker (LMSW) and Limited License Master's Social Worker (LLMSW). *For those clinicians who are trained and certified to administer the GAIN, they are required to use the GAIN as their assessment tool from certification date forward to prevent skill regression from fidelity.*

GAIN training activities can be reimbursed by MSHN for in-region providers by use of the GAIN Billing Form available on the : Provider Network →Provider Requirements →Substance Use Disorder with detailed instructions.

Provider sites are required to engage Chestnut Health Systems to initiate their locations GAIN ABS (electronic Assessment Building System) as well as manage activating and deactivating

~~appropriate staff. Each clinician certified to administer the GAIN is expected to enter all data in GAIN ABS including assessment data, update/revise narrative reports and transfer consumer files to referred/transferred agencies. In addition, clinicians will upload assessments (GAIN Recommendation and Referral Summary (GRRS) report) to the REMI system for reimbursement of assessment services.~~

~~Due to the ability to transfer the GAIN-I Core among provider agencies, a GAIN-I Core is an allowable expense every 6 months. This is the maximum allowable reimbursement for this clinical function. The GAIN-I Core should be billed as a H0001-HV code in REMI. At a minimum re-assessment should be completed annually. If an individual has a significant change prior to the 6-month marker, the clinician can utilize the M-90 form in the GAIN ABS system and bill this service as a H0001 code.~~

~~For further questions regarding the MSHN GAIN implementation please refer to the : Provider Requirements→Substance Use Disorder→GAIN or contact:~~

~~Jan Maino, GAIN Implementation Coordinator~~

~~517-252-7673~~

FINANCE AND CLAIMS

Claims: Please contact the claims department for billing inquiries at claims@midstatehealthnetwork.org. Please note for billing issues that require action to services submitted and for submission of Explanation of Benefits documentation, providers should use REMI.

Finance: For finance matters not related to Claims Processing, please contact MSHN's Chief Financial Officer at Leslie.Thomas@midstatehealthnetwork.org, or Finance Manager Amy.Keinath@midstatehealthnetwork.org, or Financial Specialist Brandilyn.Mason@midstatehealthnetwork.org. This may include items such as budgeting questions, payment frequency, and Financial Status Report (FSR) submission.

General Business Requirements

Providers are responsible to ensure all provision of services are in compliance with local municipality and state and federal business requirements, including business records, reporting, and adherence to all relevant statutes. Providers must be in compliance with all applicable standards and expectations from the most current *MDHHS Substance Use Disorder Services (SUDS) Program Audit Guidelines,* which include single financial audit requirements for providers in receipt of federal funds above a $750,000 level in a fiscal year.

Medicaid Verification/Reimbursement

The provider, upon admitting a client record into the REMI system, is responsible to determine a client's Medicaid or HMP eligibility. Each month while the client is in the program the provider must verify eligibility and coverage. It is the provider's responsibility to verify if there has been a change of coverage if the client has third party insurance coverage, Medicaid, or Healthy Michigan Plan (HMP) eligibility prior to authorization. Since federal regulations are specific regarding billing for Medicaid, HMP, or ~~a portion of federal community (block) grant funds~~Community Grant (Block Grant), and eligibility requirements change from month to month, active eligibility in Medicaid, HMP, or other third-party insurance plans must be verified on a monthly basis.

Retrospectively, if it is determined that the client was NOT covered by Medicaid during the service period, the claim may be rejected, and the provider notified. It is then the responsibility of the provider to notify the ~~Access Management System~~Utilization Management Department and follow the established policy/procedure for obtaining payment under ~~the~~ Community Grant ~~program~~ (Block Grant).

Providers may be requested to assist clients or MSHN in submitting evidence of client disability and/or treatment provision or cost~~,~~ in order to obtain and maintain benefit eligibility, including justification for ongoing Medicaid deductibles.

Healthy Michigan Plan (HMP)

~~The~~ Healthy Michigan Plan (HMP), which became effective April 1, 2014 ~~in Michigan,~~ has served to expand SUD services to ~~newly~~ enrolled persons and has also expanded the array of services available ~~under this new benefit~~ for persons with substance use disorders in need of treatment. MSHN providers will ~~be seeking to~~ continue to ~~expand~~ offer defined services under

this benefit to support clients (eligible enrollees/beneficiaries) with substance use disorders, according to published Medicaid Manual parameters.

Provider Authorizations & Claims

The provider shall electronically submit a claim utilizing REMI to request reimbursement for authorized services once provided. The provider will submit all the necessary information and support for all billed services. MSHN is the payer of last resort and the provider must be knowledgeable ~~about~~ and seek other payment options wherever appropriate. Questions about payment source should be directed to MSHN whenever necessary to ensure funded services are provided. Claims for unauthorized services will not be paid by MSHN. Any determination of inappropriate use of funding may result in provider repayment to MSHN. Visit the MSHN website: Provider Network → Provider Requirements → Substance Use Disorder for more information about reporting requirements.

Medicaid Recipients with other Primary Insurance

MSHN will authorize Medicaid payment of services only after all other active insurances have been billed and/or denied. Medicaid recipients who have any other insurance~~ code~~ either listed on the Medicaid Card or~~,~~ indicated through 270/271 ~~information, or~~information or have coverage through Medicare Part B~~,~~ must be transferred into a program that has an authorized provider. If ~~ Medicare is the primary insurance for SUD treatment, ~~ and these clients must be transferred into a program that has an authorized Medicare provider.

For Medicaid recipients who have a primary insurance other than Medicaid~~ other than those listed above~~, the primary insurance must be billed for SUD treatment coverage prior to billing MSHN~~Medicaid~~. ~~These client s~~Services will not be authorized or paid by MSHN using Medicaid funding until all other insurance coverage has been exhausted. Providers can contact Third Party Liability to notify MDHHS of any changes to third party insurance coverage here: Medicaid Coverage page.

Medicare/Third Party Liability (TPL) Primary For All Levels of Substance Use Disorder (SUD) Care	
What if Provider is not on the third-party panel?	Beneficiary must go to a Medicare or TPL Provider if the service is a covered benefit in the individual's insurance policy. Note: Healthcare Common Procedure Coding System (HCPCS) procedure codes are non-Medicare covered services unless provided by a SAMHSA certified Opioid Treatment Program. ~~, per the American Medical Association (AMA) 2016~~.
Exceptions	• The beneficiary has a primary SUD diagnosis for which SUD-specific treatment services are needed, meets medical necessity criteria, and the provider provides the necessary American Society of Addiction Medicine (ASAM) level of care necessary to meet the beneficiary's treatment needs. • For office or site-based services, the location of primary service providers must be within 60 minutes/60 miles in rural areas, and 30 minutes/30 miles in urban areas, from the beneficiary's residence (i.e. there are no Medicare SUD-licensed programs or providers within these distances). • Must get pre-approval from MSHN Utilization Management (UM) department. • If MSHN UM Department approves exception for Medicare or TPL covered service, bill Block Grant only and include supporting notes.
Who do I bill first?	• Must bill covered services to third party insurance first, if paneled with the third-party insurance. • Can only bill Medicaid or HMP if a denial with supporting Explanation of Benefits (EOB) is obtained from the primary insurance first. In cases where it is not possible to obtain a denial, Medicaid or HMP cannot be billed. The services can only be billed to Block Grant, provided the client meets the income eligibility guidelines for Block Grant and there is documentation in the client chart. • Note: Medicaid can be billed if the beneficiary has a tribal benefit.
Denied Claims	• If the provider is able to bill Medicare or TPL and obtains the denial with supporting EOB, then the provider can bill Medicaid or HMP, provided the previously noted guidelines are met. ~~• Fax EOB to 517.574.4093, ATTN: Claims Department or email securely to claims@midstatehealthnetwork.org.~~ • Place EOB in beneficiary's chart. • In cases where it is not possible to obtain a denial and supporting EOB for covered services from Medicare or TPL (i.e. not paneled and/or credentialed), Medicaid or HMP cannot be billed. The services can only be billed to Block Grant, provided the client meets the income eligibility guidelines for Block Grant and there is documentation in the client chart. • Note: HCPCS procedure codes are non-Medicare covered services unless provided by a SAMHSA Opioid Treatment Program. MSHN will pay with Medicaid or HMP, if beneficiary is eligible.
Partial Payment	• Bill beneficiary's secondary insurance up to third party insurance's allowable amount or MSHN's contracted rate, whichever is less, (minus first party co-pay for Block Grant funds). ~~• Fax EOB to MSHN.~~ • Place EOB in Beneficiary's chart.

Deductible	• Bill beneficiary's secondary insurance up to third party insurance's allowable amount or MSHN's contracted rate, whichever is less, (minus first party co-pay for Block Grant funds). ~~• Fax EOB to MSHN.~~ • Place EOB in Beneficiary's chart.

Reimbursable Diagnoses

Services for clients with substance use disorders will be provided only for applicable and appropriate substance use disorder diagnoses as included in the DSM-V (effective October 1, 2015) converted to an ICD-10 code. The SUD diagnosis must be the primary diagnosis for SUD funds to be used for payment of services provided. SUD diagnoses applicable for reimbursement are delineated in the REMI system. The appropriate ICD-10 code (not DSM) shall be selected from the drop-down menu for admissions and discharges. When a client does not have a SUD diagnosis, but requires an assessment or early intervention services, ~~this~~ services can be billed through MSHN. According to the Coding Instructions for Michigan Behavioral Health Treatment Episode Data Set (BH-TEDS), 999.9997 should be used when no substance use diagnosis exists OR it has not been determined if a SUD exists based on the assessment performed. The full BH-TEDS instructions can be found in REMI under 'Documentation' on the main menu. It is also acceptable to use the diagnosis code Z03.89 in instances where use or problems associated with a specific drug is identified, but the individual does not meet criteria for a full diagnosis.

NOTE: While it is acceptable to use either 999.9997 or Z03.89 as the primary diagnosis for BH-TEDS admission and discharge records, the diagnosis code 999.9997 is not an allowable billing diagnosis. For instances when an individual does not have a full substance use diagnosis but a billable service was provided, the diagnosis code Z03.89 must be used for billing purposes.

Service Codes & Rates

Fee for service payment rates, by each service code, are included in each SUD treatment provider's specific contract as ~~Attachment B~~*Provider Fee Schedule Report*. MSHN seeks to have common regional rates and consistent payment methodologies for providers in the region. MSHN expects funds to be used in accordance with relevant guidelines and to include supporting documentation. Rates are based on best value, competitive, and comparable market information. Unless otherwise referenced directly in the contract with providers with specific codes, the reference for service codes is the *PIHP/CMHSP Encounter Reporting, HCPCS and Revenue Codes, Reporting Cost per Code and Code Chart* published by MDHHS, the most current version, located at: Service & HCPCS Codes.

PREVENTION PROVIDERS

MSHN's Prevention Specialists are available to assist with SUD Prevention Provider needs, including but not limited to: county prevention coalitions, prevention initiatives, professional and other trainings, and the Michigan Prevention Data System (MPDS). The prevention specialists are specific to parts of the region: MSHN-South (Sarah Andreotti), MSHN-West (Kari Gulvas), and MSHN-East (Jill Worden). Please contact the prevention specialist in your part of the region to address any needs or concerns or call (517) 253-7525.

Sarah Andreotti:	Sarah.Andreotti@midstatehealthnetwork.org
Kari Gulvas:	Kari.Gulvas@midstatehealthnetwork.org
Jill Worden:	Jill.Worden@midstatehealthnetwork.org

Contracted Prevention Providers must adhere to appropriate cultural competency, recipient rights, confidentiality, and privacy conditions in this manual, as well as any other policies of MSHN or the State of Michigan applicable to the provision of prevention services. Prevention contract arrangements funded by MSHN are based on identified local community needs and will vary from one community to another, including short-term projects, ongoing services, and collaborations with key community partners. Each contract for prevention services will include specific detail regarding scope of work, reporting and/or outcomes, as well as financial status reports (FSR) or claims submission for MSHN reimbursement.

Contracted Prevention Providers must notify and receive written permission to make changes to their submitted and approved prevention services plan.

Prevention Services

MSHN will elect to contract for appropriate prevention services based on local community needs.

Prevention Providers are required to verify in writing the use of evidence-based services at the time of contract initiation and/or renewal. In cases of contract renewal, evidence-based services will be identified in Contracted Provider's Annual Plan submission.

MSHN requires that all Contracted Prevention Providers adhere to the following MDHHS prevention guidelines (subject to revisions by MDHHS):

- A Substance Abuse Prevention License is required for any organization offering or purporting to offer prevention services. To meet this requirement, Contracted Prevention Providers must possess an active Community Change, Alternatives, Information, and Training (CAIT) License registered with the Michigan Department of Licensing and Regulatory Affairs (LARA).
- Contracted Prevention Provider Staff must possess an active Certified Prevention Specialist (CPS) or a Certified Prevention Consultant (CPC) certification through the Michigan Certification Board for Addiction Professionals (MCBAP). Staff may also be funded if they have a registered development plan through MCBAP, which is being actively pursued and properly supervised. In some cases, this certification requirement may be waived if prevention services are delivered by specifically-focused prevention staff. Specifically-focused staff are those that consistently provide a specific type of

prevention service and do not have responsibilities for implementing a range of prevention plans, programs, or services. Specifically-focused prevention staff must have completed formal training for the specific program they are conducting, demonstrable through certificates of completion or similar documentation.

- For each Contracted Prevention Provider Staff (1.0 FTE), a minimum of 700 hours of direct prevention services must be conducted annually. Of these 700 hours a minimum of 560 must be face to face services identified in the MPDS system with the remaining hours being allowable additional hours submitted on their additional hours reports. Prior to the beginning of the fiscal year, Contracted Prevention Providers must submit an annual prevention plan detailing the intended scope of work, evaluation method(s), responsible staff, and anticipated number of direct service hours.
- All direct prevention activities, funded in part or whole with MSHN funding, must be captured in MPDS, identifying staff providing service.
- All Contracted Prevention Provider Staff funded by MSHN must complete Level 1 Communicable Disease Training at least once every two years. Free Level 1 Communicable Disease Training is available online at: http://improvingmipractices.org. For new staff, training should be completed within 90 days of hire.
- Prevention activities must be focused on State and Regional priorities which include; 1) Reduction of Underage Drinking, 2) Reduction of Youth Tobacco Use, 3) Underage Marijuana Use Prevention and/or ~~3~~4) Reduction of Prescription Drug and Over the Counter Medication misuse and abuse. Services should focus on ~~and~~ risk and protective factors associated with these problems. Providers may also address additional priority areas, if local data supports them.
- At a minimum, ninety-five percent (95%) of all services must be research~~ed~~-based. Contracted Prevention Providers are to follow the guidelines outlined in the Guidance Document on Evidence-Based Programs developed by the State. The document can be found on the MDHHS website (https://www.michigan.gov/documents/mdch/Mich_Guidance_Evidence-Based_Prvn_SUD_376550_7.pdf). Identified evidence-based programs, must be administered with fidelity.
- Services should address both high-risk populations and the general community, unless approved by MSHN prevention staff.
- No more than twenty-five percent (25%) of total direct services/units can be in the Federal Strategy of Information Dissemination and services under this category must tie into your agencies overall prevention plan. Contracted Prevention Providers must have a system in place to track total number of services/units delivered in each of the approved Federal Strategies. Providers will be asked to share their tracking system at the time of MSHN site visit audit.
- Services need to be based on identified, current community needs.
- Services are collaborative in nature representing coordination of resources and activities with other primary prevention providers – e.g. local health departments, community collaboratives and the MDHHS's prevention programs for women, children and families, and older adults.
- Services need to be supportive of local coalitions. New providers interested in providing prevention services should be a regular participant in county prevention coalition meetings, and have documented discussions during those meetings in order to be considered for funding.

- Services must fall within one of the six federally defined strategies: information dissemination, education, problem identification and referral, alternatives, community based, or environmental.
- Services must be provided in a culturally competent manner. Contracted Prevention Providers must have a cultural competency policy and staff must attend at least one cultural competency training annually.
- All media promoting programs funded all or in part by MSHN must acknowledge the funding source by using text or a logo provided by MSHN.
- If Provider is planning on conducting a local Media Campaign, all materials must be approved by MSHN and/or OROSC.

Coordination of Services

All Contracted Prevention Providers must be able to identify at their site visit how services are coordinated with other community agencies and coalitions. Coordination of services should minimally include:

- Local Department of Health and Human Services
- Local Community Mental Health Service Provider
- Local Schools
- Law Enforcement
- School Resource Officers (where applicable)
- Teen Health Centers (where applicable)
- Community Coalitions
- Local Health Departments
- Federally Qualified Health Centers (where applicable)

Whenever possible, Contracted Prevention Providers are encouraged to enter into referral agreements with community agencies. MSHN will offer or support technical assistance for this upon request.

Program Evaluation

Providers should be aware of and attempt whenever possible to collect data elements identified in the National Outcome Measures (NOMs), such as: 30-day use, perception of risk/harm of use, age of first use, perception of disapproval/attitudes, perception of workplace policy, average daily school attendance rate, number of persons served by age, gender, race, and ethnicity, family communication around drug and alcohol use, number of evidence-based programs (EBPs) and strategies used, percentage of youth seeing, reading, watching, or listening to a prevention message, alcohol-related traffic fatalities, and alcohol- and drug-related arrests. Visit SAMHSA for more information related to NOMs.

Providers are expected to provide MSHN an outcome report after the end of the fiscal year. This report should identify how activities were evaluated, outcome of those evaluations, and how the evaluations were utilized to improve programming.

MSHN requires that all prevention services incorporate some method of evaluation. Contracted Prevention Providers must include all process evaluation data as outlined in Michigan Licensing rules. In addition, Providers need to incorporate the following processes: Completion of Short-term Outcome Evaluation identifying knowledge, attitude and behavior changes. For all

programming, outside of information dissemination, providers must be able to demonstrate program effectiveness, i.e. what were the goals of the program and were those goals obtained? Development of a Performance Improvement Plan, which incorporates evaluation outcomes, utilizing data to make program changes, and identifying how services impacted program goals and objectives. Provider should also collect satisfaction surveys of prevention programming. In ~~FY20~~ OROSC is requiring outcome evaluation surveys to be completed for certain types of programming. Guidelines for this requirement include:

State Prevention Outcomes Surveys: If Provider has services that meet State requirements, the Provider will complete State Outcome Surveys as part of both pre and post-test administration of program. Programs that meet the following criteria will be required to survey participants;

- On-going sequential program.
- Participants must be 7th grade or older (including adults)
- Population is selective or indicated.
- Program will be over 30 days in duration.

Providers will receive a stipend for each pre- and post-test completed. MSHN Prevention staff will train providers who meet programming criteria on data collection instructions.

Contracted Prevention Providers need to have an agency/department Performance Improvement Policy and must demonstrate how prevention services are incorporated into the plan.

Charging for Prevention Services

If a Contracted Prevention Provider charges a fee for prevention activities, funded in whole or part by MSHN, the provider must adhere to the following guidelines:

- Providers must have a policy in place that is specific to charging for prevention services,
- This policy must ensure that services will not be denied based on ability to pay,
- A copy of this policy must be submitted to MSHN prior to the beginning of the contract period, and revised annually,
- Any prevention activities that require payment to participate must have a brochure/flyer that clearly states that scholarships are available; these materials should be used whenever promoting the activity, and
- Providers must identify fees collected for prevention activities on the monthly FSRs under Provider Sources of Funds > Fees & Collections.

Prevention Activity Reporting

To capture activity data, all direct services, funded in whole or part by MSHN, must be accurately entered into the Michigan Prevention Data System (MPDS) as outlined in the MPDS User Manual. Provider staff are responsible for reading the MPDS User Manual upon hire and periodically and must have a process in place to monitor the accuracy of activity data entered; this process will be reviewed during the site visit.

Activity data must be entered into the MPDS on a monthly basis. Failure to enter activity data by the 10th of the month following the date of service may result in delayed payment by MSHN. MSHN Prevention Specialists are available to provide MPDS- related technical assistance and

training to Contracted Prevention Providers upon request. Please consult the MPDS User Manual prior to contacting your MSHN Prevention Specialist for assistance.

Designated Youth Tobacco Use Representatives (DYTURs)

The federal Synar Amendment requires states to have laws in place prohibiting the sale and distribution of tobacco products to persons under 18 years-of-age and to enforce those laws effectively. Annual Synar checks, required by the amendment, show that great strides have been made the reduction in retailer violations of the law and youth access to tobacco products in Michigan.

To ensure that the region complies with the expectations set forth by the state, MSHN will contract with one provider in each of its 21 counties to deliver services through Designated Youth Tobacco Use Representatives (DYTURs). Providers contracted for DYTUR services will be responsible for:

- Maintaining and updating the master tobacco retailer list (MRL) at least annually for each represented county, which minimally includes visiting or calling each retailer to verify/update contact information;
- By May 15th of each year, providing face-to-face vendor education to at least 25% of the tobacco retailers in the DYTUR's designated county(ies) utilizing the official OROSC protocol. DYTURs should encourage all retailers to enroll employees in the online Tobacco Retailer Education course upon hire (additional vendor education may be completed after the Formal Synar period ends);
- By May 15th of each year, conducting non-Synar compliance checks with at least 25% of the tobacco retailers in the DTYUR's designated county(ies) utilizing the official OROSC protocol. Non-Synar compliance checks can be conducted with civilians or in collaboration with local law enforcement* and/or the Michigan State Police Marihuana and Tobacco Investigation Section ~~Tax Team~~ whenever possible; and
- Annually conducting and completing the Formal Synar compliance checks to all retailers in the sample draw during the designated time period, taking care to utilize the official OROSC protocol. MSHN Prevention Staff will meet with DYTUR providers on securing proper youth employment requirements.

In addition, DYTURs are expected to:

- Actively engage in county-level tobacco prevention/reduction coalitions or other substance use disorder prevention coalitions if no tobacco-related coalition is in place;

- Provide education to local law enforcement, chambers of commerce, and other community groups on the Synar Amendment;
- Maintain records of all tobacco compliance checks being completed within their designated county(ies), including compliance checks conducted outside of MSHN's purview;
- Complete the Youth Access to Tobacco Activity Report annually. Appropriate technical assistance, training, and protocol forms will be provided by MSHN's prevention specialists; and

- Attend state-level DYTUR/Youth Tobacco Act (YTA) meetings when possible. If/when DYTUR staff are not able to attend, please contact your MSHN Prevention Specialists in advance for call-in information, agendas, minutes, etc.

DYTUR Reporting

Providers contracted for DYTUR services are expected to submit the following annual reports to MSHN by the due dates provided in separate documentation:

- **Revised Master Tobacco Retailer List (MRL)**—Please remember, all tobacco retailers on the MRL must be verified by a phone call or personal visit. Verification must include the retailer name, address (including county), vendor type, and phone number. In addition, while electronic nicotine delivery systems (ENDS) are not currently part of the Formal Synar process, DYTURs are expected to identify retailers selling ENDS (e.g., e-cigs, vape pens, hookah pens, etc.) in their establishments during the MRL revision process. DYTURs must also add any known new retailers to the MRL;
- **Vendor Education Report**—IMPORTANT: A minimum of 25% vendor education must be completed prior to the start of the Formal Synar period.
- **Non-Synar Report**—IMPORTANT: A minimum of 25% non-Synar must be completed prior to the start of the Formal Synar period;
- **Formal Synar Compliance Check Forms**; and
- **Youth Access to Tobacco Activity Report**

In addition, all providers contracted for DYTUR services are expected to enter Youth Tobacco Act (YTA) activities into the MPDS by the 10th of the month following the date of service. These activities should minimally include: vendor education, non-Synar compliance checks, and Formal Synar compliance checks. To ensure standardization of regional data, DYTURs will be provided with a data entry guide for YTA-related activities and are expected to input data accurately according to the instructions given.

DYTUR reporting forms and due dates will be provided by MSHN. Providers are responsible for reviewing all reporting forms for completeness and accuracy prior to sending to MSHN.

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* SAPT Block Grant funds cannot be used for law enforcement compliance checks~~;~~, ~~this includes~~ including Formal Synar and non-Synar activities, or tobacco cessation programs.

Early Intervention-Prevention

MSHN adheres to the recommendations described by OROSC in *Treatment Technical Advisory #9: Early Intervention*. ~~As Early Intervention under SUD treatment services is described elsewhere in this manual, t~~This section will focus on prevention's role in Early Intervention services.

Prevention Early Intervention (PIR) services typically exist within the community being served (e.g. schools, community centers, etc.). "Prevention" refers to this level of service under the federal strategy of Problem Identification and Referral (PIR), and defines it as "helping a person with an acute personal problem involving or related to SUDs, to reduce the risk that the person might be required to enter the SUDs treatment system" (U.S. CFR, 1996).

PIR aims to identify those who have indulged in the illegal use of drugs in order to assess if their behavior can be reversed through education. PIR does not include any activity designed to determine if an individual is in need of treatment. Examples of PIR include driving while intoxicated education programs, employee assistance programs (EAPs), and student assistance programs (SAPs) (FY 2012-14 Action Plan Guidance).

PIR service activities are not required to occur in the context of an existing licensed SUD treatment program, however providers of Prevention Early Intervention (PIR) services must have appropriate prevention licensure (CAIT).

PIR services must be delivered by individuals credentialed as a Certified Prevention Specialist (CPS) or Certified Prevention Consultant (CPC) with appropriate documentation submitted to and approved by the Michigan Certification Board for Addiction Professionals (MCBAP). Supervision of PIR programs must be provided by a MCBAP-approved CPS/CPC or a MCBAP-approved alternative.

Community Coalitions

MSHN strongly believes in the power of community coalitions. MSHN believes that Prevention Coalitions belong to their communities. As such, MSHN does not fund community coalitions, but rather supports them in the following ways:

1. MSHN Prevention Staff will provide guidance if requested and attend, whenever possible, local coalition meetings.
2. MSHN will support a contracted prevention staff member to assist coalition in a part time coordinator role.
3. MSHN will provide a $5,000 stipend to each of the 21 county's coalition to be utilized as deemed appropriate by the coalition members. Process for this funding includes:
    a. Funding will be given yearly to one MSHN contracted provider in each county for the purpose of acting as the fiduciary for this funding.
    b. In order for funding to be utilized, coalition members must discuss, approve and vote on funding decisions.
    c. Coalition voting must be identified in coalition meeting minutes.
    d. Provider acting as fiduciary for this funding should provide coalition members regular budget summary.

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APPENDICES:

Appendix A: Utilization Management Program Manual

MID-STATE HEALTH NETWORK

SUBSTANCE USE DISORDER UTILIZATION MANAGEMENT PROGRAM MANUAL

Introduction

The utilization management process consists of the authorization of treatment, concurrent and retrospective reviews of services, appeals, implementation, evaluation, and monitoring of operations and system trends. The protocol and guidelines adopted reflect the medical necessity and program contractual standards that comply with the Michigan Department of Health and Human Services (MDHHS) requirements and Center for Medicare and Medicaid Services federal regulations.

The MSHN Utilization Management (UM) team is dedicated to providing prompt, professional, and helpful support to its treatment provider network. MSHN has established consistent UM practices based on commonly accepted medical necessity criteria consistent with the Office of Recovery-Oriented Systems of Care (OROSC) prevention and treatment policies, as well as the Medicaid Managed Specialty Supports and Services ~~Concurrent 1915 (b)/(c) Waiver Program~~ contract, the Michigan Medicaid Manual and other accepted clinical sources (i.e. the current editions of the DSM and ASAM), which are designed to benefit eligible consumers across the MSHN region.

The MSHN UM team has 3 full-time specialists who are available Monday through Friday from 8am-5pm via telephone and email:

Nicole Jones: Nicole.Jones@midstatehealthnetwork.org
Cammie Myers: Cammie.Myers@midstatehealthnetwork.org
Kate Flavin: Kathrine.Flavin@midstatehealthnetwork.org

Additionally, the UM Department has a toll-free phone number which should be used to reach any available UM specialist, as well as a departmental email which is monitored daily:

Toll-Free Phone: **844-405-3095**
E-mail: **um@midstatehealthnetwork.org**

Access Management System/Service Access

MSHN adheres to requirements for access management as described in MDHHS Access Systems Standards. The link to the revised MDHHS Access Standards (Attachment P4.1.1.) is here: MDHHS Access System Standards. MA/PIHP Contract

All clients residing or presenting in MSHN's 21-county region who request SUD treatment services must be screened by the MSHN Access Management System (AMS). The AMS must provide access, screening and referral 24/7days a week. For emergency services, this requires the capacity to make information available as to what other entity is providing the emergency service and how to access services.

MSHN is responsible for assuring the availability and operation of an efficient and effective AMS including assurance that staff performing these functions is skilled, trained, supervised, and

appropriately credentialed when carrying out clinical functions. MSHN expects providers to ensure that access to services for individuals seeking SUD treatment services is efficient, consumer-friendly, timely, and effective. Furthermore, there is an overarching goal that SUD treatment access be integrated with Community Mental Health Service Programs' (CMHSPs) 24/365 crisis and access services. To see what CMHSP covers your county, click here: Region 5 CMHSPs. For out-of-region persons, access will be coordinated with the appropriate CMHSP and/or PIHP access center.

Individuals seeking SUD treatment services may access SUD services at each of the funded providers listed in the *Customer Services Handbook*. They may also receive health information, referrals to community resources, and screening appointments through the AMS at any access point for MSHN, including any CMHSP.

MSHN is responsible for providing SUD treatment services to individuals covered under Medicaid insurance or the Healthy Michigan Plan. Under special situations, MSHN may serve some clients who have commercial or other insurance. Individuals who have Medicaid or Healthy Michigan Plan and need medically necessary services receive their services as an enrollee benefit. For individuals who have no insurance, there is no guarantee of services if there is no funding available to provide those services. MSHN must provide services to as many individuals as possible within the financial resources that are available. Sometimes individuals may be placed on a waiting list if there is not enough funding to provide services immediately and the individuals do not qualify for Medicaid or Healthy Michigan Plan. Individuals may not be put on a waiting list if they have Medicaid or Healthy Michigan Plan.

In some circumstances MSHN may need to fund services from an agency that does not have a contract with the local region in order to meet a client's needs. If that is the case, the purchase of 'off panel' provider services should be facilitated by MSHN. MSHN utilization management staff as well as provider staff will coordinate to help make these arrangements for clients when necessary and appropriate.

The AMS must abide by priority populations according to the SAPT community (block) grant regulations at CFR 96.131. MDHHS has defined the following as priority populations for SUD treatment services:

Population	**Admission Requirement**	**Interim Service Requirement**
Pregnant Injecting Drug User	1) Screened and referred within 24 hours. 2) Detoxification, Methadone, or Residential – Offer admission within 24 business hours. Other Levels or Care – Offer admission within 48 business hours.	*Begin within 48 hours:* 1. Counseling and education on: a) HIV and TB. b) Risks of needle sharing. c) Risks of transmission to sexual partners and infants. d) Effects of alcohol and drug use on the fetus. 2. Referral for pre-natal care. 3. Early intervention clinical services.

Pregnant Substance Use Disorders	1) Screened and referred within 24 hours. 2) Detoxification, Methadone, or Residential – Offer admission within 24 business hours. Other Levels or Care – Offer admission within 48 business hours.	*Begin within 48 hours:* 1. Counseling and education on: a) HIV and TB. b) Risks of transmission to sexual partners and infants. c) Effects of alcohol and drug use on the fetus. 2. Referral for pre-natal care. 3. Early intervention clinical services.
Injecting Drug User	Screened and referred within 24 hours. Offer admission within 14 days.	*Begin within 48 hours – maximum waiting time 120 days:* 1. Counseling and education on: a) HIV and TB. b) Risks of needle sharing. c) Risks of transmission to sexual partners and infants. 2. Early intervention clinical services.
Parent At-Risk of Losing Children	Screened and referred within 24 hours. Offer admission within 14 days.	*Begin within 48 business hours:* Early intervention clinical services.
Individual Under Supervision of MDOC and Referred by MDOC or Individual Being Released Directly from an MDOC Without Supervision and Referred by MDOC	Screened & referred w/in 24 hrs. Offer Admission w/in 14 days	Begin w/in 48 business hrs Early Intervention Clinical Services Recovery Coach Services
All Others	Screened and referred within seven calendar days. Capacity to offer admission within 14 days.	Not required.

Each MSHN contracted provider must meet the needs of individuals in these groups first. After that, MSHN may fund services for others who meet criteria for treatment.

If individuals in the priority population have to wait for services, they are to be offered interim services according to Section 96.121 of the SAPT Block Grant. Interim services must minimally include what is listed in the state policies, and provision of these services, or the refusal of such, will be documented in client files.

Clients should have freedom to choose their provider from the available options. If a provider is unable to offer treatment to a person seeking services, a 'warm transfer' should be offered to connect the person to an eligible and appropriate provider and/or level of care.

Eligibility Determination

Residency in MSHN Region: MSHN does not limit access to the SUD programs and services only to the residents of the MSHN region, because the funds provided by the MDHHS come from federal and statewide resources. Members of federal and state-identified priority populations must be given access to screening and to assessment and treatment services, regardless of their residency. However, for non-priority populations, MSHN may give its residents priority in obtaining services when the actual demand for services by residents eligible for services exceeds the capacity of the agencies.

If a consumer enters a treatment program outside of the MSHN region, it is expected that the consumer shall retain their county of residence to which his or her Medicaid is attached. MSHN has established contracts with certain out of region (i.e. outside of the MSHN 21-county area) SUD treatment providers for residential and/or withdrawal management services. In other cases, MSHN will engage in "single-consumer" letters of agreement with providers outside of the MSHN provider network to facilitate needed care.

It has been the historical practice of some SUD residential and/or withdrawal management treatment providers to contact local DHHS eligibility personnel to transfer the consumer's Medicaid County of residence coverage to the county in which the treatment facility exists. Per the Medicaid Services Administration (MSA), there is no type of eligibility requirement dictating such a change in address when the consumer enters any treatment program. The unintended consequence of a provider switching a consumer's county of residence in their Medicaid is that the switch in counties results in the beneficiary being a part of a different Pre-Paid Inpatient Health Plan (PIHP) region. Also, when the person returns home, he or she will not get services in their home area until their information has been changed back. This increases the chance of reduced continuity of care, which is a key element in ensuring ongoing individual stability and treatment efficacy

Medical Necessity: In considering the appropriateness of **any** level of care, the four basic elements of Medical Necessity should be met:

- Client is experiencing a Substance Use Disorder reflected in a primary, validated, DSM5 or ICD-10 Diagnosis (not including V Codes) that is identified as eligible for services in the MSHN Provider Contract.
- It is the most appropriate, cost-effective, and least restrictive level of care that can safely be provided for the client's immediate condition based on The ASAM Patient Placement Criteria, 3rd Edition.
- A reasonable expectation that the client's presenting symptoms, condition, or level of functioning will improve through treatment.

- The treatment is safe and effective according to nationally accepted standard clinical evidence generally recognized by substance use disorder or mental health professionals.

Please Note: Court-ordered treatment is not the same thing as medical necessity. An individual with a court order for SUD services will still need to participate in a biopsychosocial assessment to determine their needs and make recommendations for clinically appropriate, medically necessary services.

Block Grant Funding

A limited amount of Block Grant funding is available each fiscal year on a first-come, first-serve basis for those consumers residing within the MSHN service region who meet the established financial eligibility criteria. The purpose of the Block Grant funding is to facilitate entry into necessary Substance Use Disorder treatment for those persons who are uninsured or underinsured. Please see the Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program and MSHN Policies and Procedures: Substance Use Disorder Income Eligibility & Fee Determination, for additional information regarding consumer eligibility around the use of Block Grant funding and applicable co-pays for which the consumer is responsible. It is the responsibility of the SUD provider to procure a completed and signed copy of the Income Verification and Fee Waiver form for all consumers accessing Block Grant funding. A signed copy of this form is required to be placed in the consumer record.

All consumers must submit proof of application for Medicaid/Healthy Michigan Plan insurance benefits within 30 days of admission to treatment under the Block Grant funding source. SUD providers should place documentation of the submitted application in the client file. MSHN reserves the right to discontinue Block Grant funding if consumers do not participate in the requested activities to secure health insurance benefits.

Veteran's Coordination of Benefits: If a consumer served or is currently serving in the U.S. armed forces, they must attempt to access any treatment benefits for which they may be eligible through the Veteran's Administration or other approved provider relative to individual coverage. The use of Medicaid/HMP/Block Grant funding is allowable in assisting the consumer in being referred for the medically necessary SUD services, provided the consumer has Medicaid, HMP, and/or no other insurance coverage. The following exceptions may apply:

- There is not a VA provider within 40 miles of the client's home residence.
- The medically necessary level of care or type of service is not available to the veteran/military service member through the benefits provided by the VA.
- The consumer would have to wait more than 14 days for admission to a VA service provider.

For an explanation of Veteran's access to MSHN SUD services, please refer to *Appendix B. MSHN Veteran's Eligibility Technical Requirement* in the MSHN SUD Provider Manual.

Out of Network Services

When extenuating circumstances prevent a consumer from otherwise obtaining services, MSHN provides a system of procedures for referral to other providers and access to non-network providers through its out-of-network panel policy. Providers may include: Accredited licensed Substance Use Disorder health facilities, other Substance Use Disorder licensed professionals and other health service providers that provide direct Substance Use Disorder health services. The purpose is to ensure that access objectives and standards are met.

When a consumer chooses a non-network provider for services or when the MSHN UM department refers for a service that is not available in the MSHN Network, such organizations or professionals must contact MSHN for authorization. All out-of-network services should be pre-authorized.

A Letter of Agreement (LOA) with a negotiated rate may be assembled. If multiple services are anticipated, MSHN may choose to complete a formal contract via the credentialing process. If services have been rendered prior to contact with MSHN, MSHN will review on a case-by-case basis to determine what action/reimbursement will take place.

Levels of Utilization Management

In order to fully implement all UM processes, MSHN shall also use data reports, REMI information, and requested treatment provider documents to review care and adherence to all policies, rules, regulations, standards of care, and the like. When necessary, the MSHN UM Specialist staff may contact the provider via REMI to request clarifications in treatment decisions/clinical practice and also to request copies of appropriate clinical and administrative documents in order to review medical necessity, amount, scope, and duration of treatment, as well as consistency with UM principles and standards of care, and all applicable contractual requirements, rules, regulations, and expectations with respect to provider treatment performance and outcomes.

A. Prospective Utilization Review (Pre-Authorization)

MSHN has a prospective utilization review process for non-emergent substance use disorder services, which will include the following components:

1. Service eligibility determination, through an access screening process
2. Verification of medical necessity, through a clinical assessment process (which may occur concurrently or sequentially with the access screening process)
3. Standardized assessments and/or level of care tools for certain clinical populations
4. Specialized testing/evaluations for certain services
5. Certification for certain enrollment based services
6. Pre-authorization (amount, scope and duration) for certain services

Service eligibility and medical necessity criteria for each clinical population are outlined in the MSHN Access System policy, including requirements for second opinions and advanced/adequate notice of denials.

1. Eligibility Determinations and Verification of Medical Necessity

Eligibility determinations and verification of medical necessity will be performed by CMHSP Participants for mental health services, and by SUD providers for substance use disorder services.

To ensure adequate integration, MSHN has established a coordinated service access process. CMHSPs and the SUD provider networks in their respective catchment areas will coordinate access processes, ensure there is 'no wrong door' for linking to services, and ensure there is a single point of contact for after-hours service inquiries from Medicaid enrollees and other individuals seeking mental health and SUD services. CMHSP Access Centers may assist with screening individuals seeking SUD services. Coordination of care will also occur with primary health care providers.

2. Monitoring Access Eligibility and Medical Necessity Determination

Each SUD Provider will monitor individual service eligibility and medical necessity determinations for consistency with local and regional policy. MSHN will monitor whether the individual eligibility and medical necessity determinations that have been made are consistent with MSHN policies through record reviews during annual on-site visits to CMHSP Participants and SUD Providers. MSHN will also review individual SUD eligibility determinations through the REMI record keeping system. The MSHN UM Committee in conjunction with MSHN UM staff will monitor regional compliance with the access eligibility and medical necessity criteria at the population level through the review of metrics. SUD Providers will offer second opinions and provide advanced/adequate notice of denials as outlined in the MSHN Access System policy.

B. Concurrent Utilization Review

Appropriate MSHN UM Specialist staff will perform concurrent SUD UM reviews. Each individual receiving services will have an individual plan of service which outlines the services to be received, including the amount, scope, and duration. The amount, scope and duration of each service, if not subject to the enrollment, authorization or other limitations described earlier in this plan, will be determined by the person who will be receiving the service and their SUD Provider or CMHSP, through a person centered and recovery oriented planning process. Utilization decisions will not be made outside of the person-centered planning process unless otherwise required by MDHHS. The individual plan of service for each person receiving services will specify the frequency of periodic (i.e., concurrent) review as determined in dialogue with the person receiving services.
SUD Providers will provide advanced/adequate notice of denials as outlined in the Medicaid Provider Manual and MSHN Access System policy for any service reduction resulting from loss of eligibility or lack of medical necessity. Unless MSHN service eligibility and medical necessity criteria are not being met, all utilization decisions will be made in the context of person centered planning activities.

Each SUD Provider will monitor individual continuing stay/eligibility/medical necessity determinations for consistency with local and regional policy. MSHN will monitor whether continuing stay/eligibility/medical necessity determinations that have been made are consistent

with MSHN policies through record reviews during annual on-site visits to SUD Providers. MSHN will also review individual SUD determinations through the REMI record keeping system as needed. The MSHN UM Committee in conjunction with MSHN UM staff will monitor regional compliance with continuing stay/eligibility/medical necessity criteria at the population level through the review of metrics.

C. Retrospective Utilization Review

Retrospective review will be performed by the MSHN UM Department for SUD services. The MSHN UM Committee in conjunction with MSHN staff will perform retrospective utilization review at the population level through the review of metrics.

Retrospective review will focus on the cost of care, service utilization, and clinical profiles. Analysis will consider encounter data in conjunction with other supplemental data as well as ASAM and other clinical need/outcomes data as available. BH-TEDS and Medicaid claims data will be incorporated as warranted.

The MSHN UM Department will review service utilization reports to identify potentially undesirable variance in service utilization at the population level. For purposes of ensuring effective management of Medicaid and Block Grant resources managed by the region, undesirable variance will be defined as:

1. Inconsistency with regional service eligibility and/or medical necessity criteria; and/or
2. Possible over and under-utilization of services when compared to the distribution of service encounters, associated measures of central tendency (i.e. mean, median, mode, standard deviation), and consumer clinical profiles (i.e., functional needs) across the region.

Based upon its findings, the MSHN UM Department will identify potential interventions for consideration. Interventions will vary, depending upon the nature of the variance and anticipated causal factors, but may include the following, presented in order of intensity, from least to highest:

1. Verify data
2. Request further analysis
3. Request change strategies from stakeholders
4. Provide regional training
5. Modify or clarify regional service eligibility and/or medical necessity criteria through proposed revisions to MSHN policy
6. Set utilization thresholds or limits
7. Address service configuration to affect utilization

REMI

REMI is the web-based managed care information system used by MSHN. REMI stands for the Regional Electronic Medical Information (REMI) system. REMI is used for collection of state and federal data elements, PIHP performance indicators, utilization management (authorization of services), and reimbursement.

All treatment providers contracted for MSHN SUD treatment services must use REMI, a product of Peter Chang Enterprises (PCE). REMI is the mechanism for the provider network members to request authorization for SUD services for clients who meet admission criteria. REMI also serves as a central location for collecting demographics and analyzing utilization data.

The MSHN SUDSP Manual provides general information related to the system requirements for REMI, as well as the appropriate procedure for requesting new user accounts and deleting user accounts. The following pages in this manual will provide more detailed information about MSHN utilization management expectations for REMI users.

Learning to Use REMI: As noted above, REMI is a product of Peter Change Enterprises, (PCE), and as such they retain proprietary rights. MSHN does not have the ability to provide user trainings for the REMI system, however MSHN staff members are available to provide support, answer questions, and troubleshoot concerns. PCE has provided instructional user manuals with step-by-step directions and screenshots explaining the various content areas of REMI which are located in the "Help" section of REMI. Also located in the REMI help menu are a series of short instructional videos which guide users through how to complete various tasks and pages in REMI.
Once logged into REMI, a user can press the gray "Help" button located in the upper right-hand corner of the screen to access the full menu of instructional documents. The following user manual documents will be of particular help to new users getting started in REMI:

- Quick Reference Guide
- Accessing SUD Services (Brief Screening and Level of Care Determination)
- SUD Treatment Episodes (Admission, Discharge, BH TEDS, Authorizations and Supporting Documents)
- Claims Submission for SUD Providers
- Signatures and Document Amendment Process
- Benefit Plans

A Note About Clinical Information When Providing Non-Clinical Services (e.g.: Recovery Supports): For agencies who provide recovery support services only, please be sure that you are not entering clinical information such as Substance Use or Mental Health Diagnoses into the admission record if the client has not received a clinical assessment by a qualified practitioner. If the client has received a clinical assessment by a qualified practitioner *and* your agency has obtained a copy of that assessment, you may enter any diagnoses that are indicated on the assessment into the admission record. A copy of the assessment must be kept in the client file.

If the client has not received a clinical assessment by a qualified practitioner, use of a provisional diagnosis or diagnostic impression is still necessary. The appropriate ICD-9-CM V code or Z code contained in the ICD-10-CM should be used to indicate factors associated

with the predisposition toward a potential diagnosis that without proper intervention, will lead to a full diagnosis. Typically, a provisional diagnosis can be used when there is strong presumption that the criteria could or will be met, but not enough information exists to make the full diagnosis. Diagnosing can only be done by appropriate master's or greater-level clinicians. The application of specialized clinical knowledge and advanced clinical skills in the areas of assessment, diagnosis, and treatment of mental, emotional, and behavioral disorders, conditions, and addictions is the purview of practice of social work at the master's level.

Authorizations

- Timeliness Standards: Authorization requests should be completed for every consumer within 1 business day of admission to withdrawal management services or within 3 business days of admission to all other levels of care. Re-authorization requests are expected to be submitted within 3 business days of the expiration of the previous authorization. Incidents of repeated non-adherence to these timeliness standards by a specific agency may result in denial of the late authorization request or approval for a reduced number of service units than requested. Authorization requests that are late may be denied. The MSHN UM Department should be contacted if the provider needs to discuss reasons for late authorization submission.

- Returned Authorization Requests: MSHN UM specialists may return an authorization after reviewing it in order to request further information or corrections from the SUDSP. In these instances, the SUDSP should respond within three (3) business days. MSHN UM specialists should then respond to returned responses within three (3) business days.

- Documentation Standards: When entering authorization requests, please adhere to the following clinical documentation standards:

    - All areas of the authorization request need to be completed in their entirety to ensure that the MSHN UM Department has enough information to justify continued treatment.

    - Please be sure that authorization date ranges are sequential and do not overlap. If the current authorization expires on 4/30/2018, please begin the re-authorization request on 5/1/2018. Providers may also choose to early terminate an authorization that is no longer needed in order to begin a new re-authorization. Please refer to page 25 of the document "SUD Treatment Episodes (Admission, Discharge, BH TEDS, Authorizations and Supporting Documents)" located in the REMI help menu for instructions about early termination of authorizations.

    - An individualized treatment/recovery plan or treatment/recovery plan review document must be uploaded to the REMI client chart accompanying each re-authorization request. The plan or review must be dated within 90 days of the start date of the authorization request or the authorization may not be approved. Treatment/recovery plans must identify treatment goals and objectives as well as specific progress the client has made toward each goal and objective.

Treatment/recovery plans must also identify any services that are being requested in the authorization.

- All reauthorizations must include a documented continuing care and/or discharge plan in order to be authorized. If a detailed plan has not yet been created, please give the estimated length of remaining treatment as well as natural and community supports that have been identified throughout the current treatment episode

- Reauthorization units will be determined on a case-by-case basis utilizing ASAM and medical necessity criteria. Please also refer to the document titled "Benefit Plans" in the REMI Help menu. This document outlines the MSHN recommended utilization guidelines for services at each ASAM level of care. Please note, the amounts of services identified are recommended utilization, not benefit limits to the client. If utilization surpasses these recommended guidelines, it triggers further review by the MSHN utilization management department to ensure medical necessity of the services.

- REMI includes a messaging feature that allows users to send secure messages to one another. Providers may use this feature to communicate questions, concerns, or other relevant information to MSHN staff members. The messaging feature within REMI meets all standards with regard to confidentiality of protected health information.

Modifier Codes: The Michigan Department of Health and Human Services (MDHHS) has developed a set of modifiers (listed in the MSHN "Benefit Plan" document) which are attached to service billing codes for the purpose of tracking service provision to certain specialty populations. Please note, these modifiers are assigned to each SUDSP on an individual basis according to established licensing and credentialing criteria so these modifiers will not be available in REMI to every treatment agency. Treatment agencies who wish to have access to specific modifiers will need to work with their designated MSHN Treatment or Prevention Specialist to submit documentation of appropriate credentialing/licensing in order to have the requested modifier made available in REMI.

Transfer Between Providers: If a client is transferring from one provider to a different provider OR if a provider has more than one (1) license and the consumer is changing levels of care to a different license number, then please complete a discharge summary and choose "transfer" as the reason for discharge. In the comments section please note which provider or level of care the client is transferring to, and date of first appointment with that provider.

Level of Care Changes Within the Same Provider: If a client is transferring from one level of care to a different level of care within the same provider, and both levels of care have the same license number, a discharge summary is not required until the client has completely finished the treatment episode and is being discharged from all services.

Dual Program Enrollment: At times it may become necessary for one client to be enrolled in treatment services with more than one SUDSP at the same time. MSHN has established the following guidelines to prevent duplication of services and facilitate best client care:

- The programs must each be providing different services to the consumer (utilizing different codes) that are not available at the same provider

- There is clinical justification for medical necessity of all services being provided, established by an assessment

- There is coordination between all programs involved in the client's care, (with appropriate client release of information), which is documented in the client's clinical chart as well as in REMI authorization requests.

- The MSHN UM department must be contacted prior to dual enrollment

Discharge Summary: A treatment episode is assumed to have ended at the time the consumer has not been seen for five (5) days for residential treatment and sixty (60) days in the case of outpatient care. Consumers not seen in these timeframes shall be discharged from the REMI system. (See State Treatment Episode Data Set (BH-TEDS) Admission/Discharge Coding Instructions at www.mi.gov/mdhhs). Please note, the discharge date recorded on the REMI system should be the last date the client received a billable treatment service from the provider.

For Medicaid/Healthy Michigan Plan Clients: If a client has not participated in scheduled services, please send the required Medicaid Advance Action notice to the client and allow them at least 12 days to respond. Once that time period has passed then proceed to enter the discharge summary on REMI, however on the discharge form the date of discharge will be recorded as the date the client was last seen for services. That date is still considered the date the client effectively disengaged from services, but they are then given the required 12-day response time to have the opportunity to re-engage in services. If the client re-engages in services within that timeframe, the discharge does not occur.

MSHN places a high level of importance on discharge/continued care planning. Please review the expectations related to Discharge Planning beginning on page 24 of the MSHN SUDSP Manual. Additionally, it is the expectation of MSHN that all discharge summaries are completed in a timely manner. For a planned discharge (i.e.: the client is referred to a different provider, the client successfully completed treatment, etc.), the expectation is that the discharge summary is completed in 24 hours for Detox service providers and 3 business days for all other levels of care. In the event of an unplanned discharge, (i.e.: client has stopped attending scheduled treatment), please follow Medicaid Notice of Action guidelines by providing the client (or mailing to client's last known address) a written Advance Action Notice to close the client's case. Once the window of response time has lapsed, please complete the discharge from REMI within 3 business days. The MSHN UM department requires providers to complete a monthly discharge report to ensure they are adhering to these established timeliness standards.

Provider Appeal Process

Mid-State Health Network (MSHN) has established a process for providers for the resolution of appeals of MSHN denials of service. This process is for when the provider has already provided

the service, the consumer is no longer receiving services at the agency, the authorization request was subsequently submitted and reviewed, and was denied by MSHN Utilization Management (UM). An Adverse Benefit Determination notice (see attachment A) shall be mailed to the consumer and a copy of the letter will also go to the provider explaining the denial of payment for services. The consumer shall be informed that as a Medicaid or Healthy Michigan Plan beneficiary, he or she is not liable to pay for the service and the provider may not bill the consumer for the services. Consumers will be encouraged to contact MSHN Customer Service should he or she receive a bill from the provider, or for any other concerns or questions regarding the denial of payment for services process. ~~A provider may file an initial appeal to the MSHN Customer Service Department regarding service authorization decisions. Providers are encouraged to contact the MSHN Utilization Management (UM) Department prior to submitting an appeal for the purpose of reaching a satisfactory resolution in the most expedient manner possible.~~

~~If MSHN should deny the provider compensation to which the provider believes it is entitled, the provider shall notify MSHN Customer Services in writing within thirty (30) days of the date of notification of denial, stating the grounds upon which it bases its claim. MSHN shall then have thirty (30) days to review and provide final determination of the appeal.~~

~~Services shall not be delayed or denied as a result of the dispute or potential dispute of payment responsibility, however at the time of delivery, each service must meet medical necessity criteria and be documented to accepted standards of care. All services provided must be clearly specified and relate to scope, amount, and duration in the approved plan of service.~~

~~When the treatment service has already been provided to the consumer and where the MSHN UM Department has denied the service authorization request, an adequate action letter (see attachment A) (including the Request for Hearing Form and envelope) shall be mailed to the consumer and a copy of the letter will also go to the provider. The consumer shall also receive a phone call and be informed as to why the adequate action letter was sent. The consumer shall be informed of the formality of the requirement, including that as a Medicaid or Health Michigan Plan beneficiary, he or she is not liable to pay for the service and does not need to do anything with the Request for Hearing Form. The consumer shall not be billed by the provider. The letter also explains that the consumer may also contact MSHN should he or she receive a bill from the provider, or if there should be any other concerns or questions about the letter or any part of the process.~~

Providers are first encouraged to contact a MSHN UM Specialist prior to submitting an appeal to explore why the service(s) was denied and what may be needed to reconsider the payment for service(s) before requesting an appeal. If a resolution cannot be reached then a provider may file an appeal through the MSHN UM Department regarding the service denials. Providers must follow the Denial of Payment for Services Appeal Process as outlined below for an appeal request to be processed by MSHN UM.

Appeal Process

1. If a resolution cannot be reached than providers have sixty (60) calendar days from the date of the denial to request an appeal. No appeal will be considered after sixty (60) calendar days.

~~1. All appeals must be in writing and include the date of the appeal, decision grieved, resolution requested, and supporting rationale for requested change in decision and indicate if issue warrants an "Expedited Review Situation."~~

2. All appeals must be in writing and include the date of the appeal, decision grieved, any provider actions taken to resolve the denial, the resolution requested, and the supporting rationale for requesting~~ed~~ a change in decision. ~~and indicate if issue warrants an "Expedited Review Situation."~~

~~3. An Expedited Review Situation is an expedited review of a service authorization denial, requested by the provider. When the provider requests the expedited review, MSHN shall determine, if the request is warranted and shall inform the provider as to the status of the decision.~~

~~4. No appeal will be considered after sixty (60) calendar days from the date of the action being grieved.~~

~~5.~~3. Appeals will be submitted to the MSHN customer service department. ~~The appeal can be made directly to the Utilization Management Department for decisions made regarding the authorization or determination of the service(s).~~

~~6.~~4. As appropriate, the MSHN Customer Service~~UM~~ Department will include input from the appropriate MSHN ~~staff and/or departments~~position/function~~,~~ including:

a. Director of Provider Network Management Systems;
b. Contract Manager;
c. Utilization Management Specialist;
d. Claims Specialist;
e. Director of Utilization & Care Management ~~and Waivers~~;
f. Chief Clinical Officer;
g. Medical Director/~~Addictionist~~ Addictionologist

~~7.~~5. The Customer Service Department will communicate the decision to the provider within thirty (30) calendar days of the receipt of the appeal.

Please note that this Denial of Payment for Services Appeal Process is separate from Mid-State Health Network's (MSHN) established Provider Appeal process for contracted providers which provides mechanisms to dispute contract concerns, payment performance review findings, contract monitoring and oversight, or adverse credentialing decisions. Please review the Provider Appeal Procedure for Substance Use Disorder (SUD) Providers procedure for more information.

~~9. The Utilization Management Department will communicate the decision to the provider within 45 45 calendar days of receipt of the appeal. If the appeal is an Expedited Review Request, the Utilization Management Department will render a decision within 10 business days of receipt of the appeal.~~

10. ~~Mid-State Health Network (MSHN) is obliged to offer contracted providers with an appropriate mechanism to dispute contract concerns, payment performance review findings, contract monitoring and oversight, or adverse credentialing decisions. The Provider Appeal Procedure for Substance Use Disorder (SUD) Providers procedure is intended to assure that a uniform process for appeal is used in the region.~~

11. ~~Any appeals that pertain to requests for provider expansion of use of treatment/service codes or additional treatment/service codes requested for authorization shall be referred to the MSHN Director of Provider Network Management Systems and the MSHN Contract Manager for review.~~

HCPCs/CPT Service Code Grid

A full list of all service codes can be found in the provider contract or on the provider section of our website.

References

- OROSC Treatment Policy #7 Access Management System
- OROSC Treatment Policy #10 Residential Treatment Continuum of Services
- MSHN CMHSP Responsibilities for 24/7/365 Access for Individuals with Primary Substance Use Disorders
- MDCH Technical Treatment Advisory #6 Counseling Requirements for Clients Receiving Methadone Treatment
- MDCH Technical Treatment Advisory #7 Recovery Support Services
- MDCH Technical Treatment Advisory #5 Welcoming
- Michigan Compiled Laws-MCL Section 333.18501
- Michigan Department of Health and Human Services "Michigan PIHP/CMHSP Provider Qualifications Per Medicaid Services & HCPCS/CPT Codes", January 2016
- Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Program
- Medicaid Provider Manual, Behavioral Health and Intellectual and Developmental Disability Supports and Services, Section 2-Program Requirements, 2.3 Location of Service
- Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition: DSM-V, American Psychiatric Association

Appendix B: Veteran's Eligibility Technical Requirement

Summary

Veterans and military service members who request services from the Mid-State Health Network's (MSHN) provider system may require additional assistance through coordination of benefits to ensure that the proper referral is made in a timely fashion. The following technical requirement has been established to further supplement MSHN's Technical Requirement, *CMHSP Responsibilities for 24/7/365 Access for Individuals with Primary Substance Use Disorders*.

Purpose

These requirements exist to establish MSHN Utilization Management (UM) guidelines for Veteran's/military service member's access to the MSHN substance use disorder (SUD) treatment system of care and/or referral to the appropriate Veteran's Affairs (VA) provider, where applicable.

Procedure

A. Veteran's Affairs (VA) Benefits

If the individual served in the active military in any branch~~, naval, or air service~~ and are separated under any condition other than dishonorable, they may qualify for VA health care benefits. Staff will seek out insight as to whether the client is covered by any/some of them. These benefits include:

1) Tricare:
Tricare, formerly known as the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), is a health care program of the United States Department of Defense Military Health System. Tricare provides civilian health benefits for U.S Armed Forces military personnel, military retirees, and their dependents, including some members of the Reserve Component.

2) CHAMPVA:
The Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) is a health benefits program in which the Department of Veterans Affairs (VA) shares the cost of certain health care services and supplies with eligible beneficiaries. In general, the CHAMPVA program covers most health care services and supplies that are medically and psychologically necessary.

3) Veteran's Choice Program:
To improve access to and quality of care for veterans, the Veterans Access, Choice, and Accountability Act (VACAA) of 2014 requires that the VA offer an authorization to receive non-VA care to any veteran who is enrolled in the VA health care system as of August 1, 2014, or who is a newly discharged combat veteran if such veteran is unable to secure an appointment at a VA medical facility within 30 days (or within 30 days that he or she wishes to be seen) or resides more than 40 miles from the nearest VA medical facility. The VACAA requires the VA to provide a Veterans Choice Card to eligible veterans to facilitate care provided by non-VA providers. Veterans Choice Program (VCP) provides primary care, inpatient and outpatient specialty care, and mental health care for eligible Veterans when the local U.S. Department of Veterans Affairs (VA) health care facility cannot provide the services. To verify eligibility, Veterans must call the Choice Program call center at: 866-606-8198

B. Verification and Coordination of Benefits

MSHN shall screen any Veteran/military service member to determine whether the individual has active VA benefits, other third-party liability coverage (TPL), is covered by Medicaid or Health Michigan Plan (HMP), or has no coverage. The MSHN UM Specialists shall verify the coverage of the client, including the following details:

1) Federal regulations require that all identifiable financial resources be utilized prior to expenditure of Medicaid funds for most health care services provided to Medicaid beneficiaries. Medicaid is considered the payer of last resort.
2) Information about a beneficiary's other insurance is available through the CHAMPS Eligibility Inquiry and/or vendor that receives eligibility data from the CHAMPS 270/271 transaction.
3) Coordination of Benefits (COB) is the mechanism used to designate the order in which multiple carriers are responsible for benefit payments and, thus, prevention of duplicate payments. Third party liability (TPL) refers to an insurance plan or carrier (e.g., individual, group, employer-related, self-insured or self-funded plan), commercial carrier (e.g., automobile insurance and workers' compensation), or program (e.g., Medicare) that has liability for all or part of a beneficiary's medical coverage.
4) If a Medicaid beneficiary is enrolled in a commercial health insurance plan or is covered by a traditional indemnity policy or military/veteran insurance, the rules for coverage by the commercial health insurance, traditional indemnity policy, or military/veteran insurance must be followed (Michigan Medicaid Provider Manual, 2016, p. 129).
5) Verification of Medicaid or HMP eligibility at the time the screening is performed. If the client has Medicaid or HMP, the MSHN UM Specialist will proceed with authorizing services as with any other caller who possesses the same coverage. Note: Veterans/military service members who possess Medicaid and are professing barriers to accessing treatment through VA should be granted access if a good faith effort has been made to connect with VA services.
6) Verification of Medicaid or HMP eligibility before action is taken on provider's request for authorization or reauthorization for treatment services (i.e. the client has already started service with the SUD treatment provider). If the request for authorization or re-authorization is made, it shall include the details necessary to assist the MSHN UM Specialist in determining eligibility for coverage.
7) If the Veteran/military service member qualifies for VA health benefits, a warm transfer to the appropriate VA Community Based Outpatient Clinic (CBOC) should be initiated.
8) If the client is uninsured (i.e. does not have Medicaid or HMP), a warm transfer to the VA should be made to determine the Veteran's VA eligibility and/or level of care.
9) If the uninsured client is ineligible for VA services, then the MSHN UM Specialist should ensure there are no other funding options present for the Veteran/military service member before assigning Block Grant funds.
10) The VCP benefit may be limited in the service area, including access to specialty care (i.e. case management, recovery support, and concurrent psychiatric care), and MSHN UM Specialists should authorize SUD services consistent with medical necessity criteria and VA benefit limitations in order to close service gaps and enhance care access and delivery.
11) If the Veteran/military service member has no third-party coverage and has Medicaid or HMP, then MSHN is the primary authorizer of substance use disorder (SUD) services.

The MSHN-contracted SUD treatment provider shall also verify the coverage of the Veteran/military service member, including the following:

1) Responsibility for client's Medicaid or HMP eligibility verification, regardless of whether confirmed by the client or UM Specialist at time of the client's admission.

2) Provider will also perform monthly Medicaid or HMP eligibility verification and maintain evidence of having done so.

C. Veteran Service Access

Providers should note that a client's service in the U.S. military does not automatically mean they receive Veteran's Affairs (VA) benefits. Providers should, however, work with clients to ensure VA benefits are used as primary insurance, *if available*. Eligibility for VA benefits are determined by the VA upon review of a Veteran's discharge paper (known as the DD-214). The Veteran may use the following site for obtaining their DD-214 if it has been misplaced: Michigan Veteran's Affairs Agency A Veteran may begin applying for health benefits by completing the Department of Veteran's Affairs form 10-10EZ, located here: 10-10EZ Form. A Veteran, whom may not have internet access, can also go into a CBOC to receive assistance in applying and completing the 10-10EZ form. The basic requirements for VA health care eligibility include, but are not limited to:

1) Honorable or General Discharge from Service. (Note: There is also Other Than Honorable, Bad Conduct, and Dishonorable Discharge from Service. Dishonorable discharge is the only type of discharge that a Veteran is not able to receive VA benefits, but a Veteran is able to request an upgrade in their discharge to possibly allow an opportunity to obtain VA services).
2) Veterans who have enlisted after September 7, 1980 or entered active duty after 10/16/1981 that have provided 24 months of continuous service.
3) National Guard and Reservists may also qualify for VA benefits if they were called to active duty (other than for training) by Federal order. National Guard must have Title 10 status. This is federal activation and must be activated for more than 30 days to qualify for VA benefits. Activation can be state side or overseas. National Guardsman with a Title 32 status do not qualify for VA benefits as they are paid by the state of Michigan and are not federally activated.

This website https://www.michiganveterans.com/find-benefits-counselor has up to date information on service officers for each county who can assist clients in determining eligibility for VA benefits. County Veteran's Affairs offices are another good place to start when a client needs assistance with accessing VA benefits, applying for disability (if appropriate), connecting to local transportation, and financial resources. Generally, the client will find out if he or she is eligible for VA healthcare benefits rather quickly. Veterans/military service members are encouraged to complete the 10-10EZ form with the assistance of the Enrollment Coordinator at their local VA health care facility or a Service Officer/Benefits Counselor in their county; mailing the form in is not encouraged due to the delay it will cause.

The VA has Relapse Prevention and Intensive Outpatient (IOP) services available to eligible Veterans/military service members. The VA also has Veteran's Justice Outreach (VJO). The VJO is designed to collaborate with the local justice system partners to identify Veterans that enter the criminal justice system and are in need of treatment services rather than incarceration.

Residential/Detox: requests for eligible Veterans/military service members should be sent to the VA. If the client is not eligible or professing barriers to accessing treatment through the VA, treat them as any other client. MSHN may pay for detox if the VA does not. The client should have no other funding options.

Methadone Services: If a Veteran is uninsured, the VA can contract with the Victory Clinic, depending on the county they reside in.

SUD Outpatient Care (OP): The VA also has a contract for those who are uninsured and are in need of SUD OP services. The VA contact person should be contacted to determine whether the Veteran/military service member is eligible for coverage.

References/Legal Authority

- Department of Veteran's Affairs
- Michigan Medicaid Provider Manual, 2016
- Veterans Access, Choice, and Accountability Act of 2014 (VACAA): Veteran's Choice Program

Appendix C: MSHN MAT Protocol

INSTRUCTIONS AND PROTOCOLS FOR THE IMPLEMENTATION OF MEDICATION-ASSISTED TREATMENT (MAT)

Note: This document establishes technical and service requirements that providers are contractually obligated to incorporate into the design and delivery of all medication-assisted treatment (MAT) services funded through Mid-State Health Network (MSHN). MAT service providers are required to adopt these protocols in their entirety, as well as incorporate the requirements of the Michigan Department of Health and Human Services, Behavioral Health and Development Disabilities Administration's (MDHHS-BHDDA) policies and advisories, and the Michigan Medicaid Provider Manual.

This document was written and reviewed by MSHN Clinical and Utilization Management staff as well as reviewed by MSHN's SUD Medical Director, Dr. Bruce Springer and the MSHN MAT workgroup. While a primary focus is MAT for Opioid Use Disorder (OUD), additional sections address MAT's applications to other addictive disorders as well. Should you have any questions, please contact MSHN at 517-253-7525

Introduction:

For several decades, addiction to drugs and alcohol was viewed as a character flaw, a sign of moral weakness. Treatment and recovery were almost exclusively abstinence-based, rooted in the 12-step model, and often utilized 30-90-day inpatient stays. This paradigm worked for some patients, but not all.

Medication Assisted Treatment, therefore, broadly refers to the use of medication in treating addiction to a variety of substances: opioids (prescription analgesics and heroin), alcohol, cocaine, benzodiazepines, and marijuana. It is worth noting, however, that MAT has been a standard medical practice in medicine for many decades in both physical and behavioral domains, insulin for diabetes, for example, or Prozac for depression.

Consistent with Medicaid rules, MSHN's policy is that *clients should have a full-service array of treatment options available*. This should include MAT for all persons who have been determined medically and clinically eligible for MAT. Since not all individuals are appropriate for MAT (even when they may meet clinical criteria), MSHN expects providers to assess and stage every client to determine the client's readiness for change as a means of ensuring that the provision of MAT services will best meet the individual needs of the client. MAT providers must inform clients of daily attendance requirements, mandatory counseling requirements, toxicology testing requirements and other program participation requirements outlined in this protocol document both at admission and throughout the course of treatment as applicable.

Although MSHN realizes that Opioid Use Disorder is a chronic, relapsing brain disease that can last a lifetime, it is not the intention of MSHN to provide funding for MAT indefinitely. It is the goal of MSHN to provide intensive MAT to those clients with Opioid Use Disorder in order to enable them to acquire/reacquire the life skills as well as the degree of recovery to assume the financial responsibility for their own treatment. Reviews to determine continued eligibility for methadone dosing and counseling services must occur at least every four months by the opioid

treatment provider (OTP) physician during the first two years of service. This documentation should be included in the authorization request sent to MSHN as well as in the client's record. An assessment of the ability to pay for services and a determination for Medicaid coverage must be conducted monthly.

MEDICATION-ASSISTED TREATMENT & OPIOID USE DISORDER

With the evolution of Methadone Maintenance Treatment in 1968 (and FDA approval in 1972), a reliable and effective treatment for chronic, long-term opioid users became available. In the mid-1980's, buprenorphine (*Suboxone and others*) was introduced as an effective detoxification medication for Opioid Use Disorder (OUD). The Drug Abuse Treatment Act of 2000 enabled specially trained physicians to prescribe approved forms of buprenorphine for the detoxification and/or treatment of OUD. These medical and statutory developments were reinforced by recent research into the neurochemistry of addiction—the role of dopamine in particular--leading to a more robust understanding of addiction as a chronic, often lifelong, brain disease which, like other diseases, may require medications as a component of treatment.

Opioid addiction, however, has received most attention due to what is now viewed as a national public health crisis. According to the American Society of Addiction Medicine (ASAM), of the 20.5 million Americans 12 or older that had a substance use disorder in 2015, 2 million had a substance use disorder involving prescription pain relievers and 591,000 had a substance use disorder involving heroin. Over time, individuals who are addicted to opiates develop an increasing tolerance requiring more and more of the pharmaceutical drugs to achieve the desired effect. Many individuals with opiate addiction are unable to afford costly prescription medications and begin using heroin, which is cheaper and more accessible. Hence the boom in prescription painkiller abuse and a growing heroin epidemic are inextricably linked.

According to the Treatment Improvement Protocol #43, as published by the U.S. Department of Health and Human Services (USDHHS), Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT), the definition of Medication-Assisted Treatment for Opioid Use Disorder is:

"Any treatment for Opioid/Opiate addiction that includes a medication (e.g. methadone, buprenorphine, naltrexone) approved by the U.S. Food and Drug Administration (FDA) for Opioid/Opiate addiction detoxification or maintenance treatment.

"A patient's daily pattern of opioid abuse should be determined. Regular and frequent use to offset withdrawal is a clear indicator of physiological dependence. In addition, people who are opioid addicted spend increasing amounts of time and energy obtaining, using, and responding to the effects of these drugs" (p. 48).

Medication Assisted Treatment may be provided at a licensed and state-regulated OTP (methadone, buprenorphine, naltrexone) or in a physician's office or other healthcare setting (buprenorphine and naltrexone only). Comprehensive maintenance, medical maintenance, interim maintenance, detoxification, and medically supervised withdrawal are types of MAT services.

- Comprehensive Maintenance Treatment: combines pharmacotherapy with a full program of assessment, psychosocial intervention and support services; it is the

approach with the greatest likelihood of long-term success for many clients. Maintenance treatment is typically indicated for the first two years of a methadone program.

- Medical Maintenance Treatment: is provided to stabilize clients and may include long-term provision of methadone, buprenorphine, or naltrexone with a reduction in clinic attendance and other services. A client may receive medical maintenance at an OTP after he or she is stabilized fully and typically subsequent to the first two years of a methadone program.

Medication Assisted Treatment is part of a broader continuum of care for substance use disorders that may include recovery supports, case management and outpatient therapy. The minimum required services for MAT are outlined in Federal regulations (42 Code of Federal Regulations [CFR], Part 8). The MDHHS-BHDDA has published Treatment Policies for both methadone and buprenorphine/naloxone. These treatment policies are identified in the reference section of this document and are available on the MDHHS website.

Eligibility Criteria:

To be eligible for medication assisted treatment services funded through MSHN, the intended recipient must meet the level of care (LOC) determination using the most current edition of the American Society of Addiction Medicine Patient Placement Criteria (ASAM-PPC) and the most current Diagnostic and Statistical Manual of Mental Disorders (DSM). Medical necessity requirements shall be used to determine the need for methadone or buprenorphine/naloxone as an adjunct treatment and recovery service (Medicaid Provider Manual). Further, the intended recipient should be assessed for the ability to benefit from MAT services, including the stage of change in which the client is presenting. Individuals are afforded a choice of provider upon determination of appropriate level of care.

Admission procedures for MAT require a physical examination. This examination must include a medical assessment to confirm the current DSM diagnosis of Opioid Use Disorder (OUD) and rule out chronic pain disorder without a diagnosis of OUD considered to necessitate use of opioids. It is the expectation that clients seeking opioids for chronic pain issues will be referred to a primary care physician. MSHN does not fund the use of methadone or buprenorphine/naloxone for pain management. A clear diagnosis of Opioid Use Disorder must be present prior to any MSHN funds being utilized for clients with chronic pain.

General Expectations:

Individual needs and rate of progress vary from person-to-person and, as such, treatment and recovery must be individualized and based on the needs and goals of the individual (Treatment Policy #06: Individualized Treatment Planning, 2012). Collaborative care ideally includes: "multiple professional, individual patients, family members, and to assist patients as they maneuver through often complex multi-component systems of care," (Waller, 2014, p.14). The use of case managers, care coordinators, and recovery coaches is recommended for individuals whenever possible (Treatment Policy #08: Substance Abuse Case Management Requirements, 2008). Increasing the individual's recovery capital through these supports, will assist the recovery process and help the individual to become stable and more productive within the community.

Counseling services should be conducted by the opioid treatment program (OTP) that is providing the methadone whenever possible and appropriate. When the ASAM LOC is not outpatient or when a specialized service is needed, separate service locations for methadone dosing and other substance use disorder services are acceptable, as long as coordinated care is present and documented in the individual's record. (Treatment Policy #05: Criteria for Using Methadone for Medication-Assisted Treatment and Recovery, 2012). These exceptions must be approved by the MSHN Utilization Management (UM) Department prior to admission into another treatment program. Please see the Dual Program Enrollment section of the UM Manual for further instruction.

Comprehensive Recovery Planning:

MSHN expects the provider to begin working on a comprehensive recovery plan with EVERY client immediately upon admission and be able to show documentation of assisting the client with developing a comprehensive recovery plan, which includes but should not be limited to: building a recovery support network, developing a relapse prevention plan, achieving a stable living environment, securing stable employment (when appropriate), and improving overall wellness and quality of life.

Progress will be measured by the documentation of active participation in treatment as evidenced by: quantifiable evidence of progress toward goals and objectives on a collaborative recovery plan designed to address treatment, promote recovery and self-sufficiency; reduction in problem severity, and negative toxicology screens or evidence of engagement in strategies to address recovery.

According to the Medication-Assisted Treatment Guidelines for Opioid Use Disorder (Waller, 2014), if there is evidence that progress is not being made toward agreed-upon goals, the diagnosis, treatment modalities, treatment intensity, and treatment goals will be reassessed in order to revise the treatment plan rather than introduce a premature termination from treatment.

All agencies that provide methadone assisted treatment will be responsible for completing the annual assessment to determine if the client will continue in treatment and to update assessment information. An annual assessment, post the initial two-year review, is required in order to ensure that clients continue to qualify for MSHN-funded substance use disorder treatment services. At this time, and throughout treatment, the client should also be evaluated and educated on the possibility of tapering off their medication. Tapering should be done with significant client input due to increased relapse potential. Throughout the course of medication-assisted treatment, specific documentation must be included in the client file which evidences attempts at decreasing the dosage tapering off of the medication, decreasing problem severity, and provider assisting the client in achieving employment and other recovery goals that promotes self-sufficiency. Without such documentation medication-assisted treatment services may cease to be funded.

Clients funded through Medicaid for buprenorphine/naloxone or methadone may continue treatment according to their specific Medicaid benefit as long as medically necessary and clinically appropriate. Justification for this continued treatment must be documented in the

client file and in the REMI system, including treatment attendance, medical necessity, and ASAM Patient Placement Criteria.

Regulatory Compliance/Coordination of Care:

All MAT providers must obtain client consent to contact other MAT providers within a 200-mile range to have the ability to regularly monitor for enrollment in other medication-assisted treatment programs.

Legally prescribed medication including controlled substances must be presented to the physician, who will decide whether these prescriptions are appropriate for the patient who is taking methadone. Coordination of care with the prescribing physician is required. Upon admission (within five business days), a release of information and a letter explaining client's involvement in MAT will be faxed to the prescribing physician, with a copy being placed in the client file. A response from the prescribing physician is expected. If the MAT provider is unable to elicit a response within the first 30 days from the prescribing physician, the provider is to contact the MSHN UM Department for assistance. Updates to the prescribing physician regarding client's progress in MAT will be completed during each re-authorization period. These updates need to be included in the client file as well as documented in the REMI system.

All MAT providers will require that clients provide a complete list of all prescribed medications. Legally prescribed medication, including controlled substances, must not be considered as illicit substances when the provider has documentation that it was prescribed for the client. Legally prescribed medications that are not being used as prescribed will be treated as illicit substances and must be documented in the client file. Approved examples of such documentation include copies of the prescription label, pharmacy receipt, or pharmacy printout.

A Michigan Automated Prescription System (MAPS) report must be completed at admission into the program ("Treatment Policy #05: Criteria for Using Methadone for Medication-Assisted Treatment and Recovery," 2012). For clients receiving methadone, a MAPS report must be completed prior to initial dosing and prior to off-site dosing being approved. Off-site dosing is not allowed without documented coordination of care by the MAT provider's physician and the prescriber of identified controlled substances, which include, but may not be limited to: Opioid/Opiates, benzodiazepines, muscle relaxants. This coordination must be documented in the doctor's notes. Documentation must be individualized, identifying the client, the diagnosis, and the length of time the client is expected to be on the prescribed medication.

A MAPS report must be run prior to all reauthorization requests for individuals that are receiving MAT with either methadone or buprenorphine/naloxone. If a MAPS report shows prescriptions of controlled substances, this will be addressed on the client's individualized treatment plan.

According to Treatment and Recovery Policy #05: Criteria for Using Methadone for Medication-Assisted Treatment and Recovery (2012, p. 5), "Michigan law allows for individuals with the appropriate physician approval and documentation to use medical marijuana. Although there are no prescribers of medical marijuana in Michigan, individuals are authorized by a physician to use marijuana per Michigan law. For enrolled individuals, there must be a copy of the MDHHS registration card for medical marijuana issued in the individual's name in the [client] chart or

the 'prescribed medication log'." A copy of the client's *registration card* must be included in the client chart and documented in REMI.

Nine percent of people exposed to Cannabis develop Cannabis use disorder. MSHN strongly agrees that Cannabis is a gateway drug to other substances and to relapse. There is real concern that marijuana negatively alters the pleasure center of the brain and may pave the way for psychotic illness in vulnerable individuals. MSHN asks that all of its providers continue to work with their clients to encourage abstinence from marijuana while undergoing MAT for opiate/opioid use disorders. Evidence of continued use of Cannabis will be sought during site reviews and will remain a subject of ongoing discussion with MSHN contracted providers.

Drug Screens:

Drug screens for clients receiving methadone assisted treatment are considered part of the daily dosing rate. For clients receiving buprenorphine/naloxone services, there are two codes available for drug screens: H0003 Laboratory Analysis for Drug Screen and H0048 Instant Drug Testing Collection and Handling Only. H0048 should be used for most screens and H0003 only when medically necessary. For further information regarding appropriate use of drug screens, please contact the UM Department at 844-405-3095.

This item does not apply to medication-assisted treatment (MAT) services.

Department-administered treatment funds can be used to pay for drug screens, if all three of the following criteria are met:

- No other responsible payment source will pay for the screens. This includes self-pay, Medicaid, and private insurance. Documentation must be placed in the client file; and
- The screens are justified by specific medical necessity criteria as having clinical or therapeutic benefit; and
- Screens performed by professional laboratories can be paid for one time per admission to residential or withdrawal management services, if specifically justified. Other than these one-time purchases, Department funds may only be used (in residential and WM settings) for in house "dip stick" screens.

METHADONE ASSISTED TREATMENT

Methadone Assisted Treatment Expectations:

Disclaimer: the use of medications, or not, is the responsibility of the medical practitioner with which the consumer is engaged and nothing in MSHN protocols should be interpreted as medical advice, promotion of one form of medication over another, or in any other way to interfere with or modify the physician's orders or practice.

Upon assessment, every individual wishing to enter or re-enter methadone assisted treatment will be provided with *Methadone Assisted Treatment Expectations* form (Appendix A). Upon admission to the methadone assisted treatment provider, the individual will sign the *Methadone Assisted Treatment Expectations* form assuring his/her understanding of the expectations,

which include the following and will be reviewed annually or as necessary by the outpatient treatment provider (if applicable) and methadone assisted treatment provider:

- Discontinuation of the use of all illicit and non-prescribed drugs and alcohol;
- Regular attendance at the MAT provider for dosing (daily, with the possible exception of Sundays and holidays, until such time that the individual meets criteria for take-home dosages in the case of methadone, and as clinically and medically appropriate for buprenorphine);
- Submit to toxicology sampling as requested;
- Attendance and active participation at all group, individual treatment sessions, and/or other clinical activities;
- Comply with the individualized treatment and recovery plan, inclusive of following through on other treatment and recovery plan related referrals. Repeated failure should be considered on an individual basis and only after the MAT provider and outpatient treatment provider (if applicable) have taken steps to assist the individual to comply with activities;
- Adherence to all program rules and policies;
- Manage medical concerns/conditions, including adherence to physician treatment and recovery services and use of prescription medications that may interfere with the effectiveness of methadone and may present a physical risk to the individual;
- Provide the names, addresses, and phone numbers of all medical, dental, and pharmacy providers;
- Sign Authorizations to Release Information with medical, dental and pharmacy providers in order to better coordinate treatment. If an individual refuses to meet these expectations, it could negatively impact the individual's success with treatment;
- Produce valid prescription or medication bottles with the physician's name on the label for all controlled substances within one week of admission. If the individual tests positive for a controlled substance that he/she has not previously provided a valid prescription for, the individual agrees to present a valid prescription or current medication bottle(s) with the physician's name on the label for the controlled substance before the individual receives his/her next regular or full methadone dose. Coordination should occur with prescribing doctor if that this the case. If illicit use is determined, the illicit source should be discontinued;
- Prescribed medications may have to be changed in order to better coordinate treatment;
- Enrollment in one MAT provider only (methadone and/or buprenorphine). If an individual is enrolled in more than one (1) medication-assisted treatment Provider at a time (methadone and/or buprenorphine), the individual may be administratively discharged from the methadone program;
- Evidence of continued work toward goals outlined in treatment plan; and,
- No altered urine screens or non-compliance with drug testing.

<u>General eligibility guidelines to consider when authorizing treatment for methadone-assisted treatment services:</u>

- Client meets criteria for a diagnosis of Opioid Use Disorder;
- Client has been opioid dependent for a minimum of one year;
- Is 18 years of age or older. A client under 18 years of age is required to have had at least two documented unsuccessful attempts at short-term detoxification and/or drug-

free treatment within a 12-month period to be eligible for maintenance treatment with the exception of a pregnant woman for which detoxification is not recommended;
- There must be no acute, serious, and unmanaged medical problems. This would require hospitalization and stabilization of the medical issue prior to assisting the client with substance use disorder treatment;
- Other drug/alcohol use will be considered. Other drug use is not necessarily a reason to deny methadone-assisted treatment. If clinically appropriate (alcohol and benzodiazepines), send client to detox before admission to MAT;
- Concurrent illnesses can be stabilized and maintained on an outpatient basis;
- No psychiatric illnesses that need to be addressed that could complicate treatment; (Untreated, un-medicated, unmanaged psychiatric issues or psychiatric issues that the Methadone-assisted treatment facility is not equipped to handle);
- Client is in immediate danger of continued using behavior without the treatment;
- Sufficient, safe, and supportive living environment (or client agrees to work toward obtaining);
- Client exhibits moderate to severe withdrawal or potential moderate to severe withdrawal;
- Client is pregnant and has a documented Opioid/Opiate dependency in the past and may continue to engage in active use during the pregnancy;
- Client is not seeking Methadone dosing for pain management (for pain management, refer to PCP or pain clinic, etc.);
- Provider will communicate to the client the importance of full participation in coordination of care efforts with the primary care physician(s); and,
- Client must have access to transportation (as they will be required to present at the facility on a daily basis).

<u>General minimum service requirements for authorizing methadone assisted treatment services:</u>

- Comprehensive biopsychosocial assessment with an initial diagnosis of Opioid Use Disorder of at least one-year duration;
- Coordination of care with all prescribing physicians, treating physicians, dentists and other health care providers;
- Physical examination upon admission and as appropriate during the course of treatment;
- Mandatory 90-day review for initial requests and the first re-authorization request followed; by 120-day reviews to determine continued eligibility;
- Daily attendance requirements for medication dispensing;
- Must be used as an adjunct to Opioid Use Disorder treatment which must include a counseling component;
- Mandatory toxicology screening at intake and randomly thereafter, toxicology screening must assay for Opioid/Opiates, cocaine, barbiturates, amphetamines, cannabinoids, benzodiazepines and methadone metabolites; urinalysis testing shall be performed for clients in accordance with Federal, State, and Licensing rules.
- Identification, treatment, or referral for treatment of co-occurring disorders and neuropsychological problems;
- Counseling to assist in discontinuation of substance abuse and manage drug cravings and urges;
- Evaluation of and interventions to address family problems;

- HIV and Hepatitis C Virus (HCV) education, counseling, and referral for testing and/or care; and,
- Referral for additional services as needed.

Behavioral Contracts:

It is MSHN's expectation that all clients and providers will adhere to the rules of MAT as dictated by MSHN as well as the Federal and State governments. However, as per the Department of Health and Human Services memo dated June 29, 2017, MSHN will not support the use of behavioral contracts in its provider network. Similarly, MAT providers shall not mandate or require behavioral contracts for any of their clients receiving MAT services. Illicit use should be addressed in a meaningful way on the client's individualized treatment plan.

Block Grant Wait-list for Methadone Assisted Treatment:

At times, the demand for an individual funded through Block Grant and seeking methadone services may exceed capacity. When this occurs, the MSHN UM Department will place the individual on a waiting list. Census of the Block Grant funded individual must remain static. As such, methadone assisted treatment providers may admit an individual approved by the MSHN Utilization Management Department, *only when a treatment slot becomes available*. Such admission slots become available only when an existing individual funded through Block Grant is discharged from treatment services; whether due to program non-compliance, transfer to self-pay status, obtaining Medicaid, or successful program completion.

The individual funded through Block Grant and placed on the waiting list should 1) be encouraged to go to local Outpatient treatment services while on the waiting list, 2) be encouraged to apply for Medicaid or Healthy Michigan Plan, and 3) be told to contact the MSHN UM Department if he/she obtains Medicaid or Healthy Michigan Plan and is still interested in receiving methadone assisted treatment services. An individual on the Block Grant waiting list will be admitted to methadone assisted treatment services according to his/her current priority status on the waiting list.

When an admission slot becomes available, the MSHN UM Department will make three attempts to contact the next client on the Block Grant waiting list (according to priority status) via telephone. If unable to make contact with client via telephone, the MSHN UM Department will move to the next client according to priority status and repeat the above process until a client is successfully contacted.

Clients so contacted, will be warm transferred to a methadone assisted treatment provider of their choice to arrange for an admission appointment. Clients contacted will have 14 calendar days from the date of initial contact to be admitted into methadone-assisted treatment services. After 14 calendar days have lapsed, the methadone assisted treatment provider will contact MSHN UM Department indicating whether the client failed to present for admission.

If the client fails to present at the methadone assisted treatment provider within 14 calendar days of initial contact by MSHN UM Department, the provider will inform MSHN UM Department. MSHN UM Department will then review the waiting list to determine the next client to be admitted to methadone-assisted treatment services according to their current priority status.

If the client does present at the methadone assisted treatment provider within 14 calendar days, the provider will inform MSHN UM Department of the client's admission date.

Block Grant-funded clients meeting criteria for urgent priority population (pregnant injecting drug users and pregnant substance abusers) will be allowed direct admission into methadone assisted treatment, if appropriate and will not be placed on the Block Grant waiting list.

Individuals funded through Medicaid or Healthy Michigan Plan will not be placed on the Block Grant or any other waiting list. Clients determined to meet eligibility criteria for this level of care will be directed to the provider of their choice.

For buprenorphine/naloxone assisted services: clients receiving buprenorphine/naloxone assisted services will not be placed on a waiting list. Buprenorphine/naloxone assisted services are NOT an alternative to methadone assisted treatment services. Therefore, if a client is assessed as needing methadone assisted treatment services, they would not be placed in treatment with buprenorphine/naloxone. Clients cannot receive buprenorphine/naloxone while on the waiting list for methadone-assisted treatment services.

BUPRENORPHINE/NALOXONE ASSISTED TREATMENT

General eligibility guidelines to consider when authorizing treatment for buprenorphine/naloxone services:

- Client meets criteria for a diagnosis of Opioid Use Disorder.
- Is 18 years of age or older. There is evidence to support the use of buprenorphine/naloxone in adolescents 16 years and older.
- No acute (serious, unmanaged) medical problems.
- Other drug/alcohol use will be considered. Other drug use is not necessarily a reason to deny buprenorphine/naloxone-assisted treatment. If clinically appropriate (alcohol and benzodiazepines), send client to detox before admission to MAT.
- Concurrent illnesses can be stabilized and maintained on an outpatient basis.
- No psychiatric illnesses that need to be addressed that could complicate treatment. (Untreated, un-medicated, unmanaged psychiatric issues or psychiatric issues that the Medication-Assisted Treatment facility is not equipped to handle).
- Client must agree to and fully participate in Coordination of Care efforts with primary care physicians.
- Client is in immediate danger of continued using behavior without the treatment.
- Sufficient, safe, and supportive living environment (or client agrees to work toward obtaining).
- Client exhibits moderate to severe withdrawal or potential moderate to severe withdrawal.
- Client must have access to transportation.

General minimum service requirements for authorizing buprenorphine/naloxone assisted treatment services:

- Comprehensive psychosocial assessment with an initial diagnosis of Opioid Use Disorder

- Coordination of care with all prescribing physicians, treating physicians, dentists and other health care providers
- Used as an adjunct to Opioid Use Disorder treatment which must include a counseling component
- Physical examination upon admission
- Mandatory 90-day review for initial requests followed by 120-day reviews to determine continued eligibility
- Mandatory toxicology screening at intake and randomly thereafter, toxicology screening must assay for Opioid/Opiates, cocaine, barbiturates, amphetamines, cannabinoids, benzodiazepines and methadone metabolites; urinalysis testing shall be performed for clients in accordance with State, Federal, and Licensing rules.
- Identification, treatment or referral to treatment of co-occurring disorders and neuropsychological problems
- Counseling to assist in discontinuation of substance abuse and manage drug cravings and urges
- Evaluation of and interventions to address family problems
- HIV and hepatitis C virus (HCV) education, counseling, and referral for testing and/or care
- Referral for additional services as needed.

Special Notes regarding the use of buprenorphine/naloxone as part of medication-assisted treatment for Opioid Use Disorder:

- All physicians prescribing buprenorphine/naloxone must have a waiver from the Substance Abuse and Mental Health Services Administration (SAMHSA) permitting them to prescribe buprenorphine/naloxone.
- Buprenorphine/naloxone medication is a medical benefit administered through the client's qualified medical health plan and not funded through MSHN.

<u>Medically Supervised Withdrawal Treatment using buprenorphine/naloxone (Suboxone):</u>

It is required of all contracted methadone providers with MSHN that they will offer many various services such as; individual and group therapy, recovery support, case management. MSHN believes that there is great therapeutic value to the client to be included in group sessions with other clients. MSHN promotes the use of group therapy in Medication Assisted Treatment. All services provided must be documented clearly in the record of the person served.

Note: A client entering an outpatient program with buprenorphine/naloxone will usually not require sub-acute detoxification services prior to admission to the outpatient program. It is expected that the majority of clients will enter directly into buprenorphine/naloxone-assisted treatment at the outpatient level without first receiving services through sub-acute detoxification. Special exceptions should be referred to MSHN UM Department at 1-844-405-3095.

According to the Treatment Improvement Protocol #40: Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction (McNicholas, 2004, p. 48), as published by the U.S. Department of Health and Human Services (USDHHS), Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT):

"The literature suggests that the use of buprenorphine for gradual detoxification over long periods is probably more effective than its use for rapid detoxification over short or moderate periods. Patients who are unwilling or unable to engage actively in rehabilitation services without agonist support may not be appropriate candidates for short-term detoxification, however such patients may benefit from long-term detoxification (or even more so, from maintenance treatment)."

DISCONTINUATION/TERMINATION/READMISSION

Per the Michigan Medicaid Provider Manual, (methadone-assisted treatment Provider is referred to as an Opioid Treatment Provider (OTP). Providers that offer buprenorphine assisted treatment are considered Office Based Opioid Treatment (OBOT) providers.÷

12.2.F. DISCONTINUATION/TERMINATION CRITERIA

Discontinuation/termination from methadone treatment refers to the following situations: Beneficiaries must discontinue treatment with methadone when treatment is completed with respect to both the medical necessity for the medication and for counseling services. Beneficiaries may be terminated from services if there is clinical and/or behavioral noncompliance.

If a beneficiary is terminated:

- The OTP must attempt to make a referral for another LOC assessment or for placing the beneficiary at another OTP.
- The OTP must provide an Adverse Benefit Determination and follow Medicaid due process procedures.
- The OTP must make an effort to ensure that the beneficiary follows through with the referral.
- These efforts must be documented in the medical record.
- The OTP must follow the procedures of the funding authority in coordinating these referrals. Any action to terminate treatment of a Medicaid beneficiary requires a "notice of action" be given to the beneficiary and the parent, legal guardian, or responsible adult (designated by the relevant state authority/CPS). The beneficiary and the parent, legal guardian, or responsible adult (designated by the relevant state authority/CPS) has a right to appeal this decision. Services must continue and dosage levels maintained while the appeal is in process, unless the action is being carried out due to administrative discontinuation criteria outlined in the subsection titled Administrative Discontinuation.

Services are discontinued/terminated, either by Completion of Treatment or through Administrative Discontinuation. Refer to the following subsections for additional information.

12.2.F.1. COMPLETION OF TREATMENT

The decision to discharge a beneficiary must be made by the OTP's or OBOT's physician, with input from clinical staff, the beneficiary, and the parent, legal guardian, or responsible adult (designated by the relevant state authority/CPS). Completion of treatment is determined when the beneficiary has fully or substantially achieved the goals listed in their individualized treatment and recovery plan and no longer needs methadone as a

medication. As part of this process, a reduction of the dosage to a medication-free state (tapering) should be implemented within safe and appropriate medical standards.

12.2.F.2. ADMINISTRATIVE DISCONTINUATION

~~Administrative discontinuation relates to non-compliance with treatment and recovery recommendations, and/or engaging in activities or behaviors that impact the safety of the OTP environment or other individuals who are receiving treatment. The OTP must work with the beneficiary and the parent, legal guardian, or responsible adult (designated by the relevant state authority/CPS) to explore and implement methods to facilitate compliance.~~

~~Non-compliance is defined as actions exhibited by the beneficiary which include, but are not limited to:~~

- ~~The repeated or continued use of illicit opioids and non-opioid drugs (including alcohol).~~
- ~~Toxicology results that do not indicate the presence of methadone metabolites. (The same actions are taken as if illicit drugs, including non-prescribed medication, were detected.)~~

~~In both of the aforementioned circumstances, OTPs must perform toxicology tests for methadone metabolites, opioids, cannabinoids, benzodiazepines, cocaine, amphetamines, and barbiturates (Administrative Rules for Substance Use Disorder Service Programs in Michigan, R 325.14406).~~

~~OTPs must test the beneficiary for alcohol if use is prohibited under their individualized treatment and recovery plan or the beneficiary appears to be using alcohol to a degree that would make dosing unsafe.~~

- ~~Repeated failure to submit to toxicology sampling as requested.~~
- ~~Repeated failure to attend scheduled individual and/or group counseling sessions, or other clinical activities such as psychiatric or psychological appointments.~~
- ~~Failure to manage medical concerns/conditions, including adherence to physician treatment and recovery services and use of prescription medications that may interfere with the effectiveness of methadone and may present a physical risk to the individual.~~
- ~~Repeated failure to follow through on other treatment and recovery plan related referrals. (Repeated failure should be considered on an individual basis and only after the OTP has taken steps to assist beneficiaries to comply with activities.)~~

~~The commission of acts by the beneficiary that jeopardize the safety and well-being of staff and/or other individuals, or negatively impact the therapeutic environment, is not acceptable and can result in immediate discharge. Such acts include, but are not limited to, the following:~~

- ~~Possession of a weapon on OTP property~~
- ~~Assaultive behavior against staff and/or other individuals~~
- ~~Threats (verbal or physical) against staff and/or other individuals~~
- ~~Diversion of controlled substances, including methadone~~
- ~~Diversion and/or adulteration of toxicology samples~~
- ~~Possession of a controlled substance with intent to use and/or sell on agency property or within a one-block radius of the clinic~~
- ~~Sexual harassment of staff and/or other individuals~~

- ~~Loitering on the clinic property or within a one-block radius of the clinic~~

Administrative discontinuation/discharge refers to termination of medication assisted treatment (MAT) due to non-compliance with treatment recommendations, and/or engaging in activities or behaviors that impact the safety of other clients and/or staff in the treatment environment.

Non-compliance includes but is not limited to:

- Repeated or continued use of illicit opioids and non-opioid drugs (including alcohol).
- Toxicology results that do not indicate the presence of methadone metabolites (for methadone assisted treatment only).~~a~~
- Evidence of alcohol use if
  a) alcohol is prohibited under their individualized treatment & recovery plan or
  b) the client appears to be drinking alcohol in amounts that would make dosing unsafe.
- Repeated failure to submit to toxicology sampling as requested.
- Repeated failure to attend scheduled individual and/or group counseling sessions, or other clinical activities.
- Failure to manage medical concerns/conditions, including adherence to physician treatment and recovery services and use of prescription medications that may interfere with the effectiveness of methadone and may present a physical risk to the individual.
- Repeated failure to follow through on other treatment and recovery plan related referrals.

The commission of acts by the beneficiary that jeopardize the safety and well-being of staff and/or other individuals, or negatively impact the therapeutic environment, is not acceptable and can result in immediate discharge. Such acts include, but are not limited to, the following:

- Possession of a weapon on OTP property
- Assaultive behavior against staff and/or other individuals
- Verbal or physical threats against staff and/or other individuals
- Diversion of controlled substances, including methadone
- Diversion and/or adulteration of toxicology samples
- Possession of a controlled substance with intent to use and/or sell on or near agency property
- Sexual harassment of staff and/or other individuals
- Loitering on or around the clinic property

Process for Implementing Administrative Discontinuation:

Repeated episodes of non-compliance or other infractions should be considered on a case-by-case basis. Unless there is an immediate and urgent safety concern, the provider should document efforts taken to assist clients in coming into compliance. If unsuccessful in achieving compliance, a warm transfer should (when it's possible) be attempted and facilitated to another MAT provider.

Administrative discharge can leave the client at risk of severe withdrawal symptoms, relapse, overdose and death. It should be a last resort when other efforts have been unsuccessful. If discharge is determined to be the only appropriate option, the MAT provider should contact Dan Dedloff at dan.dedloff@midstatehealthnetwork.org at MSHN prior to initiating discharge.

METHADONE: Administrative discontinuation of services can be implemented by *Immediate Termination* or *Enhanced Tapering Discontinuation* which involves accelerated decrease of the methadone dose (usually by 5 percent a day).

The manner in which methadone is discontinued, immediate termination or enhanced tapering, is at the discretion of the OTP physician, but must be based on both the client's individual circumstances and the severity of the precipitating event that prompted the decision to terminate.

- Client variables to consider include but are not limited to the individual's history of infractions including non-compliance with medication, treatment and recovery recommendations, frequency of positive drug screens, stage of recovery, other health/medical conditions, etc.
- Situational variables related to the precipitating infraction include but are not limited to the severity of threat/risk to the safety of others in the OTP (staff and clients), circumstances surrounding the infraction, etc.

(Sources: Medicaid Provider Manual 12.2.F.2, p.87-89 & Treatment Policy #5, p.9-11)

~~Administrative discontinuation of services can be carried out by two methods:~~

- ~~Immediate Termination - This involves the discontinuation of services at the time of one of the above safety-related incidents or at the time an incident is brought to the attention of the OTP.~~
- ~~Enhanced Tapering Discontinuation - This involves an accelerated decrease of the methadone dose (usually by 10 mg or 10 percent a day). The manner in which methadone is discontinued is at the discretion of the OTP physician to ensure the safety and well-being of the beneficiary.~~

It may be necessary for the OTP to refer beneficiaries who are being administratively discharged to the local access management system for evaluation for another level of care. Justification for non-compliance termination must be documented in the beneficiary's chart."

PROVIDER REQUIREMENTS

Medication-Assisted Treatment Providers must have an appropriate license issued by the State of Michigan and a contract with MSHN in order to be reimbursed for medication-assisted treatment and outpatient treatment through MSHN.

The Michigan Department of Health and Human Services (MDHHS) states:

- The program must be identifiable and distinct with the agency's service configuration; and
- The agency must offer or purport to offer MAT services as a separate and distinct program among any other program services that may be offered.

Providers must base their program of services on the principles detailed in Treatment Improvement Protocol (TIP) #43, "Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs" and Treatment Improvement Protocol (TIP) #40, "Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid/Opiate Addiction."

Individuals employed by provider organizations must be appropriately credentialed to provide the services described in this document (see "Staff Credential Requirements" below).

STAFF CREDENTIALS AND PROGRAM SUPERVISION REQUIREMENTS

Medication-Assisted Treatment for Opioid/Opiate Addiction services must be delivered by individuals in provider organizations who have been credentialed as a Certified Addictions Counselor or Certified Advanced Addictions Counselor, or an individual who has a registered Development Plan with the Michigan Certification Board for Addiction Professionals.

Supervision of an identifiable MAT program within a licensed provider organization must be by an individual credentialed as a Certified Clinical Supervisor, or an individual who has a registered Development Plan for Certification as a Clinical Supervisor with the Michigan Certification Board for Addiction Professionals.

MAT services must be provided under the supervision of a physician licensed to practice medicine in Michigan. The physician must be licensed to prescribe controlled substances. Within a methadone program, the physician must be specifically licensed to work at a methadone program. Methadone must be administered by an MD/DO, physician's assistant, nurse practitioner, registered nurse, licensed practical nurse, or pharmacist. A physician prescribing buprenorphine/naloxone must have completed all certification requirements mandated by the State of Michigan. All MAT providers must follow the State of Michigan Licensing and Regulatory Affairs (LARA) Administrative Rules (R 325.14403 Medical staffing patterns. Rule 403) in regard to appropriate staffing.

INCLUDED SERVICES

Medication-Assisted Treatment in an outpatient setting is intended for the purpose of 1) managing the effects of withdrawal from opioids (prescription painkillers and heroin) and/or alcohol; 2) stabilizing the client and 3) providing maintenance treatment. Ancillary services such as individual therapy, group therapy, Recovery Supports, acupuncture, and/or Case Management will be available during a client's episode of care.

Covered services for methadone and pharmacological supports and laboratory services, as required by Federal regulations and the Administrative Rules for Substance Abuse Service Programs in Michigan, include:

- Methadone medication

- Nursing services
- Physical examination
- Physician encounters (monthly)
- Laboratory tests
- TB skin test (as ordered by physician)

Clients diagnosed with Opioid Use Disorder may be provided Medication-Assisted treatment using methadone as an adjunct to therapy. Provision of such services must meet the following criteria:

- Services must be provided under the supervision of a physician licensed to practice medicine in Michigan.
- The physician must be licensed to prescribe controlled substances, as well as licensed to work at a methadone program.
- The methadone component of the substance abuse treatment program must be licensed as such by the state and be certified by the OPAT/CSAT and licensed by the Drug Enforcement Administration (DEA).
- Methadone must be administered by an MD/DO, physician's assistant, nurse practitioner, registered nurse, licensed practical nurse, or pharmacist.

Service providers are required to document all services on the appropriate clinical form (i.e., Assessments on Assessment Forms, Individualized Treatment Plans on an appropriate form, contacts on progress note forms, etc.). All documents will be made a part of the permanent clinical record.

As each client is unique and presents with individual concerns, MSHN encourages contact to discuss exceptions on a case-by-case basis.

AUTHORIZATION PARAMETERS

Please see the MSHN Utilization Management authorization parameters included in REMI for a complete list of codes.

Please note the following:

- A reauthorization will not be approved unless the provider has entered *every* toxicology report for the client into REMI prior to the reauthorization request.
- Providers will be required to complete an annual re-assessment for continuing care and will enter re-assessment information into REMI.
- Additional services such as medication reviews, drug screens, and actual dosing may vary depending on the service provider.

MAT GUEST DOSING

Guest dDosing is allowable between different locations of the same MAT provider. The MAT provider that has an approved authorization in REMI will call MSHN UM Department to discuss the client and circumstances of the guest dosing to get a pre-authorization. The two locations are to have an internal policy for documentation and payment. Situations where guest dosing is

to occur between different providers will be reviewed on a case by case basis by the MSHN UM Department.

MEDICAL MARIJUANA CARD: EXPECTATION OF PROVIDERS

When a client presents for medication-assisted treatment and also possesses a valid medical marijuana card, the following issues should be carefully addressed by the MAT provider as an integral part of the individualized treatment plan:

Verification of Medical Marijuana Card: According to Treatment and Recovery Policy #05: Criteria for Using Methadone for Medication-Assisted Treatment and Recovery (2012, p. 5), "Michigan law allows for individuals with the appropriate physician approval and documentation to use medical marijuana.

For enrolled individuals, there must be a copy of the MDHHS registration card for medical marijuana issued in the individual's name in the [client] chart or the "prescribed medication log"." A copy of the client's *registration card* must be included in the client chart. *MSHN expects verification will be made for any consumer with a MM card, not just consumers on methadone.*
Diagnosis for which the client is receiving treatment and the length of time the individual is expected to be on the medication (including the diagnosis for which the client was certified to use medical marijuana) should be documented in the client's chart.

Assessment for Overuse/Misuse of Prescription: Clinicians should carefully assess for the possibility of overuse/misuse of any controlled substance prescription medications (including medical marijuana). Misrepresentation of medical symptoms in order to obtain prescription medication is often a primary function of substance use disorder and *must also be ruled out for medical marijuana* use. A detailed medical history should be obtained as part of the assessment process, including other forms of treatment the client has attempted in order to manage the chronic medical condition prior to obtaining medical marijuana certification. Onset age of the use of marijuana should also be considered in relation to the onset of the medical condition for which the client is certified to use medical marijuana. Whenever possible, exploration of other treatment modalities with the potential to adequately address the client's medical condition(s) without the use of controlled substance prescription medications.

Coordination of Care with Other Treating Physicians: Coordination of care should occur between the MAT program physician, the client's primary care physician, and any other prescribing physicians including the physician who certified the use of medical marijuana. This coordination of care should occur upon admission to the MAT program and address the following which must be clearly documented in the client chart and individualized to the client (i.e. a "form letter" sent to the physician's office is not sufficient).

Nine percent of people exposed to Cannabis develop Cannabis use disorder. MSHN asks that all of its providers continue to work with their clients to encourage abstinence from marijuana while undergoing MAT for opiate and alcohol use disorders. Evidence of continued use of Cannabis will be sought during site reviews and will remain a subject of ongoing discussion with our providers.

NOTE: If the consumer does not consent to coordination of care with all prescribing physicians, including the physician who certified the use of medical marijuana, off-site dosing will not be permitted in accordance with Treatment and Recovery Policy #05: Criteria for Using Methadone for Medication-Assisted Treatment and Recovery (2012, p. 5).

ALCOHOL USE DISORDER & MEDICATION-ASSISTED TREATMENT

Medication-Assisted Treatment (MAT) for alcohol use disorder includes three FDA approved oral medications that help reduce cravings for alcohol and can be a component of MAT in working with clients struggling with alcohol use disorder. The MSHN expectation is that medication will be an adjunct to other services like outpatient individual and group therapy, case management and peer recovery supports as dictated by ASAM and medical necessity.

1. ***Disulfiram*** *(*Brand name**:** *Antabuse)* – This medication blocks an enzyme that is involved in metabolizing alcohol. Disulfiram produces unpleasant side effects when combined with alcohol in the body. *Antabuse* is used in certain people with chronic alcoholism. This medicine can help keep the client from drinking because of the unpleasant side effects that will occur if consuming alcohol while taking *Antabuse*. *Antabuse* is used together with behavior modification, psychotherapy, and counseling support to help stop drinking.

2. ***Acamprosate Calcium*** *(Brand name: Campral)* – This medication helps promote abstinence from alcohol in patients with alcohol dependence *who are abstinent at treatment initiation*. Treatment with Acamprosate should be part of a comprehensive management program that includes psychosocial support. The efficacy of Acamprosate in promoting abstinence has been demonstrated most effective in subjects who have undergone detoxification and achieved alcohol abstinence prior to beginning Campral treatment. The efficacy of Campral in promoting abstinence from alcohol in polysubstance abusers has not been adequately assessed.

3. ***Naltrexone HCL*** *(Brand name: Re-Via, Vivitrol)* This medication, (an opiate antagonist that works in the brain to prevent feelings of well-being, paint relief, etc.) is used to treat alcohol abuse by reducing cravings. It can help clients drink less alcohol or stop drinking altogether. The efficacy of naltrexone in promoting abstinence has been demonstrated most effective in subjects who have undergone detoxification and achieved alcohol abstinence prior to beginning naltrexone treatment. It decreases the desire to drink alcohol when used with a treatment program that includes counseling, support, and lifestyle changes.

PLEASE NOTE: *The medications referenced in this section are not funded through MSHN. However, MSHN will fund medically appropriate ancillary services that accompany medication like outpatient therapy, case management and peer recovery supports for clients receiving these medications as part of their substance abuse treatment.*

BENZODIAZAPINE USE DISORDER & MEDICATION-ASSISTED TREATMENT

Medication-Assisted Treatment (MAT) for Benzodiazepine Use Disorder includes the anticonvulsant medication *Neurontin*. The MSHN expectation is that medication will be adjunct to other services like outpatient individual and group therapy, case management and peer recovery supports as dictated by ASAM and medical necessity.

Gabapentin *(Brand name: Neurontin)* – The anticonvulsant Neurontin has demonstrated a positive impact on reducing cravings for benzodiazepines as well as offering a reduction in the severity of withdrawal effects like seizures and anxiety. Recently, there have been reports of patients overusing or misusing gabapentin. Gabapentin remains an important medication in treating SUD with various drugs. Patients receiving gabapentin should be followed carefully, prescribed in the lowest effective dose and receive counseling around this issue. Gabapentin should not be stopped abruptly. It may be prudent in certain situations to give one or two refills at a time and monitored for misuse. Other anticonvulsants such as carbamazepine and valproate have shown benefits also.

PLEASE NOTE*: The medications referenced above are not funded through MSHN. However, MSHN will fund medically appropriate ancillary services that accompany medication like outpatient therapy, case management and peer recovery supports for clients receiving these medications as part of their substance abuse treatment.*

ATTENTION: Please note that use of gabapentin (Neurontin) to reduce cravings and/or to reduce the severity of withdrawal symptoms is not FDA-approved. There is evidence of its effectiveness for this use, however. Any decision regarding use of this medication for MAT purposes should only take place after a transparent and clear conversation between doctor and patient regarding benefits and risks and notification of its FDA status.

COCAINE USE DISORDER & MEDICATION-ASSISTED TREATMENT

Medication-Assisted Treatment (MAT) for cocaine use disorder includes two oral medications that help reduce cravings. The MSHN expectation is that medication will be adjunct to other services like outpatient individual and group therapy, case management and peer recovery supports as dictated by ASAM and medical necessity. These medications include:

~~1. ***Citalopram Hydrobromide*** *(Brand name: Celexa)* – Celexa is most commonly used for depression, but has been shown to help reduce cravings for cocaine.~~

1. ***Desipramine***, an antidepressant may be helpful in patients with cocaine use disorder, with depression and without antisocial personality disorder. May work with patients with comorbid opioid use disorder on buprenorphine MAT or along with contingency management.

2. ***Disulfiram*** (250 mg/day) blocks conversion of dopamine to norepinephrine and has been shown to be helpful for cocaine use disorder. It is FDA approved for alcohol use disorder.

3. ***Topiramate*** (an anticonvulsant) has also shown benefit in decreasing cocaine use.

~~2.~~4. ***Bupropion HCL*** *(Brand name: Wellbutrin)* - Wellbutrin is most commonly used for depression but has been shown to help reduce cravings for cocaine.

PLEASE NOTE: *The medications referenced above are not funded through MSHN. However, MSHN will fund medically appropriate ancillary services that accompany medication like*

outpatient therapy, case management and peer recovery supports for clients receiving these medications as part of their substance abuse treatment.

ATTENTION: Please note that use of ~~Citalopram Hydrobromide (Celexa)~~ Desipramine, Disulfiram, Topiramate, and Bupropion HCL (Wellbutrin) to reduce cravings is not FDA-approved. There is evidence of its effectiveness for this use, however. Any decision regarding use of this medication for MAT purposes should only take place after a transparent and clear conversation between doctor and patient regarding benefits and risks and notification of its FDA status.

MARIJUANA USE DISORDER & MEDICATION-ASSISTED TREATMENT

Medication-Assisted Treatment (MAT) includes two medications that have been effective as one component of working with clients who have marijuana use disorder. The MSHN expectation is that medication will be adjunct to other services like outpatient individual and group therapy, case management and peer recovery supports as dictated by ASAM and medical necessity.

1. ***Gabapentin*** *(Brand name: Neurontin)* – The anticonvulsant Neurontin, used primarily to treat seizures, has demonstrated a positive impact on reducing cravings for marijuana as well as a reduction in the severity of withdrawal effects in adults. Recently there have been reports of patients overusing or misusing gabapentin. Gabapentin remains an important medication in treating SUD with various drugs. Patients receiving gabapentin should be followed carefully, prescribed the lowest effective dose and receive counseling around this issue. Gabapentin should not be stopped abruptly. It may be prudent in certain situations to give one or two refills at a time and monitor for misuse.

2. **Acetylcysteine** (*(Brand name: Mucomyst)* – This medication, when inhaled, helps open the airways due to lung diseases such as emphysema, bronchitis, cystic fibrosis and pneumonia. When taken orally, Acetylcysteine helps prevent liver damage caused by an overdose of acetaminophen (Tylenol). For use with adolescent clients abusing marijuana, this medication may help reduce cravings according to one study.

PLEASE NOTE: The medications referenced above are not funded through MSHN. However, MSHN will fund medically appropriate ancillary services that accompany medication like outpatient therapy, case management and peer recovery supports for clients receiving these medications as part of their substance abuse treatment.

ATTENTION: Please note that use of gabapentin (Neurontin) to reduce cravings and/or to reduce symptoms associated with withdrawal from marijuana use is not FDA-approved. There is evidence of its modest effectiveness for this use, in some studies. Any decision regarding use of this medication for MAT purposes should only take place after a transparent and clear conversation between doctor and patient regarding benefits and risks and notification of its FDA status.

REFERENCES AND IMPLEMENTATION GUIDANCE

The U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment, has issued treatment improvement protocols (TIPs) to assist with the implementation of these services.

Treatment Improvement Protocol #43 (TIP-43), "Medication-Assisted Treatment for Opioid/Opiate Addiction in Opioid/Opiate Treatment Programs ", Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment (http://www.atforum.com/SiteRoot/pages/addiction_resources/MAT-TIP_43-MMT_Guidelines2005.pdf)

Treatment Improvement Protocol #40 (TIP-40), "Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid/Opiate Addiction", Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment (available from http://buprenorphine.samhsa.gov/Bup_Guidelines.pdf)

Substance Abuse Treatment/Recovery Policy # (TP-5), "Criteria for Using Methadone for Medication - Assisted Treatment/Recovery", Michigan Department of Community Health, Bureau of Substance Abuse and Addiction Services (available from http://www.michigan.gov/documents/Treatment_Policy_05_Enrollment_Criteria_for_Methadone_145925_7.pdf)

Substance Abuse Treatment/Recovery Policy # (TP-3), "Buprenorphine", Michigan Department of Community Health, Bureau of Substance Abuse and Addiction Services (available from http://www.michigan.gov/documents/Treatment_Policy_03_Buprenorphine_145923_7.pdf)

"Medication for the Treatment of Alcohol Use Disorder: A Brief Guide," Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment (available from http://store.samhsa.gov/shin/content//SMA15-4907/SMA15-4907.pdf)

Additional resources used in the development of this treatment protocol include:

Michigan Medicaid Provider Manual (available from http://www.mdch.state.mi.us/dch-medicaid/manuals/MedicaidProviderManual.pdf)

American Society of Addiction Medicine Patient Placement Criteria-3rd Edition (available from http://www.asam.org/publications/patient-placement-criteria)

Waller, R.C., MD, MS. "Medication-Assisted Treatment Guidelines for Opioid Use Disorders", (available from https://macmhb.org/sites/default/files/attachments/files/Waller%20-%20Opioid%20Tx%20Guidelines.pdf).

Appendix D: SUD Case Management (H0006) Protocol

Covered Service
Case management (CSM) services are those services which will assist consumers in gaining access to needed medical, social, educational/vocational and other services, and can be an effective enhancement to other formalized treatment interventions for substance use disorders. This is especially true for individuals with multiple chronic disorders who require multiple services over extended periods of time, and/or who face difficulty gaining access to those services. Case management is a set of social service functions that includes case management needs assessment; individualized case management service planning; assistance with linking to, accessing, and using community resources; monitoring the individualized plan of services; coordination of services between the individual served and the individuals or organizations delivering services to them; and advocacy. Case management can establish a stronger foundation for a client's recovery, reduce costs and enhance long term recovery for those persons who have addictive disorders by assuring they have access to all needed services.

SUD CSM services can be staged flexibly throughout the episode of care, from the beginning of treatment through the post-treatment support period. Consumers can receive SUD CSM services as an adjunct to treatment at all levels of care and as a step-down support service following discharge from formalized treatment for up to 6 months. MSHN will not provide funding for stand-alone SUD CSM services other than during the post-treatment support period. SUD CSM services can be utilized flexibly in regards to location where service is provided to meet the needs of the individual, with either office based or community based as supportive options.

Typical SUD CSM Services (Including but not limited to):

- Assess for functional and social needs
- Address the detection and prevention of communicable diseases, including hepatitis, tuberculosis, and HIV
- Link the consumer to community resources including support services
- Advocate for the consumer and/or represent the consumer in getting their needs met with other agencies or service providers
- Assist in developing social supports
- Assist with obtaining necessary basic needs (food, clothing, hygiene items, etc)
- Assistance with development of Community Living Skills.
- Assist the consumer in securing necessary physical and/or mental healthcare services
- Referral and coordination with other levels of SUD treatment
- Aid the consumer in securing stable and affordable housing
- Assist the consumer with securing stable and affordable transportation
- Coordinate employment training or assist in securing employment
- Link the consumer to financial assistance services
- Address any possible educational/vocational needs the individual may have
- Assistance in other functional area of life appropriate to client need.

SUD CSM Services Do Not Include:

- Therapy or other clinical services
- Peer Recovery/Recovery Support services
- Transportation
- Brief (less than 15 continuous minutes) phone contacts

Current MSHN Procedure Code **Unit Type- Encounter**
Case Management – H0006

Eligibility Criteria and Service Priorities

Diagnosis: The beneficiary is currently experiencing a substance use disorder reflected in a primary, validated, DSM-V or ICD-10 Diagnosis (not including V Codes)

Severity of Illness: In addition to the client agreeing to participate in CSM services, at least one of the following criteria must be present in order for the client to be eligible for MSHN- funded SUD CSM services:

a. Client has a documented need in at least one domain involving community living skills, health care, housing, employment/financial, education or another functional area in that person's life.

b. Client has a demonstrated history of recovery failure with or without recovery support services.

c. Client has a substance use disorder involving a primary drug of choice that will require longer-term involvement in treatment services to support recovery (such as methamphetamine, heroin/opiates, inhalants).

d. The chronicity and severity of the client's disorder is such that ongoing support is needed to increase the probability of recovery (such as years of use and first involvement with treatment, or a co-occurring mental health disorder is present with substance use disorder).

Intensity of Service:

a. The frequency and intensity of SUD case management encounters is to be determined by the individualized needs of the client based on the results of a needs assessment

b. The amount, scope and duration of CSM services shall be guided by each client's treatment plan which will incorporate case management goals and outcomes and is consistent with the individualized, coordinated, comprehensive treatment plan of service.

A client who is receiving CSM services from another CSM service or program (mental health, Child welfare, justice system etc.) is not eligible for SUD CSM services regardless of the criteria met above. Also, a client who has needs that could be met through another CSM service, for which the client qualifies, is not eligible for SUD CSM services

Associated Outcomes

The beneficiary is eligible for discharge at the time that the presenting condition is no longer consistent with the aforementioned severity of illness / intensity of service criteria. The intended outcomes of this service are:

a. The focus of service is on facilitating access to and use of needed community-based resources by the person served, at first with significant support from the service provider. The person served is better able to access and use needed services and resources more and more independently as the service progresses; the expected outcome is independent ability to access and use needed resources

b. The goals and objectives of the individual served, as reflected in the individualized plan of service, have been achieved.

Typical Service Utilization Pattern

Maximum of twenty-four (24) encounters of H0006 in a six-month period. Providers may request additional units of service provided appropriate and clear justification exists. In these cases, the MSHN Utilization Management department will review any case management service requests beyond the twenty-four initially authorized units to verify medical-necessity criteria is present for continuing service

Authorization Exceptions: SUD CSM services will not be authorized in conjunction with Withdrawal Management Services (H0010, H0012) or Residential Substance Abuse Treatment Services (H0018, H0019) as case management is considered an inherent part of the delivery of these services and is included in the per diem rate of reimbursement for these services.

Appendix E: Technical Requirement for SUD Case Management Services

Purpose

A. Case Management is an intervention that addresses a client's primary needs which, if unattended to, may be distracting from the recovery process. Once these needs are being addressed, the client's ability to focus on his or her recovery with successful outcomes can be greatly enhanced.

B. Case management services are those services which will assist clients in gaining access to needed medical, social, educational/vocational and other services, and can be an effective enhancement to intervention in the treatment of substance use disorders. This is especially true for clients with multiple disorders, who may not benefit from traditional substance use disorder treatment, who require multiple services over extended periods of time, and/or who face difficulty gaining access to those services. Case management services may establish a stronger foundation for a client's recovery, reduce costs and enhance long term recovery for those who have addictive disorders, by assuring they have access to all needed services.

C. The purpose of this procedure is to provide guidance to Substance Use Disorder (SUD) providers to provide and report case management services and to ensure:

    1. Compliance with the requirements for case management as described in the OROSC *Treatment Policy #08: Substance Abuse Case Management Program Requirements*.
    2. Ensure clients receive case management services based on medical necessity and individualized need(s).

Procedure

A. Core elements of case management include a needs assessment, evaluation, planning, linking, coordinating, and monitoring to assist clients in gaining access to needed health and dental services, financial assistance, housing, employment, education, social services, and other services and supports initiated through the individualized treatment planning process. Services are provided in a responsive, coordinated, and efficient manner focusing on process and outcomes.

B. Case management service providers shall be accredited as a substance abuse treatment program with a case management license.

C. SUD treatment providers may determine that case management services are medically necessary during the initial assessment process or at any time during the treatment planning or treatment review process.

D. The case management needs assessment should be documented in the client record and incorporated into the client's treatment plan and treatment plan review(s).

E. The general frequency of case management encounters should be determined by the individualized needs of the client based on the needs assessment.

F. For specific utilization management protocol related to case management, refer to the SUD Case Management UM Protocol, in addition to the examples listed below. Examples of billable case management activities include (but are not limited to):

    1. Assessing for functional and social needs;
    2. Administering screenings for communicable diseases, provide brief education about risk & protective factors, and link the client to any necessary follow-up services;

3. Assisting with basic needs (such as food, clothing, housing, hygiene items, etc.);
4. Advocating for the client and/or represent the client in getting their needs met with other agencies or service providers (ie: assist the client with making calls together; accompany the client in person to appointments with other agencies to assist them with self-advocacy, etc);
5. Coordinate employment training or assist in securing employment through activities such as helping clients with acquiring, filling out, and submitting job applications.

G. SUD case management services shall be available only to MSHN clients who are *not* eligible or served by case management through mental health, public health, or other community human service agencies (i.e., MSHN will not fund SUD case management services if case management is being provided through another provider/entity).

H. Case management services shall be guided by each client's individualized treatment plan. Treatment plan review(s) will incorporate case management goals and outcomes with targeted completion dates that are consistent with the treatment plan and are reflected and/or modified in treatment plan review(s).

I. Indirect activities are not billable. This includes activities like emailing clients, calling a client after a missed appointment, listening to a voice-mail message from a client, completing a monthly report to a social worker, etc.

J. An Activity Log Sheet should be used to record indirect or peripheral case management activities such as phone calls, email contacts, leaving messages, reporting information to referral sources, etc., rather than using a formal case management progress note. The peripheral case management activities are *not* entered into REMI.

K. Case managers may follow clients as they progress through the continuum of care. Case management services may continue after discharge from treatment for up to six (6) months as stated in OROSC Treatment Policy #8 and as authorized by MSHN.

L. Case management service providers shall establish linkages with other agencies in the human services and community resources network for referral to ensure continued case management services beyond six (6) months after discharge, as required by the client's individualized plan.

M. Case management services can, under limited circumstances, be a stand-alone service (i.e. when case management is <u>not</u> tied to other treatment services like Outpatient Therapy (OPT), Intensive Outpatient services (IOP), etc.). Stand-alone case management is only billable after discharge as a step-down transitional service from a higher, more intensive level of care to a lower level of care (see Treatment Policy #8, p. 2, "Eligibility" here). MSHN will allow this exception for post-discharge stand-alone case management for up to six (6) months or, for Women's Specialty Services clients, for up to twelve (12) months in accordance with *Treatment Policy #12 here).*

N. The treatment record of clients receiving case management services must contain documentation for the determination of medical necessity for case management services, and case management activity notes indicating the following information:
1. Date of contact and/or service;
2. Duration of case management contact/services;
3. Name of agency and/or person being contacted;
4. Nature of case management services requested and extent of services requested; and/or

5. Nature of case management services provided and extent of services provided;
6. Place of service and/or referral.

O. Case Management services will be authorized for up to 24 units per 6-month period. There is no limit on the number of units billed in one day; however, case management services must be documented accurately in the client's record with start/stop times. Case Management services are not billable to Medicaid/HMP, but are billable to Block Grant only.

Appendix F: Recovery Housing Technical Requirement

Purpose

To establish requirements as the Pre-Paid Inpatient Health Plan (PIHP) for the implementation of recovery housing. Individuals with substance use disorders (SUD) who have embarked on a treatment and recovery pathway often have living environments in the community that contributed significantly to their drug and/or alcohol abuse. It puts them at risk for relapse and death. Recovery housing is a vital resource for individuals seeking a supportive housing environment that can promote and sustain the recovery process.

Definitions

Recovery housing is defined by the Office of Recovery Oriented Systems of Care (OROSC) as "providing a location where individuals in early recovery from a behavioral health disorder are given time needed to rebuild their lives, while developing the necessary skills to embark on a life of recovery. This temporary arrangement will provide the individual with a safe and secure environment to begin the process of reintegration into society, and to build the necessary recovery capital to return to a more independent and functional life in the community. These residences provide varying degrees of support and structure. Participation is based on individual need and the ability to follow the requirements of the program." Recovery housing is expected to be a safe, structured, and substance free environment.

Policy

Across Region 5's twenty-one counties, MSHN supports active and vibrant recovery communities of which recovery housing is a critical component. Drawing on MDHHS's Office of Recovery-Oriented Systems of Care (OROSC)'s Treatment Technical Advisory #11, the National Alliance of Recovery Residences (NARR) guidelines, and clinical best practices, MSHN has established the following expectations of recovery houses which are part of MSHN's SUD provider network.

Clients residing in recovery housing must be actively engaged in formal outpatient treatment with a credentialed outpatient provider that is paneled with MSHN. Case management, although part of the outpatient treatment services, is not sufficient on its own. Recovery housing is an adjunct to treatment and an individual in recovery housing must attend treatment in a formal outpatient setting that is paneled with MSHN at least one time in 30 days to receive funding for recovery housing. The recovery housing provider is responsible for monitoring client attendance in treatment by coordinating care with the treatment provider. A Coordination of Care form or TECC, is an effort to improve the coordination of care between the recovery houses and the treatment providers. The recovery house will upload the information into Box by 9 am each Friday. The treatment provider will then fill out the treatment section with information from the previous week and upload back into Box by the COB each subsequent Monday. The recovery house will then write a response, if necessary, and upload to Box each Wednesday by 5 pm. Recovery housing must be identified as medically necessary in the client's recovery plan and the recovery plan must be present in the client's recovery housing file.

Service Description

MSHN expects recovery housing providers to employ recovery coaches to enhance a client's recovery experience. If the provider cannot offer this service, they must coordinate care with another local provider of recovery coaching services while the recovery house actively seeks to hire a *trained* recovery coach.

The provider of the recovery house will maintain a file on each client admitted. All provided services must be formally documented on the consumer's individual service/recovery plan. This includes, but is not limited to, individual peer support services, peer group services, and/or case management. All services provided must be documented via an individualized progress note. All progress notes should include a summary of what occurred during the service, start and stop time, date of service, and be signed by the facilitator. In addition, facilitators must indicate any relevant certification/credential and list the date the note was signed.

The recovery house file should include but not be limited to:

- Basic demographic information
- Releases of information are required in client file for the following: primary care physician, outpatient provider, MSHN, emergency contact.
- Primary Care Physician information needs to minimally include the physicians name, practice name, address, and telephone number to meet MDHHS standards.
- ~~Admission screen copied from outpatient provider~~
- Evidence of enrollment with a MSHN paneled outpatient provider
- Application
- Screening: This includes an agency screening as well as the Brief Screening completed in REMI
- Signed client acknowledgement of discussion and receipt of recovery housing rules and expectations
- Recovery Plan developed with the client and recovery coach and included in the client's file at the Recovery House. Recovery/Service Plans must include the following components:
    - Individualized Plans of Service developed in partnership with the consumer as evidenced by the consumer's words
    - Goals & objectives are written using specific, measurable, attainable, realistic & time limited elements.
- Evidence of regular care coordination with service providers
- Evidence of regular attendance with a formal outpatient provider in the MSHN network.
- Evidence of regular drug screening, if necessary (this service is not billable to MSHN)
- Evidence of weekly house meetings
- Recovery coaching progress notes if recovery coaching is being provided on location
- Block Grant Income Eligibility & Fee Determination form

It is the expectation of MSHN that clients who meet medical necessity and clinical criteria will be admitted to services regardless of their participation in a medication assisted treatment program.

Length of Stay

MSHN will fund up to 180 days of transitional housing based upon determination of medical necessity. Providers will work with each consumer and the consumer's outpatient treatment provider to develop an individualized plan identifying either alternative housing to which the consumer will go after discharge or alternative sources of funding to pay for the consumer's continued stay in transitional housing.

Utilization Patterns

Recovery housing providers will submit two authorizations requests for recovery housing services (H2034):

- The initial authorization request will be for a maximum of 90 days
- The re-authorization request will also be for a maximum of 90 days and include a plan for client's continued housing past 180 days and/or a discharge plan.

~~Effective 10/1/2018, Peer Recovery Support Services (PRSS) will be included in the daily rate for recovery housing and should not be requested separately in authorization requests for clients who are living in recovery housing. REMI will not permit a recovery housing provider to authorize PRSS (H0038, H0038:TT, T1012, T1012:TT) for an individual when that person is also authorized for recovery housing (H2034).~~ Peer Recovery Support Services (PRSS) will be billed in REMI using the H0038 and H0038:TT for those who are State Certified Peer Coaches and T1012 and T1012:TT codes for those coaches not meeting the State Certification criteria but who are CCAR certified. Some recovery housing providers may offer PRSS to individuals in the community who are NOT living in recovery housing; PRSS for those individuals will also ~~should~~ be authorized in REMI as usual using the appropriate PRSS code(s) (H0038, H0038:TT, T1012, T1012:TT).

Recovery Housing providers shall follow all outpatient request guidelines in the MSHN SUD Provider Manual (located in Appendix A).

Levels of Recovery Housing

The four levels of recovery housing are as follows:

- **Level I** - Peer Run: This level of housing is democratically run with clear policies and procedures. Staff positions are not paid. ***MSHN does not reimburse for this level of Recovery Housing.***
- **Level II** – Monitored: This level of housing maintains structure and a minimal level of structure. There is at least one paid staff position. ***MSHN does not reimburse for this level of Recovery Housing.***
- **Level III** – Supervised: This level of housing has administrative oversight and provides more structure. Paid staff positions include a facility manager and certified staff or case managers.
- **Level IV** - Service Provider: This level of housing is highly structured and employs administrative and credentialed clinical staff.

MSHN requires that recovery houses be certified through MARR/NARR at a level III or higher.

Standards for Recovery Housing

Access – Screening: All recovery houses should have a standard screening tool which rules out admission of individuals who may present a safety risk to staff or other residents. The screen should rule out admission for people with violent felonies including Criminal Sexual Conduct (CSC) and individuals struggling with self-harm, prominent suicidal or homicidal ideation, or other serious mental health concerns with no treatment supports in place. These clients should be referred to the appropriate service provider.

Access - Application for Admission: Once screened as admissible due to an absence of safety concerns, recovery houses should have an application process that allows for current residents to offer input on prospective new residents. This input should not constitute veto power over any individual's admission. Clear criteria should be established regarding what are and are not appropriate variables for residents to consider. Race, religion or sexual orientation, for example, should *not* be considered relevant for consideration whereas a known history for being emotionally abusive corroborated by multiple residents might be relevant for consideration by the group.

Health and Safety: All recovery houses should have an on-call emergency contact who is available on a 24/7/365 basis. The individual who is on-call does not need to be on-site, but *does* need to be accessible by phone during non-business hours including evenings, weekends and holidays.

House Rules & Meetings: Recovery houses play a critical role in establishing a sense of what a healthy and functional family (in this case, a surrogate family) can look like. Towards that end, house rules including mutual respect, clear and appropriate boundaries and shared division of labor should be in place. Weekly house-meetings should take place at the house where residents live and where they are permitted to strengthen relationships, share concerns, air grievances and problem-solve disputes in a way that allows for and models healthy and respectful dialogue. If a recovery house has multiple locations in a community, there is value in having a regular meeting that brings together multiple houses to establish a larger sense of a recovery community beyond the individual recovery house. This multi-house recovery community meeting should not replace the house-level meeting more than once per month. This establishes an expectation that the house will function like a family unit with a designated weekly time that the unit comes together to ensure things are operating smoothly.

MAT-inclusion: Medication assisted treatment (MAT) is another vital resource needed by many individuals, particularly those with an opioid use disorder. MAT and recovery houses evolved out of separate communities, siloed service delivery systems, and disparate belief systems, resulting in a severely limited supply of recovery houses that adequately support persons receiving MAT. In 2018, NARR, produced a White Paper titled "MAT-Capable Recovery Residences: How government can enhance and expand recovery residence capacity to adequately support Medication Assisted Recovery." NARR notes that "A residence [RR] may deny residency based on eligibility requirements that are essential to the safety and welfare of the residents and maintenance of the recovery support environment. While an applicant prescribed MAT can be legally denied for other reasons, *categorical exclusions solely based on the MAT prescription violate provisions of the ADA* [emphasis added]." NARR refers individuals who face discrimination or exclusion based on their use of MAT to the SAMHSA *"Know Your Rights"* brochure here which concludes simply: "It is illegal to discriminate against people because they are on MAT."

MSHN's expectation is that recovery houses in MSHN's provider network will comply with federal law and NARR standards and will be inclusive of people who are on Medication Assisted Treatment. If technical assistance is needed regarding how to integrate people on MAT in a recovery house with people who are on an abstinence-based recovery pathway, please contact your MSHN Treatment Specialist for assistance.

Reporting Criteria: Any overdose or incident that requires the administration of Narcan on the property must be reported through the Sentinel Event and Critical Incident process as required within 48 hours of the occurrence.

Training for Recovery Housing Staff: In addition to Peer Recovery Coach training, and trainings required by MSHN, the following trainings are highly *recommended* for all recovery housing staff. Please refer to the MSHN Regional Training Grid attached to your contract for a list of all *required* trainings.

- Peer Recovery Support Service (PRSS) plan – How to write them, implement them and document them
- Progress notes – What to include
- Care Coordination – How to coordinate with other providers (treatment, PCPs, social or legal services, etc.)
- Ethics
- First Aid/CPR

Please check MSHN's weekly newsletter in Constant Contact for news of upcoming trainings.

Warm Transfer: In the event that the recovery house does not have the capacity to meet the needs of an individual, appropriate services, will be identified and a warm transfer will be conducted between the recovery house and the identified services.

References/Legal Authority

- Treatment Technical Advisory #11: Recovery Housing (http://www.michigan.gov/documents/mdhhs/TA_T_11_Recovery_Housing_532174_7.pdf)
- National Alliance of Recovery Residences (http://narronline.org)
- SUD Treatment- Income Eligibility & Fees (http://www.midstatehealthnetwork.org/provider-network/docs/Finance%20-%20Income%20Eligibility%201%200-08-2015.pdf)
- SUD Treatment- Income Eligibility & Fee Determination (http://www.midstatehealthnetwork.org/provider-network/docs/Finance%20-%20SUD%20Income%20Eligibility%20Procedure.pdf)
- Mid-State Health Network Substance Use Disorder Provider Manual (http://www.midstatehealthnetwork.org/provider-network/docs/MSHN%20SUD%20Provider%20Manual%20Final%202-1-17.pdf)
- Michigan Association of Recovery Residences (https://narronline.org/cm-business/michigan-association-of-recovery-residences/)
- National Alliance for Recovery Residences (http://narronline.org/)

Appendix G: Technical requirement for SUD Transportation Services

MSHN strives to reduce transportation barriers to accessing SUD treatment and recovery services, using the best quality, consumer-friendly, cost-efficient means possible. Transportation services are not a guaranteed benefit and are limited by the availability of Substance Abuse Block Grant funding during each fiscal year. Transportation needs must be identified during the screening and assessment process and clearly documented within the consumer's individualized treatment plan. If transportation needs arise during the course of a treatment episode, documentation of the need must be included in the consumer chart (i.e.: progress note, treatment plan review, recovery plan, etc.) and it must be included on an amended treatment or recovery plan. The treatment or recovery plan must include goals related to helping the consumer reduce barriers to transportation, and must promote consumer self-sufficiency and empowerment.

Transportation services authorized by the PIHP are available only after all other transportation options have been exhausted. These options include but are not limited to: natural/community supports and Medicaid Health Plans (MHPs). Efforts to obtain other available and appropriate means of transportation must be documented in the consumer chart and shall be subject to MSHN confirmation. For consumers using transportation services, a transportation log must be included in the consumer chart. Transportation logs must include the following: date of service, signature/initials of consumer and program staff person(s), purpose of transportation and destination(s) with total mileage or number of bus tickets or gas cards issued.

***All transportation CPT/HCPCS service codes shall be pre-authorized. Providers should request the codes through the REMI system for review.** The MSHN Utilization Management department will monitor the utilization of transportation codes region-wide and will work closely with the MSHN Finance department to monitor availability of block grant funding for transportation assistance. Eligibility for transportation services is ~~de~~delineated in Appendix G: Technical Requirement for SUD Transportation Services.~~termined using the following criteria:~~

LEVEL OF CARE

Detoxification & Residential Treatment

Transportation services are available to all consumers who meet medical necessity criteria for these levels of care. The detoxification or residential service provider is responsible for determining the consumer's transportation needs during the course of the screening process. The following parameters apply to transportation services for these levels of care:

- Least costly method of transportation must be used; starting travel begins at the consumer's home and/or point of pick up (i.e. bus station) and destination is complete when consumer reaches the designated treatment center.
- Return transportation assistance from detox/residential treatment to the consumer's return home will not be funded if the consumer leaves treatment against medical advice or due to program rules violation. Exceptions to this policy may be authorized on an individual case basis with supporting clinical documentation. The treatment provider requesting the exception must contact the MSHN Utilization Management department for authorization.

- Routine transportation provided to the consumer during the course of the residential treatment episode is considered intrinsic in the residential service delivery and is factored into the per diem reimbursement rate for residential treatment services (H0018/H0019). Additional mileage reimbursement may be authorized for excessive, non-routine transportation that is provided to the consumer during the course of the residential treatment episode. Authorization requests for excessive, non-routine transportation must be submitted to the MSHN Utilization Management department via REMI for review.
- Examples of *routine transportation* during the course of the residential treatment episode include but are not limited to: transporting the consumer to local stores for the purpose of obtaining necessary personal items; transporting the client to local recovery-support meetings; and transporting the consumer for medical services such as methadone treatment and physician visits in close proximity to the residential treatment center.
- Examples of *excessive, non-routine transportation* include, but are not limited to: transporting the client to his/her home community to participate in required court proceedings, Department of Health and Human Services (DHHS) case conferences, or visitations with children in foster care; transporting the client to his/her home community to receive specialty medical or behavioral health treatment from a provider with whom the client has an established treatment history or for the purpose of establishing aftercare.

Available Transportation Codes

- A0110 Bus Transportation- supporting documentation (i.e.: receipt for Greyhound bus ticket, etc.) must be uploaded to REMI at the time the claim is submitted
- S0215 Non-Emergency Transportation (per mile)- IRS mileage reimbursement rate; May be used by treatment center to bill for transportation expense in cases where treatment center staff members provide transportation to the client. This service code may only be used when long-distance bus transportation is not available or if this is the least costly means of transportation; May be used in combination with long-distance bus transportation to transport client from the bus station to the treatment center; May also be used when treatment center staff provide transportation to clients throughout the duration of the residential treatment episode for excessive, non-routine transportation as outlined above.

Outpatient

Transportation assistance is available for outpatient SUD services with the following priority status:

- Women's Specialty Consumers and dependent children;
- Consumers residing in rural settings (defined as 15 or more miles from the
- nearest outpatient service provider);
- All other consumers if SUD Block Grant funding permits.

Public transportation (bus tokens) should be the first method of transportation used, whenever possible. Justification for using a form of transportation assistance other than public transportation (bus tokens) must be documented in the consumer chart. Examples of justification for using other forms of transportation include but are not limited to: the consumer does not reside on a public transportation route; the consumer has a specific physical or emotional disability which would make utilizing public transportation a hardship for that

consumer; or the impairment caused by the consumer's substance use disorder poses safety concerns or high risk of relapse when using the public transportation system.

AVAILABLE TRANSPORTATION CODES

- A0110 Bus Tokens- $1.50 per unit; consumers may be given the amount of tokens necessary for one round trip between their home and the recovery treatment provider for each day they attend treatment. The same limitation applies, per day, for each dependent child accompanying a consumer to Women's Specialty treatment services.
- T2003 Gas Card- $5.00 per unit; this code is available only for consumers who do not reside on a public transportation route. The maximum units permitted depends on individual consumer needs and must be clearly documented in the consumer chart. The provider is responsible for evaluating individual need and assisting consumers with planning.
- S0215 Mileage – IRS mileage reimbursement rate; May be used in addition to A110 if/when consumer requires transportation from public transportation point to treatment facility; May also be used to assist consumers with recovery-oriented service access outside of the treatment center. Mileage is to be utilized using least costly methods and only when required to assist consumers with treatment plan goals.

References/Legal Authority

Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Program
FY17 -Medicaid Services Verification-Technical Requirements

Appendix H: MSHN Informed Consent Related to MAT

MSHN
Mid-State Health Network

Assurance of Informed Consent
Regarding Medication Assisted Treatment (MAT)

I have been fully informed about the treatment and recovery options that are available to me for substance use disorder treatment. MSHN's "Recovery Pathways for Opioid Use Disorders" information sheet was provided to me and explained.

- Medication-Assisted Treatment (MAT) was explained to me as the use of doctor-prescribed medications, in combination with counseling, case management, and recovery supports for the treatment of addiction.

- It was explained to me that MAT can successfully treat addictions, and can reduce cravings, prevent relapse and overdose, and help sustain recovery.

- I was given the opportunity to ask and discuss my questions and concerns to my satisfaction.

- I have felt encouraged to choose the recovery pathway that is best for me at this time and I feel my choice in recovery pathways has been respected.

I have read the statements above and had sufficient time to consider them carefully. I have been fully informed of my treatment options. With my signature below, I attest that I am choosing to engage in treatment with _____ [*Provider Name*]. I understand that I can stop treatment at any time and, upon request, I can receive information and assistance with transferring to a different provider of my choice.

_____ _____
Client Signature *Client Name (Printed)*

_____
Date

_____ _____
Intake Staff Signature *Intake Staff Name (Printed)*

NOTE: MSHN's "Recovery Pathways for Opioid Use Disorders" was provided and explained (initial here): _____

MSHN
Mid-State Health Network

Recovery Pathways for Opioid Use Disorder (OUD)

Note: Your choice of a treatment and recovery pathway should be informed by a comprehensive assessment of your addiction issues and with your having full information about the benefits and risks of each pathway so you can make the best possible choice for your treatment and recovery from opioid addiction.

Medication-Assisted Treatment (MAT)				Abstinence-Based Treatment	
Opioid Maintenance Medication (Buprenorphine/Methadone)		Opioid Blocking Medication Vivitrol (Naltrexone)			
Benefits	Risks/Limitations	Benefits	Risks/Limitations	Benefits	Risks/Limitations
1. Medications are safe when used as prescribed by a medical professional.	1. Patients don't always take medications as prescribed.	1. Medications block the "high" associated with opioid use.	1. Some patients are not comfortable with injections.	1. Some patients don't like taking medications.	1. Detoxification withdrawal and cravings make relapse a higher probability.
2. Medications can reduce use of illicit drugs and other criminal activity.	2. Medications can have side effects.	2. Patient makes a commitment each month to the naltrexone and their MAT.	2. Might be associated with depression in a low percentage of patients.	2. Abstinence allows a person to travel and not be tied to their MAT (medication) source.	2. Patients are left without potential protection from overdose.
3. Medications can help patients stay in treatment longer (which is the best indicator of successful recovery).	3. Medications can be expensive.	3. No sedation or withdrawal associated with naltrexone.	3. A patient must wait a week or longer from last opioid use to start naltrexone.	3. Many 12- Step fellowships encourage abstinence.	3. Abstinence-based programs require a strong ongoing commitment that may falter or be unattainable to some who could easily experience overdose & death.
4. Medications can stabilize patients and reduce cravings.	4. There is stigma associated with taking medication.	4. Successfully reduces cravings and relapses in many patients.	4. Will block the effect of opioid medications to treat pain.	4. Recovery programs for professionals (like pilots and doctors for whom job safety is critical) are often abstinence-based and often successful.	4. Such professional recovery programs are often expensive and out of reach of most people with OUD.
5. Medications can reduce relapses.	5. Some medications, when combined with other non-prescribed	5. Can protect patients by blocking potential overdoses.	5. A high enough dose of heroin or other opioids might override the	5. There is less stigma associated with an	5. High quality, long term abstinence-based programs offering continuity of care with

	opiates, can increase risk of overdose.		blocking effect resulting in overdose.	abstinence-based approach.	treatment and monitoring of other mental illness (like depression, PTSD, etc.) are often expensive & difficult to access.
6. Medications can allow the brain to heal and to re-establish normal dopamine functioning associated with motivation and pleasure.	6. Finding sympathetic providers who support MAT can be difficult.	6. Has been found to decrease cravings and relapse to alcohol.	6. Expensive and some insurance companies may not cover the injectable form for an extended period of time.		6. Prescribing of controlled substances (like medications for pain or anxiety) to an abstinent patient may be more likely to trigger a relapse.
7. Medications can be used over time to build confidence as patients re-integrate into family, work and healthier life domains.	7. Medications are addictive and can be hard to taper from.	7. Provides a "seatbelt" to help patients stay in a recovery program.	7. Use might be limited in patients with severe liver disease.		
8. Buprenorphine binds tightly to opioid receptors and if used correctly may protect against opioid overdoses.	8. Buprenorphine will not protect against overdosing on drugs or combinations of substances such as alcohol, benzos, amphetamines, etc.	8. Does not in itself contribute to overdose.	8. Does not necessarily protect against cravings for, use or relapse to other substances.		
9. Use of buprenorphine for MAT has been found to be helpful for patients with chronic pain.	9. Buprenorphine must be started after a patient is in some degree of opioid withdrawal or it may initiate the withdrawal.	9. The pill form of naltrexone is less expensive and can be used both before and after a course of the injectable form.	9. If the pill form is used a commitment to recovery must be made daily and use of the pill may need to be monitored by a person to whom the patient is accountable.		
		10. With injury or pain management, physicians can use many other effective medications or stronger opioids to provide relief.	10. With injury or pain management, patients might have to be monitored in the hospital by physicians to provide safe pain relief.		
MAT with Suboxone, Methadone or Vivitrol and Abstinence-Based Treatment are all more effective if the patient is also involved in treatment focused on long-term behavioral change, to enhance skills, to address healing of past trauma and to promote healthy coping responses to life challenges.					

Appendix J: MSHN MDOC Technical Requirements

Under an arrangement between the Michigan Department of Corrections (MDOC) and the Michigan Department of Health and Human Services (MDHHS), MSHN shall be responsible for medically necessary community-based substance use disorder treatment services for individuals under the supervision of the Michigan Department of Corrections once those individuals are no longer incarcerated. These individuals are typically under parole or probation orders and excludes individuals referred by court and services through local community corrections (PA 5ll) systems. Through the MSHN FY21 SUD Treatment contract between MSHN and the SUD Provider Network, MSHN has delegated to providers the responsibility for direct SUD treatment services.

REFERRALS, SCREENING AND ASSESSMENT:

Individuals under MDOC supervision are considered a priority population for assessment and admission for substance use disorder treatment services due to the public safety needs related to their MDOC involvement. Providers shall ensure timely access to supports and services in accordance with MDHHS Access Standards.

Admission Priority Requirements

Population	Admission Requirement	Interim Service Requirement	Authority
Pregnant Injecting Drug User	1) Screened & referred w/in 24 hrs. 2) Detox, Meth. or Residential – Offer Admission w/in 24 business hrs Other Levels of Care – Offer Admission w/in 48 Business hrs	**Begin w/in 48 hrs:** Counseling & education on: A. HIV & TB B. Risks of needle sharing C. Risks of transmission to sexual partners & infants Effects of alcohol & drug use on the fetus Referral for pre-natal care *Early Intervention Clinical Services*	CFR 96.121; CFR 96.131; Tx Policy #04 Recommended
Pregnant Substance User	1) Screened & referred w/in 24 hrs 2) Detox, Meth or Residential Offer admission w/in 24	**Begin w/in 48 hrs** 1. Counseling & education on: A. HIV & TB B. Risks of transmission to sexual partners & infants	CFR 96.121; CFR 96.131; Recommended

	business hrs Other Levels of Care – Offer Admission w/in 48 Business hrs	C. Effects of alcohol & drug use on the fetus 2. Referral for pre-natal care 3. *Early Intervention Clinical Services*	
Injecting Drug User	Screened & Referred w/in 24 hrs; Offer Admission w/in 14 days	**Begin w/in 48 hrs – maximum waiting time 120 days** 1. Counseling & education on: A. HIV & TB B. Risks of needle sharing C. Risks of transmission to sexual partners & infants 2. *Early Intervention Clinical Services*	CFR 96.121; CFR 96.126 Recommended
Parent at Risk of Losing Children	Screened & referred w/in 24 hrs. Offer Admission w/in 14 days	**Begin w/in 48 business hrs** *Early Intervention Clinical Services*	Michigan Public Health Code Section 6232 **Recommended**
Individual Under Supervision of MDOC and Referred by MDOC or Individual Being Released Directly from an MDOC Without Supervision and Referred by MDOC	Screened & referred w/in 24 hrs. Offer Admission w/in 14 days	**Begin w/in 48 business hrs** **Early Intervention Clinical Services** **Recovery Coach Services**	MDHHS & PIHP contract recommended
All Others	Screened & referred w/in seven calendar days. Capacity to offer Admission w/in 14 days	**Not Required**	CFR 96.131(a) – sets the order of priority; MDHHS & PIHP contract

The MDOC Supervising Agent (SA) will refer individuals in need of substance use disorder treatment through the following established referral process at MSHN.

For residential referrals only: If an individual has not been receiving any SUD treatment services and the supervising agent would like to refer the person to residential treatment, the supervising agent will send CFJ 306 (MDOC referral form) and the MDHHS 5515 (release of information) to MDOCreferrals@midstatehealthnetwork.org. The Utilization Management (UM) Department will review the referral documents and make a preliminary referral recommendation. If residential services are recommended, the client will call MSHN UM line (844-405-3095) and be transferred to an appropriate residential provider.
If an individual is already receiving outpatient SUD treatment services but it is determined they need residential treatment, the current SUD treatment provider can make the referral directly to a residential treatment program. MSHN approval is not needed if the referral is being made by another substance abuse treatment professional. All MDOC residential referrals must originate from MSHN or from an SUD treatment provider. If an MDOC client contacts a residential treatment provider directly to request services, the residential treatment provider should contact the MSHN UM Department to ensure that the referral has been approved.

For all other levels of care: Supervising Agents will send the CFJ 306 and the MDHHS 5515 to the receiving provider directly. MSHN UM Department does not need to complete a prior review/authorization.

Supervising Agents who have not specified a level of care will send those clients to local outpatient providers to complete a full biopsychosocial assessment. If the assessment results in a residential recommendation, the outpatient provider will refer the client to the most appropriate residential program. Residential programs receiving referrals from outpatient providers will accept those referrals as if they are coming from MSHN. Both providers will work to ensure the full assessment gets transferred to the receiving provider (with appropriate release).

To the extent consistent with HIPAA, the Michigan Mental Health Code and 42 CFR Part 2, and with the written consent of the individual, the Provider will provide notice of an admission decision to the Supervising Agent *within one business day*, and if accepted, the name and contact information of the individual's treatment provider.

If the individual is not referred for treatment services, the Provider will offer information regarding community resources such as AA/NA or other support groups to the individual.

Individuals that are subsequently referred through MDOC for substance use disorder treatment must receive an in-person assessment. The Provider may not deny an individual an in-person assessment via phone screening. In the case of MDOC supervised individuals, assessments should include consideration of the individual's presenting symptoms and substance use history prior to and during incarceration and consideration of their SUD treatment history while incarcerated. MSHN and/or Providers are not required to honor Supervising Agent's requests or proscriptions for level or

duration of care, services or supports and will base admission and treatment decisions only on medical necessity criteria and professional assessment factors. The individual's individualized master treatment plan shall be developed in a manner consistent with the principles as defined in the MSHN SUDSP Provider Manual and MDHHS – BSAAS Treatment Policy #06: Individualized Treatment and Recovery Planning.

REPORTING REQUIREMENTS:

Residential ONLY Services reporting requirements:

- If an individual referred for residential services does not appear for or is determined not to meet medical necessity for that level of care, the Supervising Agent will be notified within one business day.
- Individuals participating in residential services may not be given unsupervised day passes, furloughs, etc. without consultation with the Supervising Agent.
- Leaves for any non-emergent medical procedures should be reviewed/coordinated with the Supervising Agent.
- If an individual leaves an off-site supervised therapeutic activity without proper leave to do so, the provider must notify the Supervising Agent by the end of the day on which the event occurred.
- Residential providers may require individuals to submit to drug screening when returning from off-property activities and any other time there is a suspicion of use. Positive drug screen results and drug screen refusals MUST be reported to the Supervising Agent.
- Additional reporting for residential providers:
    - Death of an individual under MDOC supervision
    - Relocation of an individual's placement for more than 24 hours
    - The provider must immediately and no more than one hour from awareness of the occurrence, notify the MDOC Supervising Agent of any serious sentinel event by or upon an individual under MDOC supervision while on the treatment premises or while on authorized leaves.
    - The provider must notify the MDOC Supervising Agent of any criminal activity involving an MDOC supervised individual within one hour of learning of the activity
- The provider must collaborate with MDOC for any non-emergency removal of the MDOC referred individual and allow the MDOC time to develop a transportation plan and a supervision plan prior to removal.

Reporting requirements for all provides (including residential):

- Provider will complete monthly progress reports on each MDOC supervised individual on the template supplied by MDOC. Provider will ensure it is sent via encrypted/secured email to the Supervising Agent by the 5th day of the following month.
- The provider must not terminate any MDOC referred individual from treatment for violation of program rules and regulations without prior notification to the individual's Supervising Agent, except in extreme circumstances.

- Provider will ensure a recovery/discharge plan is completed and sent to the Supervising Agent within five (5) business days of discharge. The plan must include the individual's acknowledgement of the plan and the aftercare referral information.
- Notice of an admission decision to the Supervising Agent within 3 business days.
- The provider agrees to inform the Supervising Agent when Medication Assisted Treatment (MAT) is being used at their own agency. If the medication type changes, the provider must inform the Supervising Agent

REMI Documentation:
Please see the Help Menu in REMI for additional information on MDOC documentation.

The MSHN point of contact for MDOC related questions is Cammie Myers. Cammie is able to assist with questions regarding referral, screening, assessment, and training needs. Cammie can be reached by email at Cammie.Myers@midstatehealthnetwork.org.