MSHN
Mid-State Health Network

Substance Abuse Prevention and Treatment Block Grant
Frequently Asked Questions
As of March 10, 2021

New questions are marked with ***NEW*** to highlight any recent additions. Updated answers are marked with ***UPDATED*** to highlight any changes to previous guidance.

General:

1. MSHN is in good shape financially with Medicaid and Healthy Michigan funding.

2. Do you foresee any changes to how BG may be used for clients who:
    - Are on Medicare (when there is no Medicare provider available locally)?
        - Throughout FY 2021, BG changes will impact Medicare only individuals in the same manner as those with no insurance. Long term MSHN may need to establish more specific guidelines for individuals with third party insurance.

    - Have commercial insurance with a high deductible plan or higher copays, who meeting BG income guidelines, and utilize that funding as a secondary insurer?
        - Throughout FY 2021, BG changes will impact individuals with commercial insurance in the same manner as those with no insurance. Long term MSHN may need to establish more specific guidelines for individuals with third party insurance.

    - ***NEW*** Have Medicare and Medicaid spend down?
        - Throughout FY 2021, BG changes will impact these individuals in the same manner as those with no insurance. Long term MSHN may need to establish more specific guidelines for individuals with third party insurance and/or Medicaid spend down plans

3. What happens with BG clients who were in services prior to 1-1-2021 and have auths approved beyond the 30 days?
    - The changes to block grant are effective 1-1-2021. If an individual entered services before the 1-1-2021 implementation date, then they are eligible to continue in their course of services under the previous guidelines.

4. ***NEW*** If someone is refusing to or just doesn't apply for Medicaid for whatever reason, will that person lose block grant funding if they have been in services prior to 1-1-21? After 1-1-21?
    - MSHN reserves the right to discontinue Block Grant funding for any individuals who do

not participate in the requested activities to secure health insurance benefits, regardless of when the person was admitted to treatment.

Outpatient:

1. We can only request 30 days at a time for clients in treatment prior to 1-1-21. Is there a workaround for this?
    - For clients who were engaged in services prior to 1-1-21ONLY, you can request the typical number of units for a 90-day time period (individualized for each client). The dates will need to be 30 days for the system to process the auth. In the comment section of the authorization, please document the proposed end-date for the auth (no more than 90 days) and please note that the client was open prior to 1-1-21. You will still need to upload all Block Grant eligibility forms as that needs to be updated every 90 days. MSHN UM Dept will verify that all items are uploaded and included. As long as the auth meets medical necessity, we will approve the units with the new dates.

2. Can units be exchanged for other units when requesting authorizations?
    - While the system does not allow an "exchange", MSHN UM Dept will allow requesting more individual units when groups are unavailable due to COVID-19 restrictions ONLY. This information will need to be documented clearly in the comments section of the authorization or the UM staff will approve at the typical amount.

3. Block Grant (BG) Reductions outlined do not impact the current individuals in services. They can continue with planned course of treatment. Changes are effective 1-1-2021 forward for all levels of care.

4. Back prior to Healthy Michigan Plan (HMP), when BG was more prevalent, we could reduce BG co-pays based on income, but we couldn't waive it entirely. What is the position of MSHN on that type of reduction?
    - MSHN will pay the reimbursement rate less the co-pay amount to the provider for individuals using BG. It is up to the provider's discretion to collect a co-pay to offset the reduction in reimbursement with the individual in services or to waive the co-pay.

5. Would a provider get paid for an OP assessment if the treatment recommendation is Early Intervention (ASAM 0.5)?
    - *Question is about payment for the assessment, not services*
      Yes. MSHN would provide reimbursement for the initial assessment to verify the ASAM LOC determination for the person requesting services. Please note, MSHN requires the use of the REMI brief screen and level of care determination at the initial contact with the individual to also screen for the appropriate level of care to help support that connection.

6. How long are individuals considered priority populations, such as MAT clients who have been on MAT long-term and have not injected in years? Does the priority status change from the time of admission?
    - An individual's priority population status may change over time since the initial admission to treatment, especially in the case of long-term episodes of care such as MAT. MSHN will use available information at the time of re-authorization to determine an individual's current priority population status. Examples include but are not limited to:
        i. A woman was pregnant at the time of admission to treatment. She delivered the baby and is no longer pregnant, but the family has involvement with Child Protective Services. This individual would still qualify as a priority population Women's Specialty/Parent At-Risk of Losing Custody
        ii. An individual was using drugs via injection at the time of admission to treatment but has been stable in treatment with no injecting drug use for more than 12 months. This individual would not currently meet priority population requirements as an injecting drug user.
        iii. If the provider has questions about an individual's priority population status, please reach out to the MSHN Utilization Management team to consult.

7. When does the 30-day time frame for authorizations start? At the time of assessment or at Tx Planning Session when we would do the authorization as client is agreeing to services?
    - The start date of the authorization would be the first date a billable service was provided in order to be able to submit claims for the service

8. For Priority Population non-insured clients, we use the BG benefit plan for their services, correct?
    - REMI will only allow 30-day authorizations at one time for any individuals who do not have insurance but re-authorizations will be approved for priority population individuals above and beyond the limits identified on the BG benefit plan as long as services continue to be medically necessary. The reason for 30-day authorizations is to monitor the status of individuals applying for Medicaid/HMP.

9. Individuals cannot receive 9 hours of services per week even if they meet ASAM IOP level of care? What is on the benefit plan for IOP then?
    - The BG Benefit Plan includes an array of different service codes that are allowable for ASAM 2.1 including group and individual counseling, group and individual psychotherapy, case management, group and individual peer recovery support, and psychoeducation/didactic. Depending on the services offered by a provider agency, the authorized services can amount to 9 hours per week.

10. Can we request another 30-day authorization after the initial 30-day authorization for OP and IOP levels of care?
    - Yes, re-authorizations can be requested in increments of 30 days up to a maximum of 90 days for non-priority population individuals. Re-authorizations will be approved for priority population individuals above and beyond the limits identified on the BG benefit plan as long as services continue to be medically necessary.

11. If a person meets IOP level of care in the first 30 days and then at end of first 30 days, need just OP, can they get 30 days then of OP? So 30 days IOP then 30 Days OP?
    - Yes, the response for Question #9 applies in this scenario as well

12. For Non-Priority non-insured clients:
    - Are we expected to do an extensive treatment plan for client's that will have only 30 days of services or can they still be individualized but shorter than what we typically do?
        - As the provider will be supporting the person to apply for Medicaid/HMP during the first 30 days, it is unknown whether the person may only have services for 30 days or longer depending on service eligibility. It would be acceptable to focus on 1-2 individualized goals with the person in services (with subsequent objectives) during the first 30 days to prioritize the most pressing needs. If the person continues in services beyond the 30 days, the provider would need to review the treatment plan and update to reflect ongoing needs being supported in treatment services. Please remember the treatment plan goals/objectives need to justify the services provided. For example, if a person has case management needs, please ensure those are articulated in the treatment plan with the CSM service denoted with amount, scope, and duration.

    - Do we have to do ABD notices when we discharge as they won't have completed treatment and we are ending their treatment?
        - Adverse Benefit Determination Notices are only required for Medicaid/HMP beneficiaries but the provider would need to follow their own established process within their policy regarding notification for a non-Medicaid consumer's termination of services. Some form of a termination notice should be provided and discharge planning should be completed with resources to assist the consumer in connecting to any available supports and services. Alternately, the person could continue in treatment on a sliding fee scale or self-pay option at the discretion of the provider and person receiving services.

    - If their Medicaid is still pending at 30 days, we can't authorize another 30 days correct?
        - Please submit a re-authorization and indicate the individual applied for Medicaid and is still waiting for a determination from MDHHS. In that case they

will continue to be funded through MSHN until a decision is made by MDHHS. If possible, please provide documentation that the application was submitted.

Jail-Based:

1. Are incarcerated individuals who are Medicaid-eligible still subject to the Block-Grant benefit plan limitations?
    - Yes. Services provided in jail are not allowable to be costed to Medicaid/HMP even if an individual had Medicaid/HMP at the time they became incarcerated. All jail-based services are funded through Block Grant and are subject to the Block Grant benefit plan limitations.

2. If incarcerated individuals have exhausted the BG benefit plan treatment episode limits but still meet medical necessity criteria for services, will they be eligible for re-authorizations?
    - For priority population clients, yes. MSHN does not place arbitrary limits to services for priority populations so services will be re-authorized according to medical necessity for those individuals. Unfortunately for non-priority populations, MSHN can only provide the services listed in the BG benefit plan until the individual is released and able to obtain HMP/Medicaid.

3. Will MSHN approve jail-based MAT services such as daily methadone dosing?
    - Yes, jail-based MAT services will be authorized on a case-by-case basis taking into consideration a variety of factors including the individual's priority population status and the recommendations of the physician providing MAT.

Residential Providers:

1. So, since room and board (R&B) is all Block Grant the rate reduction is for all Residential clients including those on MEDICAID or HMP and priority populations, correct?
    - Correct. Room and board are paid for out of block grant therefore it impacts all populations.

2. How will providers know that a potential client has already used their 1x in 12-month period episode of care?
    - A provider should first verify that the individual has not had a treatment episode within the past 12 months at their own agency. The provider should also ask the potential client if they have received treatment at any other program in the past 12 months. If the provider needs additional verification, they may contact MSHN UM at 1-844-405-3095. If it is a night or weekend, please determine if the admission is urgent or non-urgent.

Urgent is defined as persons experiencing serious symptoms of withdrawal from alcohol, opioids, or benzodiazepines and/or pregnant women. If urgent, please admit and support. If non-urgent, please do not admit and consult with UM at next available date.

3. Are the rates for peer services reduced?
    - The reimbursement rate for peer services is not changing; however, there will be a copay for BG individuals. Providers will receive the full MSHN reimbursement rate for individuals with Medicaid/HMP; providers will receive the MSHN reimbursement rate minus the co-pay amount for individuals with Block Grant. It is at the provider's discretion to collect the copay to offset the reduction in reimbursement or to waive the copay for BG individuals.

4. The slides state "Only Region 5 residents for access to services" – what does this mean?
    - This is specific to recovery housing. MSHN will support reimbursement for recovery housing for individuals who live within MSHN's 21 counties. Historically MSHN has allowed people to access services using BG no matter where they lived per the contract with MDHHS. MSHN requested an exception to this requirement to reduce the impact of BG reduction within the region and was able to receive a contract waiver from MDHHS.

5. Is MSHN continuing to offer provider stabilization funding after 1-1-2021?
    - The provider stabilization funding will be available through September 30, 2021. Details related to the provider stabilization plans can be accessed on the MSHN website.

6. Since BG cuts are permanent and not just a FY21 issue, is there a chance that reimbursement for treatment services may be adjusted to account for services where R&B is a portion of the total reimbursement? (Residential specifically)
    - MSHN cannot increase the Medicaid/HMP reimbursement rate for residential treatment services to offset the reductions to room and board reimbursement rate caused by Block Grant reductions. MSHN cannot by law use Medicaid/HMP funds to pay for room and board.

7. Since you are allowing RH Providers to add a co-pay for lost Room & Board (R&B), does the same apply to residential providers to make up for their R&B reduction, regardless of the funding source for treatment? So, for example can a Medicaid funded client be charged a copay for the R&B portion of their residential stay, since R&B is not a covered benefit under Medicaid?
    - Medicaid consumers can be charged using other funding such as SSI, Bridge Cards, 1st party payment. *Please note copays beyond these may not be collected from Medicaid/HMP beneficiaries.

8. If a person has Medicaid/HMP and needs a second admission into residential within a 12-month period, would that have any impact on the coverage of the Block Grant funded R&B for that second stay?
    - No, MSHN does not place limits on benefits to Medicaid/HMP beneficiaries so an individual could have multiple admissions to residential treatment in a 12-month period, if it were medically necessary. MSHN would reimburse R&B for subsequent treatment episodes for Medicaid/HMP beneficiaries.

9. Is there a minimum length of stay that would trigger losing the opportunity for a second admission within 12 months? For example, if someone entered residential care and left within 7 days could they be re-considered for a second stay, if the combined total is 30 days? Another way of putting it, could both benefits be seen as a 12-month benefit with a max of 30 days of residential care within that time period?
    - The MSHN block grant benefit plan provides one admission to each level of care and recovery housing per 12-month period of time. The guidance is specific to admission and not a minimum number of days in services or a rolling amount per year. MSHN recommends having discussions with individuals at the front end of services about these limitations and helping them understand that if they leave services, they may not be able to return if they are still funded under block grant services. If an individual is eligible for Medicaid or Healthy Michigan, please support the person to be connected to these fund sources to provide the needed supports without any maximum service limitations.

Recovery Housing:

1. Does the "new admission" billing refer to Recovery Residences (RR)?
    - Yes. Block grant funding changes will take effect as of 1-1-2021. All new admissions will be affected by the new Block Grant changes.

2. Can persons that want to relocate be served in RR?
    - A person that is wishing to relocate would not be funded through MSHN. Persons residing in other regions may be funded through the region where they reside based on that region's eligibility criteria. A person would need to be living in the MSHN region to be eligible for MSHN to support recovery housing funding.

3. Is there a co-pay for recovery housing? I don't see it on the schedule. Are providers required to charge a co-pay?
    - The reimbursement rate that MSHN will pay for recovery housing is being reduced. Providers may choose at their discretion to implement a co-pay to supplement the cost of the BG reduction. The provider may need to update policies and procedures to determine if the MSHN reimbursement rate will be considered payment in full or if the

individual receiving services will pay a portion of their stay. Please note, Medicaid Provider Manual allows for Medicaid/HMP beneficiaries to be charged for non-Medicaid covered services as long as they are informed prior to admission. Established policies and procedures need to be in place to address co-pays.

4. Peer support service co-pays are only for people not billed on Medicaid/HMP or for all people?
    - Co-pays are for individuals without Medicaid or Healthy Michigan coverage. Individuals on Medicaid or HMP cannot be charged a co-pay for services that are covered by Medicaid/HMP, such as peer support services. Providers will receive the full MSHN reimbursement rate for individuals with Medicaid/HMP; providers will receive the MSHN reimbursement rate minus the co-pay amount for individuals with Block Grant. It is at the provider's discretion to collect the copay to offset the reduction in reimbursement or to waive the copay for BG individuals.

5. Do you have a schedule of recovery housing rates?
    - Please refer to the fee schedule included as an attachment to the contract.

6. If we are charging a co-pay for recovery housing to a person, is it the expectation that we would reduce the amount charged to MSHN? For example, we had charged a $25/week co-pay in months 4-6, but we would reduce our charge to you. Is that still the expectation?
    - The recovery housing rate will be reduced and reflected in REMI in billing.

7. For non-Region 5 residents, would they need to be in the community for 90 days to establish residency (what I recall the prior standards were)?
    - The individual seeking services would need to demonstrate residency by showing a change of address to their driver's license, or a previous utility bill (or other mail) to show residence in the region.

8. Is this budget cut permanent or only 3 months or until the deficit is corrected?
    - MDHHS has indicated this Block Grant revenue reduction is permanent. The changes that MSHN is implementing now, are to get the FY21 budget into alignment with that reduction. The reduction MSHN is asking providers to make will be evaluated over time.

9. If a person needs a second admission in 12 months, would we look to help them get into a different provider?
    - No. Recovery housing admissions are limited to one episode per 12-month period of time for the entire MSHN provider network.

10. With the one admission in 12-months, will people who had been in Recovery Housing (RH) that have relapsed not be able to be readmitted again until 12 months later?
    - Correct. MSHN will only be funding one episode of recovery housing per 12 months. It is at the providers discretion to determine if they would like to admit a person on a self-pay basis for additional supports after that initial episode occurs.

11. So, you put a 90-day cap on stay, what about those clients that need more time to obtain stable housing? Will there be an opportunity for them to get an extension past the 90 days? I would hate to have someone have to leave the program that is doing well and almost housed, and have to move them into a shelter?
    - For non-priority population individuals there is a maximum of 90 days MSHN-funded length of stay in recovery housing, however individuals may continue in recovery housing on a self-pay basis. Re-authorization requests for individuals belonging to priority populations will be considered on a case-by-case basis. Please note, re-authorization requests for priority populations must be submitted at least 7 days prior to the end of the initial 90-day authorization. Extensions past the 90-day maximum will not be the norm so please work to support individuals to transition by the time allotted.

12. Are there any restrictions with recovery houses adding primary care contracts with the potential in reduced beds for MSHN contracts?
    - Providers are free to explore contracts with other purchasers.

13. Are there recovery houses in all regions? If not, if there are additional contracts secured, can different regions house those outside of their current region's contract?
    - All PIHP regions have some level of recovery housing. MSHN would advise providers to reach out to the other PIHPs to consult on their contract reimbursement rates and requirements for recovery housing.

14. Is there any work with CMHA to connect with legislative funds from the federal government?
    - For the near term, MSHN does not see another revenue solution. In the future, there may be revenue options.

15. What about people who have a dual diagnosis and are involved with CMH, does CMH pick up some of the costs?
    - No. The CMH is not responsible for the services that MSHN is referring to for recovery housing.

16. Is the limiting structure of housing supports in the State plan? Do you happen to know where the State Medicaid plan is for housing supports?

- Medicaid policy has not kept up with the science of needs/services for the community's providers operate in. MSHN is not aware of another State that has included recovery housing as a part of the Medicaid benefit. MSHN would encourage providers to advocate for recovery housing to be a part of the service array for individuals seeking recovery.

17. Why would the block grant reductions be permanent?
    - The historical over allocation of block grant meant MDHHS allocated resources beyond the revenue and underutilized in other areas. The current state is that the department must only allocate to the field, what is available in the current year's revenue stream. Therefore, this past practice of allocating based on overspend/underspend is no longer able to occur.

18. When do these changes take place?
    - The FY21 block grant changes take effect as of 1-1-2021. Anyone currently in services can continue with their determined course of supports. Anyone admitted after 1-1-2021 will need to go by the guidance provided for block grant changes with a recovery housing maximum of 90 days and one episode in a 12-month period of time. The 25% reduction in reimbursement rates for recovery housing and peer supports (if funded through BG) will also take affect 1-1-21 for all people in the home, regardless of the date they moved into Recovery Housing.

19. Does the 12 months' time between services start at the beginning of the stay?
    - The 12-month time frame begins at the end of the person's stay in recovery housing.

20. Can Peer Recovery Support services be offered by the PRC for someone who has Medicaid or Healthy Michigan but is not in recovery housing?
    - The ability to provide peer supports will be dependent on a few factors including the person's insurance (either Medicaid or Healthy Michigan) and if the provider is an accredited provider. Providers with accreditation such as CARF or Joint Commission (not just certification like MARR/NARR), can provide peer recovery support services to individuals with Medicaid or Healthy Michigan Plan. Recovery Housing providers who are not accredited (such as CARF or Joint Commission) may not provide PRSS to individuals in the community. It is the recovery housing providers discretion to determine a sliding fee scale or self-pay option for individuals in this situation.

21. If a person is in Recovery Housing right now, and their 90 days will end in January or February, will they be able to get 90 additional days starting Jan 1 or does their time in Nov and Dec count toward the 90-day authorization approved Jan 1?
    - Please refer to Question #18 above. If an individual entered recovery housing before the 1-1-2021 implementation date, then they are eligible to continue in their course of services under the previous guidelines. Therefore, if a person entered services in

November or December 2020, then they would be eligible to receive a maximum of 180 days in recovery housing, based on medical necessity and ongoing needs demonstrated in their recovery plan.

22. Is there a minimum length of stay that would trigger losing the opportunity for a second admission within 12 months? For example, if someone entered recovery housing and left within a couple of weeks could they be re-considered for a second stay? Another way of putting it, could both benefits be seen as a 12-month benefit with a max of 90 days of RH within that time period?
    - The MSHN block grant benefit plan provides one admission to recovery housing per 12-month period of time. The guidance is specific to admission and not a minimum number of days in services or a rolling amount per year. MSHN recommends having discussions with individuals at the front end of services about these limitations and helping them understand that if they leave services, they will not be able to return with MSHN funding. It is the recovery housing provider's discretion to determine a sliding fee scale or self-pay option for individuals in this situation.

23. If a person went into recovery housing then a month into the program, they were admitted to a hospital for mental health reasons for a period of time, would they be allowed to return to the recovery house to complete their "episode" with the remaining days?
    - If a person residing in a recovery house is away from the house for a period of time for reasons beyond their control (such as hospitalization, jail, or a need for a higher level of care like residential) the person may return to complete the stay (for up to 90 days and depending on need) in recovery housing if they were not closed out of this service and knowing that the provider will not be compensated for days the person does not receive services within the home.