MID-STATE HEALTH NETWORK

SUBSTANCE USE DISORDER SERVICES PROVIDER MANUAL

Effective Date: October~~July~~ 1, 2024
~~Revised: April 1, 2024~~

Approved by: CEO, September 2024~~March 2024~~
Deputy Director, September 2024 ~~March 2024~~

Table of Contents

Commented [TT1]: Please note - Prevention has been moved above Treatment so the Table of contents will need to reflect that as well.

Commented [TT2]: Please make sure to add appendix G to the table of contents for **Residential Programs Food Assistance Program (FAP) Benefit Use**

MID-STATE HEALTH NETWORK
SUBSTANCE USE DISORDER SERVICES
PROVIDER MANUAL

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, and harm reduction 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→Substance Use Disorder→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 FY24-25 plan was approved by the MSHN Board of Directors in September 2023 and it identifies current priorities for behavioral health services, including SUD within the region. In FY22-23, MSHN expanded from the quadruple aim—Better Health, Better Care, Better Value, and Better Provider Systems—to include a 5th strategic priority, Better Equity, to reflect MSHN's commitment to overcoming longstanding health disparities between different sub-populations across Michigan and the U.S. MSHN also has an SUD-specific Strategic Plan for FY24-26 for SUD prevention, treatment, ~~and~~ recovery, and harm reduction efforts for the region. Prevention efforts are focused on reducing underage drinking, marijuana use, opioid prescription use, youth tobacco and nicotine use, and substance use in older adults. Treatment efforts are 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, increasing cultural competence and reducing health disparities. Recovery efforts focus on utilizing coordinated strategies, increasing coordination of care, and increasing the accessibility of recovery resources within the region.

~~During the 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 provider agreement and/or this manual and/or 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 Unwind webpage found HERE for further information.~~

Commented [TT3]: Kyle - Please add Harm Reduction to the Tabel Of Contents under the Tx Section. I tried but it would not let me.
Thanks!

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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 Requirements→Substance Use Disorder and include:

- MSHN SUD Prevention Provider contract
- MSHN SUD Treatment Provider contract
- MSHN SUD Recovery Housing Provider contract
- MSHN & MDHHS Contract, Substance Use Disorder Policy Manual
- MDHHS Office of Recovery Oriented Systems of Care (OROSC) policies & advisories
- LARA Licensing, Certification, Training
- Medicaid Provider Manual, Chapter: Behavioral Health and Intellectual and Developmental Disability Supports and Services
- 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: 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
- Compliance Reporting and Investigation
- Confidentiality and Notice of Privacy
- Conflict of Interest Policy
- Consent to Share Information
- Assessment of Member Experience~~Client Satisfaction~~
- Credentialing and Re-Credentialing Policy
- Credentialing and ~~Recredentialing~~Qualifications (SUD) - -Individual Practitioners

Commented [SG6]: Please update to Assessment of Member Experience

- Credentialing and Recredentialing – Organizational Providers
- Critical Incidents
- Cultural Competency
- Customer Service (Policy and Procedure)
- Disclosure of Ownership, Control, and Criminal Convictions.
- Disqualified Providers
- Evidence-Based Practices
- Income Eligibility for Non-Medicaid Services (Policy & Procedure)
- Media Campaign
- Medicaid Enrollee Appeals/Grievances
- Medicaid Event Verification (Policy and Procedure)
- Medicaid Information Management
- Michigan Mission Based Performance Indicator System
- Monitoring and Oversight
- Non-Licensed/Non-Board-Certified Provider Qualifications
- Performance Improvement Policy
- Provider Appeal Procedure
- Provider Contract Non-Compliance Procedure
- Provider Network Management
- Quality Management
- Recipient Rights for Substance Use Disorder Recipients
- Record Retention
- Service Philosophy, Access System
- Service Provider Reciprocity
- Sentinel Events
- SUD Services – Women's Specialty Services (Policy & Procedure)
- Use of Public Act 2 Dollars
- Trauma Informed Systems of Care

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 an 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.

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 to share knowledge, concerns and/or expertise.

Definitions

Abuse includes 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 a client's relationship with an organized treatment service when the intake process has been completed and the client is determined eligible to receive services of the treatment program.

Adverse Benefit Determination is A decision that adversely impacts the Medicaid enrollee's claim for services due to 42 CFR 438.400:

- Denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit. (42 CFR 438.400(b)(1))
- Reduction, suspension, or termination of a previously authorized service. (42 CFR 438.400(b)(2))
- Denial, in whole or in part, of payment for a service. (42 CFR 438.400(b)(3))
- Failure to make a standard Service Authorization decision and provide notice about the decision within 14 calendar days from the date of receipt of a standard request for service. (42 CFR 438.210(d)(1))
- Failure to make an expedited Service Authorization decision within seventy-two (72) hours after receipt of a request for expedited Service Authorization. (42 CFR 438.210(d)(2))
- Failure to provide services within 14 calendar days of the start date agreed upon during the person-centered planning (PCP) meeting and as authorized by the PIHP. (42 CFR 438.400(b)(4); 42 CFR 438.20).
- Failure of the PIHP to resolve standard appeals and provide notice within 30 calendar days from the date the standard appeal request is received by the PIHP. (42 CFR 438.400(b)(5); 42 CFR 438.408(b)(2))
- Failure of the PIHP to resolve expedited appeals and provide notice within 72 hours from the date the expedited appeal request is received by the PIHP. (42 CFR 438.400(b)(5); 42 CFR 438.408(b)(3))
- Failure of the PIHP to resolve grievances and provide notice within 90 calendar days of the date the grievance is received by the PIHP. (42 CFR 438.400(b)(5); 42 CFR 438.408(b)(1)).
- For a resident of a rural area with only one Managed Care Organization (MCO), the denial of the enrollee's request to exercise the enrollee's right under 438.52(b)(2)(ii), and to obtain services outside the network. (42 CFR 438.400(b)(6))
- Denial of the enrollee's request to dispute a financial liability, including cost-sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial responsibility. (42 CFR 438.400(b)(7))

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.

Commented [TT7]: Recommend this be moved this be moved to either Customer Service or UM section.

Commented [KJ8R7]: Since it's a definition it fits alphabetically in the glossary

Commented [AI9R7]: recommend changing definition to …due to 42 CFR as further outlined under the ABD section in the manual. Then move all the bullets to the section.

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 is 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 Addictionists. The members developed the patient placement criteria, the most recent of which is *The ASAM Patient Placement Criteria, ~~3rd~~ 4th Edition*.

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 diagnosis 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 individuals. 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 a client's changing needs will be met as that client 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~~ 4th 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 client.

Commented [SM10]: Recommend treatment or UM review this definition with the changes in the 4th edition of the ASAM. This is no longer .5 LOC.

Commented [TT11R10]: Thanks for this note! The MDHHS workgroup is still working on this item and hasn't made any determinations about it yet. This will likely need to be updated in FY25 for FY26 implementation.

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.

Grievances are a client's expression of dissatisfaction with the PIHP and/or the provider about any matter other than an adverse benefit determination. A grievance may include, but are not limited to, any aspect of the operations, activities, or behavior of PIHP or its Provider Network, regardless of whether remedial action is requested. Specific examples include the quality of care or services provided, problems getting an appointment or having to wait a long time for an appointment, aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's right to dispute an extension of time proposed by the PIHP to make a service authorization decision. (42 CFR 438.400(b))~~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 client, failure to respect the Client's rights regardless of whether remedial action is requested, or a Client'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 is the processes implemented to handle ~~A~~appeals of ~~A~~adverse ~~B~~benefit ~~D~~determinations and ~~G~~grievances, as well as the processes to collect and track information about them. 42 CFR 438.400.

Harm Reduction is an evidence-based approach that is critical to engaging with people who use drugs and equipping them with life-saving tools and information to create positive change in their lives and potentially save their lives. Harm reduction is a key pillar in the U.S. Department of Health and Human Services' Overdose Prevention Strategy (hhs.gov)

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.

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.

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.

Michigan Mission Based Performance Indicator System (MMBPIS) includes domains for access to care, adequacy and appropriateness of services provided, efficiency, and outcomes as required by MDHHS.

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

Office Based Opioid Treatment (OBOT) providers offer outpatient treatment that includes buprenorphine. OBOT providers are usually physician offices/private practice settings.

Opioid Treatment Provider (OTP) providers offer outpatient treatment that includes methadone.

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 individuals.

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.

Reporting Requirements allow the PIHP to 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.

Root Cause Analysis (RCA) is a process that includes but is not limited to identifying the causal factors that underlie a significant event that results in (or *could have resulted in*) serious injury or death, i.e., a Sentinel Event. The root cause analysis focuses primarily on systems and processes, not individual mistakes or performance. It is a process intended to help understand a serious and negative situation so as to avoid it in the future.

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 chance 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 is an~~:~~ ~~I~~impartial state level review of a Medicaid Client'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 Ceases are those individuals 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 seeks ~~operates~~ to enhance the relationship between the client and the provider. This includes orienting new individuals to the available services and benefits ~~available~~, including how to access them, helping individuals with all problems and questions regarding benefits, effectively and efficiently handling client 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~~ clients and other community representatives or citizens' informational needs. Customer Services is responsible ~~to provide~~for providing support and resources to meet client and provider needs, including but not limited to resource information and referrals. Provider ~~rs are required~~must ~~to~~ ensure that individuals are offered a MSHN Guide to Services Customer Handbook when they first enter services and the most current handbook version annually thereafter.

~~Providers are to assist individuals with any special needsindividuals, including but not limited to those who have hearing or vision impairments, those who need written or oral interpreter, those who have Limited English Proficiency (LEP) language needs, or individuals who need any other special accommodation to receive SUD treatment. Resources shall be provided without cost to the client. Providers may contact MSHN Customer Service, customerservice@midstatehealthnetwork.org or 844.405.3094, for assistance with client special need requests.~~

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 individuals engaged in services. Customer Service staff shall assist individuals 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 individuals. 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 individuals 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.

Providers must have processes in place to carry out Medicaid Adverse Benefit Determinations, Grievances, and Appeals. Processes are required to be completed through MSHN's REMI system. Notices of Adverse Benefit Determinations, Grievances, and Appeals are required to be

provided to Medicaid beneficiaries. Completing the process through MSHN's REMI system will allow providers to maintain records which include the required information of the name of the person for whom the Appeal or Grievance was filed, a general description of the reason for the Appeal or Grievance, the date received, date of each review, date of resolution, and the resolution details of the Appeal or Grievance. The recordkeeping must be accurately maintained in a manner accessible to MSHN and available upon request.

LEP Assistance

Providers are to assist individuals with any special needs, including, but not limited to, those with hearing or vision impairments, those who need written or oral interpreters, those who have Limited English Proficiency (LEP) language needs, or individuals who need any other special accommodation to receive SUD treatment. Resources shall be provided without cost to the individual served. Providers may contact MSHN Customer Service, customerservice@midstatehealthnetwork.org or 844.405.3094, with questions on accommodation requests.

Interpretation Service Reimbursement Process

SUD Treatment Providers

1. The treatment provider should select an interpretation service that meets the needs of the individual.
2. After the interpretation service is provided, the interpretation provider should bill the service(s) to the treatment provider.
3. The treatment provider would pay for the interpretation service(s),
4. The paid invoice should be sent to Amy Keinath, MSHN Finance Manager, via REMI messages for reimbursement.
5. MSHN finance will validate the interpretation service(s) against the service claim.
6. Once the invoice is reviewed and approved for reimbursement, a payment will be issued during the next payment cycle.

SUD Prevention Providers

1. The prevention provider should select an interpretation service that meets the needs of the individual/group.
2. After providing the interpretation service, the interpretation provider should bill the service(s) to the prevention provider.
3. The prevention provider would pay for the interpretation service(s) and the invoice should be retained for supporting documentation.
4. The cost of the interpretation service would be included in the monthly FSR.
5. Once the FSR is reviewed and approved for reimbursement, a payment will be issued in the next payment cycle.

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.

Individuals 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.
- Communicate directly with the MSHN Rights Consultant, when necessary.

The Licensing and Regulatory Affairs (LARA) Rights of Recipients poster must be displayed in a public place and a copy provided to individuals upon admission. The Recipient Rights poster 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 Regional Rights Consultant for MSHN is:

Dan Dedloff, Customer Service & Rights Manager

Office: 517-657-3011 | Fax: 517-253-7552 | Toll-Free 844-405-3094

Dan.Dedloff@midstatehealthnetwork.org

COMPLIANCE

Providers are required to report all suspected fraud, waste ~~-~~and abuse to the MSHN Compliance Officer prior to completing any investigation or taking any action. For instances involving fraud, t~~T~~he 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~~ ~~violatio~~immediately report potential fraud, waste, or abuse~~ns to determine the need to report~~ to the MSHN Compliance Officer for review prior to conducting investigations. 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) upon learning 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.

The Compliance Officer for MSHN is:
Kim Zimmerman, Chief Compliance & Quality Officer
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 individuals 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 Privacy Officer for MSHN is:
Kim Zimmerman, Chief Compliance & Quality Officer
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 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.

Steve Grulke, Chief Information Officer, Security Officer
Office: 517-253-7671 | Fax: 517-253-7552
steve.grulke@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 and/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 responsible for the development and implementation of the ensuring the responsibilities of the Quality sAssessment and Improvement Program (QAPIP)Management Program are outlined in the Quality Assessment and Performance Improvement Program (QAPIP) Plan as required by Michigan Department of Health and Human Services. The QAPIP Plan can be found on the MSHN Website: Stakeholders→Quality & Compliance→Quality Assessment Performance Improvement Program Plan. The purpose of the MSHN QAPIP is to utilize stakeholder feedback which includes both the consumer and provider to establish a system for monitoring, evaluating, and improving quality and safety for those served within the MSHN Provider Network through performance monitoring. we serve. The scope of MSHN's Quality Assessment Performance MaImprovementnagement Program is inclusive of all Substance Use Disorder Providers, CMHSP Participants and their respective provider networks., and the Substance Use Disorder Providers. Performance monitoring covers all organizational functions, and aspects of care and service delivery systems, and is. Performance monitoring is accomplished through a combination of well-organized and documented activities including performance measures. MSHN delegates to its providers the responsibility for timely access to treatment, effectiveness of treatment, individual'sclient safety, and client feedback, as outlined in the QAPIP Plan.

Sentinel Events

MSHN Residential Treatment Providers are contractually responsible for reviewing and reporting all critical incidents as identified by MDHHS and MSHN to determine if a sentinel event has occurred. The MSHN policies and procedures provide details related to the process for reporting.specific service providers in which the reporting applies to. The following events should be reviewed to determine if the event meets the criteria for a sentinel event:

- Unexpected Death of a recipient
- Accidents requiring emergency room visits and/or admissions to a hospital (includes overdose)
- Arrest or conviction of recipients
- Serious challenging behaviors
- Medication errors
- Medication Assisted Treatment (MAT) Medication Errors
- Administration of Narcan

A sentinel event must be identified within 3 business days of the incident occurring. The sentinel event must be reported by MSHN to MDHHS within 24 hours. [1]A root cause analysis must commence within 2 business days of the identification of a sentinel event.[2] 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 through the provider portal in REMI.

[1] Special Provisions Treatment. Performance/Progress Report Requirements-Sentinel Event Reporting requirements.
[2] Michigan Department of Health and Human Services Quality assessment Performance Improvement Programs for Specialty Prepaid Inpatient Health Plan Section VIII A-D.

Deaths that occur as a result of suspected staff action or inaction, subject of a recipient rights, licensing, or police investigation shall be reported to MSHN within 48 hours of the death. The report should include the following:

a. Name of individual
b. Individual Medicaid ID
c. Individual PIHP ID if there is no Medicaid ID number
d. Date, time, and place of death (if a licensed foster care facility, include the license number)
e. Preliminary cause of death
f. Contact person's name and Email address [3]

Annual ~~Client~~ Satisfaction Surveys

MSHN treatment providers shall conduct ~~client~~ satisfaction surveys of persons receiving MSHN funded treatment at least once a year. MSHN will provide the survey tool and compile the findings and regional results of the ~~client~~ satisfaction surveys. ~~for all providers.~~ The regional findings and results are available to the public and can be found on the MSHN Website: Individuals→Quality & Compliance→Satisfaction Surveys. Providers must make the results of the satisfaction survey available to the public. Individuals may be active individuals 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. [4] The information obtained through the client satisfaction survey process should be used to address individual cases of dissatisfaction, and the development of a Performance Improvement plan which incorporates the results to make program changes to improve services.

~~Michigan Mission Based Performance Indicator System (MMBPIS)~~Performance Management Standards

MSHN ~~Treatment Providers are contractually~~is contractually responsible to meet performance standards as defined by MDHHS. Performance standards include but are not limited to ~~, 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~~Michigan Mission-Based Performance Indicator System (MMBPIS) PIHP Reporting Codebook, and Performance Bonus Incentive Pool (PBIP) Metrics. The following performance measures include individuals with a substance use disorder:
~~in which there are two (2) timeliness performance indicators as listed below:~~

- MMBPIS 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. (Persons with Substance Use Disorders).
- MMBPIS 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%.
- Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence.(FUA) Reduce the disparity between the index population and at least one minority group.

Commented [SG12]: Should this title be changed and include the standardized performance measures that are currently being monitored as part of of the quality improvement process.
Also wondering if the paragraph about the Provider Enhancement Plan that is used for corrective action and quality improvement purposes should be moved to the QI or the compliance section. This would not change any of the processes that are currently in place.

[3] Michigan Department of Health and Human Services Event Notification.
[4] Special Provisions-Treatment Satisfaction Surveys

- Initiation and Engagement of Substance Use Disorder Treatment (IET-AD) Reduce the disparity between the index population and at least one minority group.
    - Percentage of new substance use disorder (SUD) episodes that result in treatment initiation through an inpatient SUD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication treatment within 14 days of the diagnosis.
    - Percentage of new substance use disorder (SUD) episodes that have evidence of treatment engagement within 34 days of initiation.

Treatment providers who do not meet the standards set by MDHHS and/or MSHN will be subject to a quality improvement or performance enhancement plan. The quality improvement plan will include causal factors or barriers for not meeting the performance standards, and interventions to improve timeliness of access to treatment. MSHN will use the information obtained to identify any regional trends that impact access to treatment.

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;
    - NOTE: Governmental entities (i.e., a government, governmental subdivision, or agency, or public corporation) cannot hold or be required to hold a substance use disorder license. *MCL 333.6233, MCL 333.1106, MCL 333.1104*
- **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, cyber security liability 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 individuals 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, 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*.

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 staff member profile in REMI needs to be added/updated to show current and valid 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.

MSHN Provider Network Policies and Procedures outline the credentialing requirements for all staff.

MSHN Monitoring and Oversight of Provider Network

In accordance with MSHN Quality policies and procedures, MSHN is responsible for conducting annual reviews for activities related to provider performance and compliance monitoring and 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 qualified entity (MSHN Service Provider Reciprocity Policy). 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.

Capacity

The treatment provider will notify MSHN in the event there are any capacity limitations and/or any inability to accept new referrals or when planning to increase capacity in residential, withdrawal management, or recovery residence programs. 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. Providers should also notify MSHN for other changes to programming/capacity including but not limited to addition of medication assisted treatment, ability to service new populations, (i.e., men, women, adolescents, adults), etc. MSHN may elect to seek or add providers to the regional panel to meet existing or new needs of individuals 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, due to contract termination or provider closure, the provider must notify MSHN 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, by the later of 30 calendar days prior to the effective date of the closure, or within 15 days from the provider's notice to MSHN, to each client who received his or her services from, or was seen on a regular basis by, the provider. The written notification to each client, as coordinated with the responsible MSHN contact, must contain:

- 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.

The terminating/closing provider will provide MSHN UM Department (UM@midstatehealthnetwork.org) and MSHN Customer Services

(dan.dedloff@midstatehealthnetwork.org) a list which includes open individuals and individuals who were recently closed within the past 60 days from the date of the notice of termination or within 30 days from closure for the purpose of transfer/discharge planning. MSHN will work closely with the terminating/closing provider through weekly reviews and/or REMI, to assist each client with their transfer to another treatment provider or termination from treatment. The MSHN Contract Specialist will provide additional instructions to assist the provider during the termination/closure process.

Providers who offer SUD services must have a mechanism to notify individuals 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 individuals 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.

- 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.

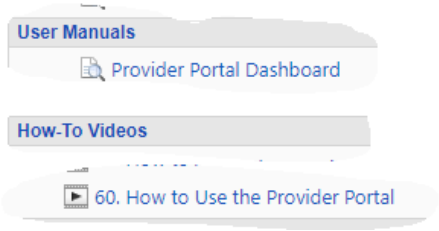
REMI Provider Portal

Providers are expected to access, monitor, and manage functions via the provider portal. Portal functions include but are not limited to staff user account setup and management, staff credentials management, required reporting, and documentation submission. It is highly recommended that at least two individuals have access to the provider portal. The provider Portal allows users with the necessary permissions to do the following;

- Add new staff;
- De-activate staff no longer employed;
- Reset staff passwords;
- Update staff credentialing records;
- Update agency credentialing records
- Review authorization request data

Agencies are requested to inform MSHN of the two individuals to be assigned the portal permissions by sending the full names and e-mail addresses to MSHN Contract Manager Kyle Jaskulka at kyle.jaskulka@midstatehealthnetwork.org.

The REMI "Help" menu contains the Provider Portal User's Manual as well as a How-to video describing in more details the functionality of the portal.



The MSHN website also has links to the training materials related to the Provider Portal.

- FAQ
- Presentation

MSHN will no longer process the "REMI User Request" forms previously used to add staff sent to the inquiries@midstatehealthnetswork.org mailbox.

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 individuals 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 individuals 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.

All trainings required for treatment and prevention providers are available through -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 documentation and tracking of completion of initial training and annual refreshers. Staff members are able to access their training transcript as well.

MSHN will monitor compliance with MSHN Regional Training Requirement with review of employee training records during annual quality assurance site review.

Conferences and Travel

MSHN allows funding for continuing education and conference fees. Travel costs incurred for conferences are allowed based on federal mileage rates and federal travel per diem. Any out-of-state conferences or travel must be approved by MSHN staff prior to registration and/or payment for travel reservations. Any out-of-state travel or conference fees not pre-approved by MSHN will result in no reimbursement for those costs.

Any conferences/trainings attended must include a treatment, prevention, or recovery focus. Provider staff attending any conferences/trainings may be asked to present information back to MSHN SUD providers in the future.

Contract Non-Compliance

Providers will be subject to contract compliance actions and corrective action plans from MSHN when contract requirements are not met or maintained. Contract actions can take many forms, including but not limited to corrective action plans, voiding of claims/encounters, 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 and in accordance with the Contract Non-Compliance Procedure.

Please contact Kyle Jaskulka, Contract Manager 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.

PREVENTION PROVIDERS

Commented [TT13]: Kyle - Please adjust Table of Contents to have Prevention Providers before Treatment. Thanks!

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). Please contact the prevention specialist in your part of the region whenever possible to address any needs or concerns or call (517) 253-7525.

Sarah Andreotti: Sarah.Andreotti@midstatehealthnetwork.org
~~Kari Gulvas~~Cari Patrick : ~~Kari.Gulvas@midstatehealthnetwork.org~~
CariPatrick@midstatehealthnetwork.org
Sarah Surna: Sarah.Surna@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):

- All staff being funded in part or whole by MSHN, should read the provider manual at the time of hire and when updated. Provider agency should have prevention staff sign an attestation that they have read the manual, which should be kept in the staff personnel file.
- A Substance Abuse Prevention License is required for any non-governmental entity 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 600 hours of direct prevention services must be conducted annually. Of these 600 hours, a minimum of 480 hours must be face to face services identified in the MPDS system with the remaining 120 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 Ethics training must be completed within one (1) year of hire. This training is required for staff on a MCBAP Development Plan, a CHES certification, and staff designated as Specifically Focused Staff. This training is found through several training agencies, both in-person and virtual.
- Prevention activities must be focused on State and Regional priorities which include 1) Reduction of Underage Drinking, 2) Reduction of Youth Tobacco Use, 3) Reduction of Underage Cannabis (Marijuana) Use and/or 4) Older Adult Prevention Activities, 5) Reduction of Prescription Drug and Over the Counter Medication misuse. Services should focus on 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-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 agency's 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. MSHN must approve in advance any materials that include the MSHN logo.
- If Provider is planning on conducting a local Media Campaign, all materials must be approved by MSHN and/or MDHHS as required in the Media Campaign Procedure. A Media Campaign Request Form must be fully completed and submitted to MSHN with any necessary attachments. MSHN will then review and send to MDHHS for approval. Please note that the approval process can take up to 30 days once submitted to MDHHS.

Substance Use Disorder Credentialing and Staff Qualification Requirements

Prevention Services Supervision: MSHN requires that staff members of the provider network who perform SUD Prevention functions and services receive adequate supervision and support, and that their performance be monitored and evaluated on an ongoing basis. A formal and written performance evaluation is required for each Prevention Professional at least annually.

Prevention Professionals must be supervised by MCBAP prevention credentialed staff or an approved alternative certification (CPS, CPC or CHES). Prevention Supervisors must have had the MCBAP prevention credential for a minimum of three (3) years. Where such an expectation is not operationally feasible, the Provider Agency will ensure that arrangements are in place to attend mandatory monthly supervision meetings with MSHN staff. Qualified Prevention Supervisors must have the supervision of prevention staff job function stated in their agency job description. Certification of Prevention Supervisors and written job descriptions will be verified during the desk audit process every other year or upon request.
It should be noted this supervision requirement is related to MSHN-funded work, and not the MCBAP Development Plan supervision requirement or their day-to-day job functions at provider agencies.

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.

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. Provider Agency must maintain documentation in the employee file that acknowledges receipt and understanding of the prevention MPDS user manual. 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.

Twice a year, prevention and community recovery providers are required to submit a MPDS Direct Service Hours Report to their assigned MSHN Prevention Specialist. This is an opportunity for the prevention or community recovery provider supervisor to review and comment on the status of meeting prevention direct service hour requirements; any adaptations to programming as a result of review of the units; timeliness of staff data entry; etc. for each prevention or community recovery staff in the organization. Reports should be run from the Activity Data Report in MPDS and include the eight fields of Group Name, Program Name, Funding Source, Activity Start Date, Activity Creation date, Units, Activity Record Number, and Staff. In the email with the report, program supervisors should summarize activity units into hours per staff person; identifying if they are on track to meet direct service hour requirements for each individual staff member, and how the organization plans to address under unit/hour adjustments if they are not on track to meet requirements. Reports are due to be submitted by the program supervisor to their agency's MSHN Prevention Specialist by **January 15** for services from 10/1/24-12/31/24 and submitted by **July 15** for services from 1/1/25-6/30/25.

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 21 years-of-age and to enforce those laws

effectively. Annual Synar checks, required by the amendment, show that great strides have been made in reduction of 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 and non-Synar checks to at least 50% of the tobacco retailers in the DYTUR's designated county(ies) utilizing the official MDHHS protocol; 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 MDHHS 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 and MSHN-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 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), type of tobacco sales, vendor type, and phone number. 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 and non-Synar Reports**—IMPORTANT: A minimum of 50% vendor education and 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. This guide is included as an attachment to the MPDS User Guide.

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. Guides, policies, print materials and more can be found on the MDHHS Synar webpage at: https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/drugcontrol/prevention/prvcontent/youth-access-to-tobacco-and-synar-info

* SAPT Block Grant funds cannot be used for law enforcement compliance checks, 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*. 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 stipend to each of the 21 county coalitions 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 a regular budget summary.

All grant funding should support the needs of respective communities/counties based upon meeting grant objectives as defined by the parameters of individual grant requirements. Coalition meeting minutes should reflect general discussion of benefit/hinderance of use of additional grant funding with reasoning for accepting/rejecting additional funds. Funding expenditures for supplemental grants (such as OEND, etc.) must be voted on by the coalition or appropriate coalition subcommittee prior to spending, and the voting results recorded in the meeting minutes. The fiduciary agency should not direct or influence voting or hinder expenditures.

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TREATMENT SERVICES

~~I.~~

MSHN's Treatment Specialists are available to assist treatment providers with questions pertaining to treatment programming. Please contact the treatment specialist assigned to support your agency to address any needs or concerns or call (517) 253-7525.

Trisha Thrush: trisha.thrush@midstatehealthnetwork.org
Kate Flavin: kathrine.flavin@midstatehealthnetwork.org
~~Rebecca Emmenecker: rebecca.emmenecker@midstatehealthnetwork.org~~
Sherrie Donnelly: sherrie.donnelly@midstatehealthnetwork.org
Beth LaFleche: beth.lafleche@midstatehealthnetwork.org
~~Kate Flavin: kathrin.flavin@@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/SUGE policies located here: MDHHS policies & advisories. MSHN offers additional guidance below:

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 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 in spring/summer for the subsequent fiscal year that begins in October.

ASAM Level of Care Designations

ASAM level of care designations are now being supported electronically in the MDHHS MiCAL system. The MiCAL system can only be accessed through the providers contracted PIHPs. If a provider is in need of a new/revised/re-enrollment ASAM designation, they should work with the PIHP in which their headquarters location is geographically located. If a provider's geographic headquarters is in the MSHN region, then please reach out to your agency lead treatment specialist for assistance in completing an ASAM Designation application in MiCAL. ASAM Level of Care Designations are approved by MDHHS for a two-year period of time. Prior to the two-year expiration, MDHHS will provide a notice of need to renew for each LOC that has been approved through MiCAL previously. Renewals can be supported by contacting your agency lead treatment specialist to initiate the application in MiCAL.

Please note if provider locations change, applicable ASAM designations will also need to be updated as well as the LARA SUD license.

ASAM Continuum Training Process~~s~~

Going forward, new staff and any untrained staff will first access training for ASAM CONTINUUM® by creating a free account on ASAM eLearning Center and complete the free on-demand training curriculum, the details are below. It is important to note that when a clinician completes the on-demand course they must download their certificate of completion and you will then submit the certificate to your MSHN Treatment Specialist to activate that user's account and be granted access to CONTINUUM® through REMI.

ASAM CONTINUUM® on-demand training product includes:

I. **Self-Paced Module**: Introduction to the ASAM Criteria and the ASAM CONTINUUM® for Michigan Providers.
II. **Recording of a live training** that includes:
    a. Presentation: ASAM CONTINUUM® Navigation and Best Practices.
    b. Demo: Patient interview with the ASAM CONTINUUM®
        i. General Information Section
        ii. Medical Section
        iii. Psychological Section
        iv. Interview Completion Section

III. Certificate of Completion

The clinicians who have already registered and attended one of the CONTINUUM® cohorts will still have access to their cohort page where they have the option to claim credits for the course they have attended. If those individuals would like to access the on-demand product as well, they are welcome to do so by following the Registration Steps below and skipping step 1. On demand trainees will not receive CE credits.

eLearning Center registration steps:

This 8-hour, on-demand workshop is designed to help counselors, social workers, administrators, and other clinical staff learn how to navigate and appropriately use the ASAM CONTINUUM tool to generate a level of care placement for individuals with alcohol and substance use problems. The workshop content is based on information found in The ASAM Criteria and incorporates an opportunity for participants to practice applying the information through interactive and case-based activities.

ASAM CONTINUUM Registration Instructions:

1. To create an account, follow this link: https://www.asam.org/login
    a. If you have recently attended a virtual ASAM CONTINUUM training session you should already have an account.
    b. If this is your first virtual ASAM CONTINUUM session, make sure you scroll to the bottom of the page and review the instructions before you begin creating an account.
        i If you run into any problems, please contact 301.656.3920 or email@asam.org.

2. To register for the ASAM CONTINUUM Course, please follow this link: https://elearning.asam.org/products/asam-continuum-course-general-on-demand
    a. Enter the discount code: MICHIGAN
    b. If you run into any problems, consult the FAQ page here: https://elearning.asam.org/faqs or contact 301.656.3920 or education@asam.org.

3. After creating an account and registering for the course, go to the course page: https://elearning.asam.org/products/asam-continuum-course-general-on-demand

4. Click on the "contents" tab to access the self-paced training

~~I. If you are signing up for an ASAM course for the first time, you will have to create an account. To create an account, follow this link: https://www.asam.org/login Make sure you scroll to the bottom of the page and review the instructions before you begin creating an account.~~
~~a. If you run into any problems, please contact 301.656.3920 or email@asam.org.~~
~~b. Please allow time for the customer service team to respond to your inquiry. The customer service team is not always able to respond immediately.~~
~~II. To register to the ASAM CONTINUUM® course, please follow this link: https://elearning.asam.org/products/asam-CONTINUUM®-course-michigan-on-demand~~
~~a. If you run into any problems, consult the FAQ page here: https://elearning.asam.org/faqs or contact 301.656.3920 or education@asam.org.~~
~~Please allow time for the customer service team to respond to your inquiry. The customer service team is not always able to respond immediately.~~
~~III. After creating an account and registering to the course, go to the course page: https://elearning.asam.org/products/asam-CONTINUUM®-course-michigan-on-demand~~
~~IV. Click on the "contents" tab to complete the self-paced module and/or watch the recordings.~~

a. Please make sure you complete the modules on a laptop or a desktop. If you are using a phone or a tablet, the system may not register your progress and your status will be marked as "incomplete".

~~V.~~II. Click on the "resources" tab to view slides and handouts.

~~VI.~~III. A downloadable certificate of completion will become available after you complete the module(s). ~~1 and module 2.~~

a. Please note that when completing the modules, you must complete **all the sections, interactions and knowledge checks**. If you miss something, the system will log your progress as "incomplete", and you may need to go back into the module and make sure you completed all the required activities.

~~a.~~ ASAM Continuum FAQ Document available on the MSHN website: MSHN_ASAM_Continuum_FAQ_7-18-24.docx (live.com)

Auricular Acupuncture

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. MSHN 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.

Behavioral Contracts:

Commented [KF14]: Removed from MAT section and added to Treatment as this pertains to all providers.

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 individuals receiving MAT services. Illicit use should be addressed in a meaningful and strength-based way on the client's individualized treatment plan.

Biopsychosocial Assessment

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 client. MDHHS has approved ASAM Continuum as the sole SUD biopsychosocial assessment tool for ***adults***. The GAIN I Core has been selected as the SUD biopsychosocial assessment tool for use with ***adolescents***. The ASAM Continuum and GAIN I Core became statewide requirements as of October 1, 2021. ASAM Continuum training is required prior to implementation of the assessment in practice. The GAIN I Core requires training and certification prior to implementation.

Per the LARA SUD Administrative Rules that went into effect as of 6-26-2023, the guideline for Assessments & Treatment Plans (ie. Service Plans) (R 325.1363 Service Plan) is the following:

- Rule 1363. (1) Based upon the assessment made of a recipient's needs, a written service plan, which may include both medical and counseling services, must be developed and recorded in the recipient's record. A service plan must be developed by a licensed or certified professional as

referenced in these rules and as promptly after the recipient's admission as feasible, but no later than either of the following:

- (a) The conclusion of the next session attended by the client for ***outpatient*** counseling programs.
- (b) Twenty-four hours for ***methadone, residential, and residential withdrawal management*** programs.

A biopsychosocial assessment should be completed annually for any person that is engaged in services with the treatment provider for longer than 12 months. The assessment should be completed prior to the 12-month date in services to assist in gauging the persons needs in treatment and recovery services and assist with informing the annual treatment plan, as needed.

The MSHN Standardized Assessment policy can be located on the MSHN website here.

The ASAM Continuum FAQ document is available on the MSHN website: MSHN_ASAM_Continuum_FAQ_7-18-24.docx (live.com)

Co-Occurring Mental Health and Substance Use Disorders

Commented [SD15]: Completed

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. This is reflected in organizational policies, procedures, assessment, and programming.

- Providers are expected to screen all individuals 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. 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.

SAMHSA also offers an advisory for Substance Use Disorder Treatment for People with Co-Occurring Disorders that can be accessed here online as an additional resource.

Corrective Action Plan (CAP Implementation Review) & Performance Enhancement Plan (PEP)

As stated in the MSHN Provider Contract Non-compliance procedure, a provider may receive support through either a Corrective Action Plan, Corrective Action Plan Implementation Review, or Performance Enhancement Plan (PEP). These efforts are a supportive measure to offer a provider more intensive technical assistance and monitoring to address quality, performance,

outcomes, and compliance issues. The CAP/PEP 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 CAP/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 CAP/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 CAP/PEP can include a variety of touch points depending on the individualized needs of the provider and the reasons for the implementation of the CAP/PEP. For occurrences when a need for a CAP/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 CAPs/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. Corrective Action Plans and 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 CAP/PEP, MSHN can engage contract non-compliance action as outlined in Section VI.I Contract Remedies and Sanctions of the ~~FY24~~current SUD Treatment 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 admission hold or placing a cap on program admissions, and communication/collaboration with LARA and/or other accrediting bodies.

Cultural Competency

MSHN is committed to supporting all Region 5 residents in achieving health and wellness. Towards that end, MSHN expects its contracted SUD providers to ensure equitable access to high quality care for all persons served regardless of race, color, national origin, religion, sex, gender identity, sexual orientation, disability, age, marital status, income derived from a public assistance program and/or political beliefs.

MSHN recognizes that cultural competence is a dynamic, ongoing, developmental process that requires a long-term commitment and is achieved over time. MSHN expects its provider network members to embrace best practices to support persons served who may be from diverse cultural backgrounds. Cultural responsiveness includes removing barriers and embracing differences in order to offer safe and caring environments both for individuals served and for staff who are members of historically marginalized populations.

SUD prevention/treatment providers should have a cultural competency policy and documentation of staff training on cultural competency available to MSHN for review. 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 should include linkages with racial, ethnic, and cultural organizations throughout the community.

The MSHN Cultural Competency Policy can be accessed here on the MSHN website.

Discharge Planning

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MSHN requires that effective discharge planning will be provided for individuals, 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, beginning at admission. 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 plan must include the date and time of appointment(s) and location for the next service provider(s).
- The MSHN contracted provider network will ensure that all individuals are appropriately discharged from their care, including entering a discharge into REMI and providing an Adverse Benefit Determination, when appropriate.
- The discharge summary will include the person's status at the time of discharge, a summary of services received, and the discharge rationale.
- 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.

Documentation Standards

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Accurate documentation is necessary to maintain the best care for people served, allows other staff to pick up services if needed, and verifies the service occurred for audit purposes. At a minimum, documentation:

- must include name of the person served, date of the service, start and stop time of the service, and be signed, inclusive of credentials, by the staff completing the service;
- identify the service code and modifiers as appropriate
- must be completed in a timely manner to ensure it accurately captures the service content;

- must be completed prior to billing for the service provided;
- identifies the treatment plan goal or objective that is being addressed during the service;
- includes session content, interventions used during the session, progress, and the response to the session;
- contains enough detail to justify the service code that was billed;
- allows a service to be reconstructed for audit purposes;
- meets the credentialing and professional ethics requirements for documentation;
- identifies any evidence-based practices that were used during the session;
- for groups must include the number of people served in the group.

Evidence-Based Practices

MSHN requires all SUD treatment providers to document and provide evidence-based programs as a part of their services. Evidence-based practices must be documented in the treatment plan and in session notes. 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 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 individuals. 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.

The MSHN Clinical Practice Guidelines & Evidence-Based Practices policy can be accessed on the MSHN website here.

Gambling Disorder Protocol

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:

<u>During Admissions process:</u>

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.

<u>During Treatment Planning process and ongoing during treatment:</u>

1. If there is a GD diagnosis, the 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 client 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 client referred to the GD Help-Line?" 3) If client 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

Group therapy is a longstanding evidence-based modality of treatment for individuals living with substance use disorders (SUD), grief, trauma and mental illness. Groups organized around therapeutic goals provide insight and guidance and enable individuals to observe others' recovery and create a culture that supports healing and recovery. Group therapy establishes a safe space in which individuals share their thoughts, feelings and stories (and to hear the same from others), which can reduce the shame and isolation of feeling alone with one's addiction. Moreover, with the guidance of a skilled trained facilitator, participants can practice important skills like effective communication, conflict resolution, and setting boundaries. To allow for *all* participants in a group to have their voices heard and to have an opportunity to practice communication and life skills, group size is usually capped at 15, though per SAMHSA TIP #41, an ideal range is 8-10 participants, i.e., "small enough for members to practice the skills being taught."

For those reasons and informed by guidance from the SAMHSA, CMS and MDHHS, the Substance Use Disorder Services (SUDS) Directors from Michigan's Regions 1-10 endorse the following best practice guidelines:

- **Therapeutic/Interpersonal (Core) Group Size:** A size limit of 8-10 participants (15 at most) for core/therapeutic/interpersonal process groups, consistent with SAMHSA and other guidance below.

- **Psychoeducation/Didactic (Core) Group Size:** Skills-building groups that hinge on participant engagement, sharing, and/or practice of skills. Group size should be limited to 20 to allow participants capacity to engage, interact, and practice individualized skills.

- **Evidence-based Therapy (Core) Group Size:** Group therapy with a particular curriculum, group structure and/or target population should follow the parameters of that program to fidelity, including group size recommendations. If the EBP does not have a specific group size parameter, then the provider will utilize the guidance for Therapeutic/Interpersonal (Core) group size listed above.

- **Lecture (non-Core) Group Size:** Educational groups that are not contingent on participant engagement, sharing and/or practice of skills presented in a lecture format. Group size should accommodate the needs of individuals served. Lectures do not count towards "core/life skills" treatment services unless the lectures are not more than 20 individuals or there is a breakout time

for smaller groups to process the lecture of no more than 20 individuals per each facilitator. The smaller group break out time period must be the majority of the duration of the activity.

Outpatient Treatment Continuum of Services Treatment Policy #9 defines the minimum in group therapy as face-to-face interventions with three or more individuals, which includes therapeutic interventions/counseling.

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 MDHHS, 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 individuals 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.

Sources:
MDHHS Treatment Policy #9: Outpatient Treatment Continuum of Services (michigan.gov)
MDHHS Treatment Policy #10, Residential Treatment Continuum of Services (michigan.gov)
TIP 41: Substance Abuse Treatment: Group Therapy | SAMHSA Publications and Digital Products
SAMHSA Advisory: Group Therapy in SUD Treatment (2021)
CMS Medicare Coverage Database: Outpatient Psychiatry and Psychology Services
CMS: Psychiatric Partial Hospitalization Programs

Harm Reduction

Harm reduction is a practical and transformative approach that incorporates community-driven public health strategies — including prevention, risk reduction, and health promotion — to empower people who use drugs (and their families) with the choice to live healthy, self-directed, and purpose-filled lives. Harm reduction centers the lived and living experience of people who use drugs, especially those in underserved communities, in these strategies and the practices that flow from them.

Harm reduction emphasizes engaging directly with people who use drugs to prevent overdose and infectious disease transmission; improve physical, mental, and social

wellbeing; and offer low barrier options for accessing health care services, including substance use and mental health disorder treatment.

Organizations who practice harm reduction incorporate a spectrum of strategies that meet people where they are — on their own terms, and may serve as a pathway to additional health and social services, including additional prevention, treatment, and recovery services.

Harm reduction works by addressing broader health and social issues through improved policies, programs, and practices. Harm reduction is a key pillar in the U.S. Department of Health and Human Services' Overdose Prevention Strategy (hhs.gov)

Source: Harm Reduction | SAMHSA

Individualized Treatment Planning

~~Per Treatment Policy #6 Treatment Policy #6 https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Folder1/Folder57/Policy_Treatment_06_Invd_Tx_Planning.pdf?rev=ca7b52dee1014fffb0cf92d8921f1d2e&hash=A360179E3A7BD69120E9D756654805C2~~ , Per MDHHS 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.

Commented [SD18]: Need assistance with link

Per the LARA SUD Administrative Rules implemented on 6-26-2023, standard R325.1363 outlines expectations for service plans (ie. Individualized Treatment Plans) for each level of care as follows:

A service plan must be developed by a licensed or certified professional as referenced in the rules and as promptly after the recipient's admission as feasible, but no later than either of the following: (a) The conclusion of the next session attended by the client for outpatient counseling programs. (b) Twenty-four hours for methadone, residential, and residential withdrawal management programs.

Outpatient: 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: Periodic review of residential/withdrawal management treatment plans should take place every fourteen (14) days for residential/withdrawal management services, or more often as the individuals treatment needs warrant it.

Source: Microsoft Word - Tx Policy 06 Individualized Tx Planning.docx (michigan.gov)

Integrated Coordination of Care

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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 client's previous and current behavioral health treatment providers. Coordination of care should include the client's primary care physician (PCP), and if the client does not have one, efforts should be made to link the client to a PCP wherever possible. To demonstrate primary care coordination, the provider should minimally send a communication to the physician notifying them of the person receiving SUD services and have documented attempts to coordinate physical/medical care needs with the physician, as appropriate in the person's agency record. Providers should maintain documentation of coordination of care between other behavioral health care providers and physical health care providers. Documentation must include a signed release of information for the primary care provider, including name and contact information, or documentation of the client's refusal to provide consent. If the client does not have a primary care provider, there is documentation that they were offered information and referral to a provider of their choice.

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. This also includes supporting the individual to the next level of care of services and providing the ASAM Continuum or GAIN I Core assessment, with appropriate release of information, to the receiving provider.

The MSHN Service Philosophy & Treatment policy can be accessed on the MSHN website here.

MDOC Priority Population Technical Requirements (Cammie/Evan)

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 511) systems.~~ . Individuals referred by court and services through local community corrections (PA 511) systems must not be excluded from these Medicaid/Healthy Michigan program funded medically necessary community-based substance use disorder treatment services. Through the current MSHN ~~FY24~~ SUD Treatment contract between MSHN and the SUD Provider Network, MSHN has delegated to providers the responsibility for direct SUD treatment services.

Referrals, Screening, & 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.

The MDOC Supervising Agent (SA) will refer individuals in need of substance use disorder treatment through the following established referral process at MSHN.

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 the CFJ 306 (MDOC referral form) and the MDHHS 5515 (release of information) to th ~~MDOCreferrals@midstatehealthnetwork.orgMDOCreferrals@midstatehealthnetwork.org. Th~~e SUD Care Navigator ~~Utilization Management (UM) Department~~. The ~~will review the~~ referral documents will be reviewed and ~~make a~~a preliminary referral recommendation provided. If residential services are recommended, the client will call MSHN ~~UM~~Access 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.

Commented [SL20]: Is this staying the same?

Commented [CM21R20]: We will need to issue an update to complete the changes in this section. Just FYI- Kyle

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. If the Supervising Agent does not provide the CFJ 306 and the MDHHS 5515, the referral is not considered an MDOC priority population status per MSHN.

Supervising Agents who have not specified a level of care will send those individuals 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).
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 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: Please see the FY254 treatment contract to view full reporting requirements.

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 Evan Godfrey. Evan is able to assist with questions regarding referral, screening, assessment, and training needs. Evan can be reached by email at Evan.Godfrey@midstatehealthnetwork.org.

Medication Assisted Treatment (MAT)

MSHN adheres to requirements described in all MDHHS/SUGE -policies related to MAT. Detail regarding the state and federal regulations and MSHN's expectations regarding MAT are in Appendix A of this manual.

MSHN seeks to ensure that no client 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 client.

Following the recommendations by SAMHSA, the Centers for Disease Control and Prevention (CDC), the ASAM, the National Institute for Drug Abuse (NIDA*), MDHHS's 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 individuals 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 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~~ individuals or in the public domain. The MSHN SUD Services – MAT Inclusion policy can be accessed on the MSHN website here.

MSHN adheres to the *MDHHS Medication Assisted Treatment Guidelines for Opioid Use Disorders.* It is a MSHN expectation that whenever possible, each provider that offers medication assisted treatment will offer all medications approved and available for Opioid Use

Disorders (OUD). All Opioid Treatment Programs (OTP) that contract with MSHN will provide a minimum of 120-day notice prior to closing the OTP program or ending their contract with MSHN.

Abstinence-Based (AB) Providers: In the interest of client choice, MSHN will contract with Abstinence-Based providers who 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 D) 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 E).
- 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, in written materials for individuals or for public consumption, or in the public domain.

A consensus statement in support of MAT inclusion was endorsed by all ten PIHP's on November 1, 2017 and subsequently included in the MDHHS contract.

Opioid Health Home

Commented [RE22]: Reviewed by Katy Hammack and Rebecca Emmenecker. No changes at this time.

According to the Michigan Department of Health and Human Services' (MDHHS) Opioid Health Home Handbook, the Opioid Health Home will provide comprehensive care management and coordination services to Medicaid beneficiaries with an opioid use disorder. Michigan's OHH model is comprised of a partnership between a Lead Entity (LE) and Health Home Partners (HHPs) that can best serve the needs of each unique beneficiary. The Lead Entity will be a regional entity as defined in Michigan's Mental Health Code (330.1204b).

Health Home Partners will be comprised of two settings – HHP Opioid Treatment Programs (OTPs) and HHP Office Based Opioid Treatment Providers (OBOTs). The OTP is defined as a program engaged in opioid treatment of individuals with an opioid agonist medication, specifically methadone. An OBOT program typically prescribes the partial opioid agonist buprenorphine and is not licensed to prescribe methadone.

All HHPs must provide Medication for Opioid Use Disorders (MOUD). HHP-OTPs must meet all state and federal licensing requirements of an OTP. HHP-OBOT providers must attain the proper

federal credentials from the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Drug Enforcement Agency (DEA) to provide MAT.

Opioid Health Home services will provide integrated, person-centered, and comprehensive care to eligible beneficiaries to successfully address the complexity of comorbid physical and behavioral health conditions. Eligible beneficiaries meeting geographic area requirements include those enrolled in Medicaid, the Healthy Michigan Plan, Freedom to Work, Healthy Kids Expansion or MIChild who have a diagnosis of opioid use disorder (OUD).

The HHP will employ the following: Behavioral Health Specialist, Nurse Care Manager, Peer Recovery Coach, Medical Consultant, and a Psychiatric Consultant. In addition to these provider infrastructure requirements, eligible HHPs should coordinate care with the following professions: dentist, dietician, nutritionist, pharmacist, peer support specialist, diabetes educator, school personnel and others as appropriate.

Furthermore, the OHH will provide the following six core health home services as appropriate for each beneficiary:

1. Comprehensive Care Management
2. Care Coordination
3. Health Promotion
4. Comprehensive Transitional Care
5. Individual and Family Support
6. Referral to Community and Social Support Services

Providers interested in exploring becoming a Health Home Partner should contact Katy Hammack, Integrated Healthcare Coordinator at katy.hammack@midstatehealthnetwork.org for more information.

Prohibition on Provision of Hypodermic Needles

Providers will assure that no federal or state funds will be used to provide individuals with hypodermic needles or syringes enabling such individuals 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 is 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. Following the brief screen, the provider would need to choose and complete the ASSERT Screening/Level of Care Determination in REMI. The ASSERT Screening/LOC consists of five pages; Basic Information, Substance Use History, Mental Health Symptoms/Medical, Screening Results/Referrals, and Signatures. If a Brief Screening was completed by the provider prior to the Project ASSERT Screening/LOC, data collected in the Brief Screening will be prefilled. A narrative guide to support provider

submission of data in REMI can be found in the REMI "Help" menu located under the title "Completing Project ASSERT Screening Documents in REMI," as well as a short video clip to walk providers through the process.

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. Utilization of the H0002 code does not require admissions records or BHTEDS data for submission.

Recovery Oriented System of Care

ROSC Participation: MSHN will continue leading the journey of transformational system change to strengthen a more Recovery Oriented System of Care (ROSC) in the region. This system 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. A link to the MSHN policy can be found here. MSHN wants to ensure that this process represents a broad range of stakeholder viewpoints.

Commented [SD23]: Completed

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.

~~clientclientclient~~

Supervision

Commented [TT24]: Kyle - please add to table of contents under treatment section.

Clinical supervision enhances the quality of client care; improves efficiency of counselors in direct and indirect services; increases workforce satisfaction, professionalization, and retention; and ensures that services provided to the public uphold legal mandates and ethical standards of the profession. Providers paneled with MSHN are expected to have active and ongoing supervision with appropriately trained and credentialed staff.

Resources for supervision best practice can be found at the following links:

- Quick Guide for Clinicians based on TIP 52 Clinical Supervision and Professional Development of the Substance Abuse Counselor (samhsa.gov)
- COMPETENCIES FOR SUPERVISION IN SUBSTANCE USE DISORDER TREATMENT: AN OVERVIEW (samhsa.gov)
- THE SUBSTANCE USE DISORDER COUNSELING COMPETENCY FRAMEWORK: AN OVERVIEW - ADVISORY 27 (samhsa.gov)

Transfer

Transfer is the movement of the client 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 client to another level of care, program, provider, or facility and the provider receiving the client to ensure the client ~~timely~~ reaches ~~-~~the referral destination for admission in a timely manner. Timely admission is defined according to MDHHS requirements. The provider receiving the client is to notify the provider making the transfer referral when the client 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. The transferring provider must ensure all coordination of care documentation is sent to the provider prior to the first appointment with a valid release. Coordination of care documentation must include the completed ASAM Continuum assessment and any relevant clinical documentation on the person's progress and clinical recommendations to allow the provider to continue care seamlessly.

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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 individuals, 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 individuals served, MSHN providers are expected to be trauma informed and to provide trauma informed care. It is the expectation of MSHN that all providers shall complete the Trauma Informed Care Organizational Survey every three years. 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.

The MSHN policy on Trauma Informed System of Care can be accessed on the website here.

Trauma-Specific Services

Trauma specific services include ~~P~~prevention, intervention, or treatment services that address traumatic stress as well as any co-occurring disorders that develop~~ed~~ 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 individuals 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, individuals, 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 individuals and among organizational staff from direct care staff to administrators.
- *Empowerment, voice, and choice*—Throughout the organization, and among the individuals 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 client and family choice, empowerment, and collaboration.

Providers shall develop a trauma-informed system of care 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, MDHHS Trauma Policy) and MSHN Trauma Informed Care Policy.

Veteran Services

~~I~~individuals who are currently serving or have served in the active military in any branch may qualify for health care benefits through Veteran's Affairs (VA). More information about various types of VA benefits, eligibility requirements, and how to apply can be found on the Veteran's Affairs website: va.gov/health-care/

SUD providers 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 Healthy Michigan Plan (HMP) or has no coverage. Federal regulations require that all identifiable financial resources and other health insurance plans, including military/veteran

health care benefits, 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.

If the Veteran/military service member qualifies for VA health benefits or if they need to apply for VA health benefits, a warm transfer should be completed to the appropriate VA Medical Center or Outpatient Clinic. A directory of Michigan VA Centers and Outpatient Clinics can be found on the Veteran's Affairs website: Michigan – Locations (va.gov)

Access and availability of SUD treatment services through the VA may be limited depending on the type of service an individual needs and distance from the individual's home to the nearest VA provider. In order to close service gaps and enhance access to necessary care, veterans/military service members may be directly admitted to MSHN-funded SUD treatment without going through the VA if one of the following exceptions apply:

- The individual requires withdrawal management and/or residential treatment
- The medically necessary level of care or type of service is not available through the benefits provided by the VA
- There is not a VA provider within 30 minutes/miles in urban areas or 60 minutes/miles in rural areas from the beneficiary's home
- The individual would have to wait more than 14 days for admission to a VA service provider.

SUD Providers may call the MSHN Access ~~Utilization Management (UM)~~ Department at 1-844-405-3095 if they have questions regarding a veteran/military member's eligibility for MSHN-funded services.

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

Tammy Foster, Veterans Navigator
Tammy.Foster@midstatehealthnetwork.org
~~tammy.foster~~@midstatehealthnetwork.org
517.483.2742

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.

Warm Transfer

Warm transfer is a process to ensure a client is connected to a live representative at another location to best provide an answer to the access to treatment requests of the client. 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 client to create a

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bond and ensure a safety check. This requires open communication and teamwork, avoiding communication breakdown.

Once the client's situation is determined to be non-urgent or non-emergent, the representative receiving the call is to ask the client if it is okay to transfer him/her and explains the reasoning for the transfer. This allows the client to understand he/she is not just being passed off to someone else but builds trust with a positive experience for the client. The representative receiving the call connects the client to a live representative to assist the client in explaining what the client is seeking. Warm transfer means a client 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 client's situation is a crisis or emergent, the client is immediately transferred to a qualified practitioner without requiring the client to call back."

FINANCE AND CLAIMS

Claims: Please contact the claims department for billing inquiries to 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	Leslie.Thomas@midstatehealthnetwork.org
Finance Manager	Amy.Keinath@midstatehealthnetwork.org
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 audit requirements for providers in receipt of federal funds greater than $750,000 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 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 Utilization Management Department and follow the established policy/procedure for obtaining payment under Community Grant (Block Grant).

Providers may be requested to assist individuals 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)

Healthy Michigan Plan (HMP), which became effective April 1, 2014, has served to expand SUD services to enrolled persons and has also expanded the array of services available for persons with substance use disorders in need of treatment. MSHN providers will continue to

offer defined services under this benefit to support individuals (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 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 either listed on the Medicaid Card or indicated through 270/271 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, individuals must be transferred into a program that has an authorized Medicare provider.

For Medicaid recipients who have a primary insurance other than Medicaid, the primary insurance must be billed for SUD treatment coverage prior to billing MSHN. 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.
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. • 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). • 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). • Place EOB in Beneficiary's chart.

Reimbursable Diagnoses

Services for individuals 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, 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 *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.

Specialty Grant Funding

MSHN may utilize specialty grant funding to support the expansion of SUD treatment, prevention, ~~and~~ recovery, and harm reduction services for priority populations. By contracting to conduct grant-funded services, providers acknowledge acceptance of the terms and conditions of the corresponding notice of award/funding opportunity (NOA/NOFO). Additional reporting may be required; see contract for full detail and due dates. Providers may contact Jodie Smith~~Heather English~~, Data and Grant Coordinator at Jodie.Smith@midstatehealthnetwork.org ~~Heather.English@midstatehealthnetwork.org~~ for more information and any grant-related technical assistance or support.

UTILIZATION MANAGEMENT

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)~~ MDHHS/SUGE prevention and treatment policies, as well as the Medicaid Managed Specialty Supports and Services 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 individuals across the MSHN region. The MSHN UM team consists of:

Utilization Management Administrator: Cammie.Myers@midstatehealthnetwork.org
Utilization Management Specialist: Nicole.Jones@midstatehealthnetwork.org
Utilization Management Specialist: Stacey.Lehmann@midstatehealthnetwork.org
Utilization Management Specialist: Keely.Hapanowicz@midstatehealthnetwork.org

The UM team is available Monday – Friday from 8:00 am – 5:00 pm. The UM department toll-free phone number can be used to reach any available UM specialist, as well as the department email which is monitored daily:

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

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Access to Services

MSHN, in partnership with its SUD Provider network and Community Mental Health Service Provider (CMHSP) network, maintains a regional "no wrong door" 24/7/365 access system for SUD outpatient (ASAM levels 0.5, 1.0, 2.1, and MAT) services in accordance with the Michigan Department of Health & Human Service (MDHHS) contracts, MDHHS Access Standards, MDHHS Medicaid Provider Manual, and Michigan Mental Health Code. Access responsibilities and requirements for SUD Providers are described in the MSHN Access System Policy and MSHN Access System Procedure.

All MSHN-contracted providers are responsible for maintaining policies, procedures, and practices that comply with the MSHN Access System Policy and ensure that the experience for individuals seeking SUD treatment services is efficient, client-friendly, timely, and effective. The ~~MSHN Access team members~~outpatient providers ~~SUD Providers~~ are required to utilize the Level of Care Screening in REMI at the time of the initial request for services to document access and referral activities. These services for withdrawal management (WM), residential services, and recovery housing services will be completed by the MSHN Access Department.

Individuals seeking SUD treatment services have the right to choose their preferred treatment provider from the available options. When outpatient providers or MSHN Access~~a provider~~ Staff perform~~s~~ a~~n~~ ~~access~~ screening with an individual, they must offer options to the person of different providers of the service(s) and level of care the person needs. ~~Once Access has completed the Level of Care Determination~~~~If the person chooses to receive services from a different provider than the one that is performing the screening, a~~A warm transfer should be completed to connect the person to the provider of their choice. Individuals should not just be

given a list of phone numbers to call, rather they should be actively assisted until a connection has been made with an appropriate treatment provider.

Eligibility Determination & Medical Necessity

Eligibility for MSHN-funded SUD treatment services is based on the following:

a. The individual is a Medicaid or Healthy Michigan Plan (HMP) beneficiary, OR,
b. If uninsured, the individual meets criteria for SUD Block Grant funding according to the MSHN SUD Income Eligibility & Fee Determination Procedure
c. Provisional diagnostic impression using the current version of the DSM.
d. Medical necessity and level of care determination criteria utilizing the American Society of Addiction Medicine (ASAM) Criteria:
    i. Dimension 1 – Alcohol Intoxication and/or Withdrawal Potential.
    ii. Dimension 2 – Biomedical Conditions and Complications.
    iii. Dimension 3 – Emotional, Behavioral, or Cognitive Conditions and Complications.
    iv. Dimension 4 – Readiness to Change.
    v. Dimension 5 – Relapse, Continued Use or Continued Problem Potential.
    vi. Dimension 6 – Recovery Environment.

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

a. Client is experiencing a substance use disorder reflected in a primary, validated, diagnosis as contained in the most recent versions of the DSM or ICD (not including V Codes) that is identified as eligible for services in the MSHN Provider Contract.
b. 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 current edition of The ASAM Patient Placement Criteria.
c. A reasonable expectation that the client's presenting symptoms, condition, or level of functioning will improve through treatment.
d. 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 for individuals 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 MSHN SUD Income Eligibility & Fee Determination Policy and MSHN SUD Income Eligibility & Fee Determination Procedure for additional information regarding client eligibility around the use of Block Grant funding and applicable co-pays for which the client is responsible.

MSHN does not limit access to Block Grant-funded SUD programs and services only to the residents of the MSHN region because Block Grant funding is a federal and statewide resource. 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.

It is the responsibility of the SUD provider to procure a completed and signed copy of the Income Verification and Fee Agreement form for all individuals accessing Block Grant funding at the time of admission to treatment. A signed copy of this form and proof of income are required to be placed in the client record and uploaded into REMI.

All individuals 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 and upload to the client chart in REMI. MSHN will deny authorization for Block Grant-funded services if individuals do not participate in the requested activities to secure health insurance benefits within the required timeframe.

Out of Region & Out of Network Services

In keeping with the guiding philosophies of a recovery-oriented system of care (ROSC), Mid-State Health Network (MSHN) strives to offer a full continuum of treatment and recovery services and supports through its SUD provider network. 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 to ensure adequate availability of these services to meet the needs of individuals from the MSHN region. Out of region providers must comply with the MSHN SUD Services Out of Region Coverage Policy.

When an individual's recovery needs or preferences include the use of a service provider that is not part of the MSHN contracted provider network, MSHN has established an SUD Services Single-Case Agreement Procedure in order to procure, authorize, and pay for medically necessary services on behalf of the individual. All single-case agreements must be approved by the MSHN UM department prior to the person being admitted to services by the non-contracted provider.

Types of Utilization Review

Prospective Utilization Review

Prospective utilization review for SUD treatment and recovery services includes the following components:

1. Service eligibility determination through an access screening process
2. Verification of medical necessity through a clinical assessment process
3. Use of ASAM Continuum as the standardized assessment and level of care tool for SUD services and supports

Eligibility determination and verification of medical necessity is delegated to MSHN SUD Providers. Each SUD provider is responsible for ensuring individual service eligibility and medical necessity determinations are consistent with MSHN policies and procedures. MSHN will monitor whether the individual eligibility and medical necessity determinations that have been made are

consistent with MSHN policies during annual quality assessment and performance improvement (QAPI) site reviews. MSHN UM staff will also review individual client records through REMI. 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.

Concurrent Utilization Review

Concurrent utilization review for SUD treatment and recovery services includes the following components:

1. SUD Providers are responsible for ensuring that each individual receiving services has an individual plan of service (also called a treatment plan or recovery plan) which outlines the services to be received.
2. The amount, scope, and duration of each service will be determined by the person receiving services and their SUD Provider through a person-centered and recovery-oriented process and documented in the treatment plan/recovery plan
3. The treatment plan/recovery plan for each person will specify the frequency of review
4. SUD Providers will perform periodic treatment plan/recovery plan reviews and document the individual's continued service eligibility and medical necessity for the services being received
5. MSHN UM Department utilizes service authorization protocols in order to trigger additional concurrent review of medical necessity for authorization requests which reflect potential over or under utilization of services.

Retrospective Reviews

Retrospective utilization review for SUD treatment and recovery services includes the following components:

1. Retrospective review will focus on the cost of care, service utilization, and clinical profiles
2. Inconsistency with regional service eligibility and/or medical necessity criteria; and/or
3. 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 client clinical profiles (i.e., functional needs) across the region.

The MSHN UM Department will review claims data and service utilization reports to identify potentially undesirable variance in service utilization and/or cost of care when compared with regional average data. MSHN UM staff may perform review of individual client records in REMI to verify that the documentation submitted by the SUD Provider supports the medical necessity and clinical appropriateness of the services that were provided.

Based upon its findings, the MSHN UM Department will use a variety of interventions at the SUD Provider level to address any identified concerns. Interventions will vary, depending upon the nature of the variance and anticipated causal factors, but may include the following:

1. Verify data
2. Request additional information and/or clinical documentation from the SUD Provider

3. Request change strategies from the SUD Provider to bring utilization more in line with regional averages
4. Provide technical assistance/training to the SUD Provider
5. Modify or clarify regional service eligibility and/or medical necessity criteria through proposed revisions to MSHN policies/procedures
6. Set utilization thresholds or limits
7. Address service configuration to affect utilization

SUD Benefit Plans

MSHN has established SUD Benefit Plans for individuals whose services are funded by Block Grant as well as individuals whose services are funded by Medicaid/HMP. Both benefit plans are available in the REMI Help menu and they can also be found on the MSHN Website: Contracts & Rates

The MSHN SUD Benefit Plans identify the specific HCPCS/CPT service codes which are available for each ASAM Level of Care as well as the authorization guidelines for each type of service. When the amount of services requested on an authorization is within the authorization guidelines identified on the benefit plan, REMI will automatically approve the authorization. When the amount of services requested exceeds the authorization guidelines identified on the benefit plan the authorization will be sent to the MSHN UM Department for additional review.

The authorization guidelines identified on the Medicaid/HMP Benefit Plan are based on "typical" service utilization patterns and are not intended to be a limitation or "cap" on services for Medicaid/HMP beneficiaries. The MSHN UM Department will review all authorization requests that exceed the benefit plan guidelines and will approve services that are:

- Clinically appropriate and medically necessary to address the individual's identified treatment and recovery needs
- Documented in the individual's treatment or recovery plan

NOTE: Requests that exceed the Block Grant Benefit Plan guidelines may not be approved subject to the availability of Block Grant funding during the fiscal year. The MSHN UM Department will review all authorization requests that exceed the Block Grant benefit plan guidelines for individuals meeting criteria for SUD priority populations and will approve services based on medical necessity and funding availability.

Authorizations

SUD Providers must use REMI to request authorization for all treatment services. Authorization requests will be reviewed and approved or denied on a case-by-case basis utilizing ASAM and medical necessity criteria. Providers should adhere to the following guidance to ensure the MSHN UM Department is able to process authorization requests efficiently and make timely authorization decisions.

Timeliness Standards: ~~While MSHN does not require prior authorization for services, MSHN strongly recommends timely submission of authorization requests in order to prevent potential delays or denials to authorization and payment for services already rendered.~~Starting in FY25, MSHN will require all withdrawal management (WM), residential, and recovery housing services to be approved through the MSHN Access Department before intakes occur. An initial

authorization will be generated for the client based on the chosen provider and intake availability.
~~The following~~The recommended timeframes for submitting authorizations are ~~recommended~~: ~~within 1 business day of admission to withdrawal management services or~~ within 3 business days of admission for all outpatient authorizations ~~to all other levels of care~~. Re-authorization requests are recommended to be submitted within 3 business days of the expiration of the previous authorization.

Returned Authorization Requests: MSHN UM specialists may return an authorization after reviewing it ~~in order to~~to request further information or corrections from the SUDSP. In these instances, the SUDSP should respond as soon as possible. Per Medicaid guidelines, an authorization decision must be reached within 14 days of the date the authorization request was submitted. If an authorization decision is not reached within 14 days it constitutes a denial and MSHN must send an Adverse Benefit Determination (ABD) notice to the person served. When the MSHN UM Department returns an authorization to a provider requesting additional information, a timely response is needed from the provider in order to adhere to the required timeframe and prevent unnecessary denials.

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 4/30/2022, please begin the re-authorization request on 5/1/2022. 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 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 for 1.0 LOC and within 14 days for residential level of care. ~~or the authorization will not process.~~ Treatment/recovery plans must identify SUD 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 SUD services that are being requested in the authorization.

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. The Utilization Management and Access Teams can be found by composing a new message and clicking the icon with 2 people. This will show a drop-down menu and Utilization Management and Acces ~~is one~~s are options. This will send a message to all of the UM or Access staff depending on the selection.

REMI Admissions, Discharges, Transfers

Admissions: An admission record must be completed in REMI for each individual on the date of their first face-to-face service with an SUD Provider.

Admission to Multiple SUD Providers: At times it may become necessary for one client to be enrolled in treatment services with more than one SUD Provider 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 client (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.

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 client 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. The level of care selected in the discharge summary in REMI should be the last level of care that the client received services.

Discharge Summary: A treatment episode is assumed to have ended at the time the client has not been seen for five (5) days for residential treatment or withdrawal management and sixty (60) days for all other levels of care. Individuals 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 and reflect the last level of care the client received services.

For Medicaid/Healthy Michigan Plan Individuals: If a client has not participated in scheduled services, please send the required Medicaid Advance Notice of Adverse Benefit Determination to the client and allow them at least 10 days to respond. Once that time period has passed then proceed to enter the discharge summary within 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 10-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.

The MSHN UM department requires providers to complete a quarterly discharge report to ensure they are adhering to these established timeliness standards. The Discharge Report and accompanying instructions can be found on the MSHN website: Provider Reporting Requirements.

ACCESS To SUD Services

MSHN Access Team

The MSHN Access Team is committed to providing prompt, professional, and supportive assistance to our treatment provider network. The team comprises dedicated professionals who are knowledgeable about available services and ready to assist with any questions or concerns. The MSHN Access team consists of:

MSHN Access Administrator: Rusmira Bektas, Rusmira.Bektas@midstatehealthnetwork.org

MSHN Access Specialist: Eric Turner, Eric.Turner@midstatehealthnetwork.org

MSHN Access Specialist: Marc Irish, Marc.Irish@midstathealthnetwork.org

MSHN Access Specialist: Sarah Winchill-Gurski, sarah.winchellgurski@midstatehealthnetwork.org

MSHN Access Screener: Tacara Pitchford, Tacara.Pitchford@midstatehealthnetwork.org

MSHN Access Screener: Elise Parker, Elise.Parker@midstatehealthnetwork.org

The Access team is available Monday – Friday from 8:00 am – 5:00 pm. The Access department toll-free phone number can be used to reach any available Access specialist, as well as the department email which is monitored daily:

Toll-Free Phone: 844-405-3095

E-mail: Access@midstatehealthnetwork.org

MSHN Access Process/Procedure:

In FY25, MSHN will be implementing a partial centralization of access for withdrawal management, residential treatment, and recovery housing services, aimed at improving operational efficiency and enhancing the overall experience for individuals seeking care.

New Access Procedures

Effective October 1, 2024: Individuals seeking withdrawal management, residential treatment, and recovery housing services should contact the MSHN SUD Access Department at (844) 405-3095. October will serve as a "soft rollout" period during which providers and MSHN can adjust to the new process.

During this time, providers will continue to conduct Brief Screens & Level of Care Determinations in REMI and admit individuals to treatment without prior approval from MSHN.

Starting November 1, 2024: Providers should direct all requests for withdrawal management, residential treatment, and recovery housing to the MSHN Access team. Providers will be required to obtain prior authorization from the MSHN SUD Access Department before admitting individuals to withdrawal management, residential treatment, and recovery housing services.

Access to Outpatient Services: Access procedures for outpatient levels of care (ASAM 1.0 & 2.1 LOCs) will remain unchanged. Individuals seeking these services can continue to connect directly with the SUD provider network and/or local Community Mental Health Service Programs (CMHSPs), as appropriate. Please note that if a person you are supporting in SUD outpatient services needs recovery housing, they should contact the MSHN Access Team for assistance. Additionally, if the individual requires a higher level of care, including withdrawal management or residential treatment, the outpatient provider can assist with the referral process.

For detailed instructions on generating a referral to the Access Referral Queue, please refer to the User Guide in the REMI Help Menu.

Emergency and After-Hours Access to Services

If you the individual is in a behavioral health emergency, seek help immediately by calling:

Community Mental Health Service Provider	**Counties Served**	**Toll-Free Phone**
Bay-Arenac Behavioral Health	Arenac, Bay	(800) 448-5498
Community Mental Health Authority of Clinton-Eaton-Ingham Counties	Clinton, Eaton, Ingham	(888) 800-1559
Community Mental Health for Central Michigan	Clare, Gladwin, Isabella, Mecosta, Midland, Osceola	(800) 317-0708
Gratiot Integrated Health Network	Gratiot	(800) 622-5583
Huron Behavioral Health	Huron	(800) 448-5498
The Right Door for Hope, Recovery, and Wellness	Ionia	(888) 527-1790
LifeWays	Hillsdale, Jackson	(800) 284-8288
Montcalm Care Network	Montcalm	(800) 377-0974

Newaygo County Mental Health	Newaygo	(800) 968-7330
Saginaw County Community Mental Health Authority	Saginaw	(800) 258-8678
Shiawassee Health and Wellness	Shiawassee	(800) 622-4514
Tuscola Behavioral Health Systems	Tuscola	(800) 462-6814

- 911 for immediate assistance
- Your local Community Mental Health Services Program (CMHSP) for after-hours support Here's the **Community Mental Health Service Providers by county:**

Language Assistance Resources

The MSHN Access Center is equipped to assist all individuals seeking services, including those who may need language assistance or services for the deaf and hard of hearing.

If an individual does not speak English as their primary language or has a limited ability to read, speak, or understand English, they may be eligible for language assistance.

For individuals who are deaf or hard of hearing, they can utilize the Michigan Relay Center (MRC) to connect with their PIHP, CMHSP, or service provider. To do so, please call 711 and request MRC to connect you to the desired number.

Provider Appeal Process

Mid-State Health Network (MSHN) has established a process for providers for the resolution of appeals of MSHN service authorization denials. This process is for when the provider has already provided the service, the client 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 shall be mailed to the client and a copy of the letter will also go to the provider explaining the denial of payment for services. The client 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 client for the services. Individuals 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.

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 Customer Service Department regarding the service denial. Providers must follow the Denial of Payment for Services Appeal Process as outlined below for an appeal request to be processed.

1. If a resolution cannot be reached then 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.

2. All appeals must be in writing and include:
    a. The date of the appeal
    b. The impacted client
    c. The decision grieved
    d. Any provider actions taken to resolve the denial
    e. The resolution being requested by the provider
    f. The supporting rationale for requesting a change in decision

3. Appeal requests must be submitted to the MSHN Customer Service department (customerservice@midstatehealthnetwork.org) and copied to the MSHN UM department (UM@midstatehealthnetwork.org).

4. As appropriate, the MSHN Customer Service Department will include input from the appropriate MSHN staff and/or departments, including:
    a. Chief Financial Officer;
    b. Chief Compliance & Quality Officer;
    c. Deputy Director;
    d. Contract Manager;
    e. Utilization Management Specialist;
    f. Claims Specialist;
    g. Director of Utilization & Care Management;
    h. Chief Clinical Officer;
    i. Medical Director/Addictionist

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.

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). Please contact the prevention specialist in your part of the region whenever possible to address any needs or concerns or call (517) 253-7525.

Sarah Andreotti: Sarah.Andreotti@midstatehealthnetwork.org
Kari Gulvas: Kari.Gulvas@midstatehealthnetwork.org
Sarah Surna: Sarah.Surna@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):

- All staff being funded in part or whole by MSHN, should read the provider manual at the time of hire and when updated. Provider agency should have prevention staff sign an attestation that they have read the manual, which should be kept in the staff personnel file.
- A Substance Abuse Prevention License is required for any non-governmental entity 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 600 hours of direct prevention services must be conducted annually. Of these 600 hours, a minimum of 480 hours must be face to face services identified in the MPDS system with the remaining 120 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 Ethics training must be completed within one (1) year of hire. This training is required for staff on a MCBAP Development Plan, a CHES certification, and staff designated as Specifically Focused Staff. This training is found through several training agencies, both in person and virtual.
- Prevention activities must be focused on State and Regional priorities which include 1) Reduction of Underage Drinking, 2) Reduction of Youth Tobacco Use, 3) Reduction of Underage Cannabis (Marijuana) Use Prevention and/or 4) Older Adult Prevention Activities, 5) Reduction of Prescription Drug and Over the Counter Medication misuse. Services should focus on 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 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 agency's 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. MSHN must approve in advance any materials that include the MSHN logo.
- If Provider is planning on conducting a local Media Campaign, all materials must be approved by MSHN and/or MDHHS as required in the Media Campaign Procedure. A Media Campaign Request Form must be fully completed and submitted to MSHN with any necessary attachments. MSHN will then review and send to MDHHS for approval. Please note that the approval process can take up to 30 days once submitted to MDHHS.

Substance Use Disorder Credentialing and Staff Qualification Requirements

Prevention Supervisors: Commonly described as prevention program supervisors and represent individuals responsible for overseeing prevention staff and/or prevention services.

Prevention Professionals: Commonly described as Program or Prevention Coordinator, Prevention Specialist or Consultant, or Community Organizer and have responsibility for implementing a range of prevention plans, programs, and services.

Prevention Services Supervision: MSHN requires that staff members of the provider network who perform SUD Prevention functions and services receive adequate supervision and support, and that their performance be monitored and evaluated on an ongoing basis. A formal and written performance evaluation is required for each Prevention Professional at least annually.

Prevention Professionals must be supervised by MCBAP prevention credentialed staff or an approved alternative certification (CPS, CPC or CHES). Prevention Supervisors must have had the MCBAP prevention credential for a minimum of three (3) years. Where such an expectation is not operationally feasible, the Provider Agency will ensure that arrangements are in place to attend mandatory monthly supervision meetings with MSHN staff. Qualified Prevention Supervisors must have the supervision of prevention staff job function stated in their agency job description. Certification of Prevention Supervisors and written job descriptions will be verified during the desk audit process every other year or upon request.

It should be noted this supervision requirement is related to MSHN-funded work, and not the MCBAP Development Plan supervision requirement.

In Michigan, to provide supervision in the substance use disorder prevention field, an individual must have one of the following MCBAP credentials or an established development plan leading to certification in one of the credentials:

- Certified Prevention Consultant – Michigan (CPC-M)
- Certified Prevention Consultant – IC&RC (CPC)
- Certified Prevention Specialist – Michigan (CPS-M)
- Certified Prevention Specialist – IC&RC (CPS) – only if credential effective for three (3) years
- Certified Health Education Specialist (CHES) through the National Commission for Health Education Credentialing (NCHEC)

If your agency does not have a supervisor that meets these requirements, you must work with MSHN to arrange an appropriate alternative. Monthly supervision meetings with MSHN staff will be implemented in FY25 for agencies lacking required supervision credentials.

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.

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. Provider Agency must maintain documentation in the employee file that acknowledges receipt and understanding of the prevention MPDS user manual. 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.

Twice a year, prevention and community recovery providers are required to submit a MPDS Direct Service Hours Report to their assigned MSHN Prevention Specialist. This is an opportunity for the prevention or community recovery provider supervisor to review and comment on the status of meeting prevention direct service hour requirements; any adaptations

to programming as a result of review of the units; timeliness of staff data entry; etc. for each prevention or community recovery staff in the organization. Reports should be run from the Activity Data Report in MPDS and include the eight fields of Group Name, Program Name, Funding Source, Activity Start Date, Activity Creation date, Units, Activity Record Number, and Staff. In the email with the report, program supervisors should summarize activity units into hours per staff person; identifying if they are on track to meet direct service hour requirements for each individual staff member, and how the organization plans to address under unit/hour adjustments if they are not on track to meet requirements. Reports are due to be submitted by the program supervisor to their agency's MSHN Prevention Specialist by **January 15** for services from 10/1/24 12/31/24 and submitted by **July 15** for services from 1/1/25 6/30/25.

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 21 years of age and to enforce those laws effectively. Annual Synar checks, required by the amendment, show that great strides have been made in reduction of 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 and non-Synar checks to at least 50% of the tobacco retailers in the DYTUR's designated county(ies) utilizing the official MDHHS protocol; 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 MDHHS 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 and MSHN-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), type of tobacco sales, vendor type, and phone number. 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 and non-Synar Reports** – IMPORTANT: A minimum of 50% vendor education and 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. This guide is included as an attachment to the MPDS User Guide.

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. Guides, policies, print materials and more can be found on the MDHHS Synar webpage at: https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/drugcontrol/prevention/prvcontent/youth-access-to-tobacco-and-synar-info

* SAPT Block Grant funds cannot be used for law enforcement compliance checks, 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*. 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 stipend to each of the 21 county's coalitions 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 a regular budget summary.

All grant funding should support the needs of respective communities/counties based upon meeting grant objectives as defined by the parameters of individual grant requirements. Coalition meeting minutes should reflect general discussion of benefit/hinderance of use of additional grant funding with reasoning for accepting/rejecting additional funds. Funding expenditures for supplemental grants (such as OEND, etc.) must be voted on by the coalition or appropriate coalition subcommittee prior to spending, and the voting results recorded in the meeting minutes. The fiduciary agency should not direct or influence voting or hinder expenditures.

SELECTED REFERENCES

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Appendix A: MSHN MAT Protocol

Commented [KJ30]: Section to be reviewed by C. Polland - See LAO for that service

Commented [TT31R30]: C. Poland reviewed and SUD Treatment Team updated to reflect revised content.

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

*Note: With the implementation expectation of 42CFR Part 8 as of 10/2/2024, MDHHS will be updating Treatment Policy 4: Off-Site Dosing Requirements for Medication Assisted Treatment and releasing it for public comment before finalizing. Once this policy is finalized and released to the SUD provider network, MSHN will compare the guidance in Appendix A with the revised policy and provide an update to the appendix, as needed.

This appendix ~~document~~ establishes technical and service requirements that providers are contractually obligated to incorporate into the design and delivery of all ~~medication assisted treatment~~medication for addiction 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~~and incorporate the requirements of the Michigan Department of Health and Human Services, ~~Behavioral Health and Development Disabilities Administration's~~Substance Use, Gambling, and Epidemiology Section's (MDHHS-~~BHDDA~~SUGE) 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 the MSHN SUD interim Medical Director, ~~as well as reviewed by MSHN's SUD Medical Director, Dr. Bruce Springer~~ Dr.Cara Polland, a~~a~~nd the MSHN MAT workgroup. W~~hile 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:

Medication Assisted Treatment, broadly refers to the use of FDA-approved medication in treating addiction to a variety of substances: opioids (prescription ~~analgesics, fentanyl and heroin~~opioids, fentanyl, and heroin), alcohol, cocaine, benzodiazepines, and ~~marijuana~~cannabis. Consistent with Medicaid rules, MSHN's policy is that *individuals should have a full-service array of treatment options available*. This should include MAT for all ~~persons who have been~~people determined to be medically and clinically eligible for MAT. ~~Since not all individuals are appropriate for MAT,~~ 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. Providers offering MAT services must inform individuals 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.~~for MAT needs and educate the individual about options for MAT when appropriate.

~~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. If the OTP makes the decision to close their location or to discontinue their contract with MSHN, a minimum of a 120-day notice is required prior to discontinuation of services.~~

MEDICATION-ASSISTED TREATMENT & OPIOID USE DISORDER

~~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.~~ Medication for Addiction Treatment for opioid use disorder is also referred to as Medication for Opioid Use Disorder or MOUD. It may be provided at either a licensed and state-regulated OTP (Opioid Treatment Program) (methadone, buprenorphine, naltrexone) or in a physician's office or other healthcare setting (buprenorphine and naltrexone only).

- Comprehensive Maintenance Treatment:~~-~~ C~~c~~ombines 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 individuals. However, it is notable that requiring counseling or therapy is not shown to improve ~~the outcome of~~ overdose death outcomes. Medication management with methadone and buprenorphine are the only evidence-based way to reduce the outcome of death for persons with an opioid use disorder.~~-~~ Maintenance treatment is typically indicated for the first two years of a methadone program.
- Medical Maintenance Treatment: Provides stabilization to ~~is provided to stabilize~~ individuals in recovery 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~~ after the first two years of a methadone program.
- In February 2024, SAMHSA issued changes to 42 Code of Federal Regulations (CFR), Part 8 (see here). These represent the first major revisions to OTP guidelines in 20 years and reflect the finding mentioned above, that MOUD *medications* are the only evidence-based intervention shown to reduce overdose deaths. The changes therefore advocate low-barrier access to MOUD and Medication-First Principles that remove mandates for clients on MOUD to participate in counseling and/or mandates to remain abstinent.
- MDHHS-~~BHDDA~~ SUGE has also published Treatment Policies that can be found here. ~~-for both methadone and buprenorphine/naloxone. These treatment policies are identified in the reference section of this document and are available on the MDHHS websiteaddressing use of MAT.~~

Eligibility Criteria:

To be eligible for ~~medication assisted treatment~~MAT 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)

Commented [RE32]: 120 day request for notice of closure for an OTP is here.

Commented [TT33R32]: Info in included in the FY25 contract. Can be removed from here.

Commented [KF34]: Dr. Poland and treatment team have recommended this be removed. However, the closure information is specific to OTPs. Is this included somewhere in their contracts where this could be removed from the SUD Provider Manual?

Commented [TT35R34]: Included in FY25 contract

Commented [TT36R34]: Closure information is included in the FY 25 contract. Support removal. Do not need to duplicate.

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~~naltrexone as ~~an adjunct treatment and recovery service~~ part of an array of available treatment and recovery services (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, including providers who support medication for addiction treatment (MAT).

~~A medical examination at admission will rule out chronic pain disorder without a diagnosis of OUD considered to necessitate use of opioids. It is the expectation that individuals seeking opioids for chronic pain issues will be referred to an appropriate medical provider. 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 individuals with chronic pain.~~ Individuals seeking opioids for chronic pain issues should be referred to an appropriate medical provider. ~~-~~MSHN does not fund the use of methadone or buprenorphine/naltrexone for pain management. ~~-~~A co-occurring diagnosis of Opioid Use Disorder must be present prior to any MSHN funds being utilized for individuals 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.~~ 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). Case managers, care coordinators, and recovery coaches are recommended for individuals whenever possible (Treatment Policy #08: Substance Abuse Case Management Requirements, 2008). Increasing the individual's recovery capital through these supports when a patient is open to receiving them, can help support long-term treatment goals.

Counseling services should be offered regularly by the opioid treatment program (OTP) that is providing the methadone or Buprenorphine, but as noted above, 2024 revisions to 42 CFR Part 8 remove counseling as a requirement to receive MOUD medications, i.e., methadone or buprenorphine. 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 section of this manual for further instruction.

~~Individualized Treatment Planning:~~

~~MSHN expects the provider to begin working on a comprehensive, individualized treatment 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 treatment plan designed to address treatment services, promote recovery and self sufficiency; promote a reduction in problem severity, negative toxicology screens and 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 is required in order to ensure that individuals 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 discussions with the client of decreasing the dosage or tapering off of the medication when appropriate, 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.~~

~~Individuals 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.~~

~~Based upon the assessment made of a recipient's needs, a written service plan, which may include both medical and counseling services, must be developed and recorded in the recipient's~~

Commented [KF37]: Remove as this is covered in the treatment section.

Commented [TT38R37]: Support removal. Covered in the Tx section.

~~record. A service plan must be developed by a licensed or certified professional as referenced in the LARA SUD Administrative Rules (R 325.1363) as promptly after the recipient's admission as feasible, but no later than either of the following: a. The conclusion of the next session attended by the client for outpatient counseling programs. b. Twenty four hours for methadone, residential, and residential withdrawal management programs.~~

Regulatory Compliance/Coordination of Care:

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.

All ~~MAT~~MOUD providers will require that individuals 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.~~ Misuse or abuse of legally prescribed medications will be treated as illicit use of substances and must be documented in the person's 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 individuals 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, stimulants and 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.~~ If a MAPS report shows prescriptions for controlled substances, this will be discussed with the physician or other prescriber and rationale for MOUD in the setting of co-prescribed controlled substances should be documented.

~~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. If the client does not consent to the 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).

Drug Screens:

Drug screens for individuals receiving methadone assisted treatment are considered part of the daily dosing rate. For individuals receiving buprenorphine/nal~~oxone~~trexone 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. Drug screens can only be requested by agencies who are providing the MAT services. With the application of 42 CFR Part 8's 2024 changes, positive drug screens should *not* automatically result in discontinuation of MOUD medications. For further information regarding appropriate use of drug screens, please contact the UM Department at 844-405-3095.

METHADONE ~~ASSISTED~~ TREATMENT

Methadone ~~Assisted~~ Treatment Expectations:

Disclaimer: the use of medications, or not, is the responsibility of the medical practitioner ~~with which whom~~treating the client ~~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.

General minimum service requirements for authorizing methadone assisted treatment services:

- 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~~throughout treatment;
- A~~Daily a~~ttendance requirements for medication dispensing;
- ~~Must be used as an adjunct to Opioid Use Disorder treatment which must include a counseling component;~~~~Must be used as an adjunct to Opioid Use Disorder treatment which must include a counseling component.~~ Must be used as treatment for an Opioid Use Disorder in accordance with Federal, State, and Licensing rules;
- 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 individuals in accordance with Federal, State, and Licensing rules.
- Identification, treatment, or referral for treatment of co-occurring disorders and neuropsychological problems;

Commented [DM39]: Is this still true with the 42 CFR Part 8 changes? No take-home doses if a client doesn't allow coordination of care with a prescriber of medical marijuana?

Commented [TT40R39]: MSHN was awaiting guidance from MDHHS on this item. As of 12/1/24, none was received. MDHHS will be putting out Tx Policy 4 draft for comments "soon" per Angie S.B. to support items like this. MSHN can compare the guidance at that time and determine if a mid-year release is needed or wait until the subsequent fiscal year, depending on timing.

Commented [TT41]: TEAM Review: I realize the requirements here have moved away from Tx, but I am not comfortable with not including it here in some way. Thoughts?

Commented [TT42R41]: Resolved through team conversation.

- ~~Counseling to assist in discontinuation of substance abuse and manage drug cravings and urges;~~~~Counseling to assist in discontinuation of substance abuse and manage drug cravings and urges;~~ Counseling should be offered based on medical necessity and ~~is~~should be addressed ~~appropriately~~ on the individual's treatment plan. Refusal to engage in counseling should be respected as clients' choice, but should also be revisited at regular intervals as the client's recovery progresses.~~:~~

  - Evaluation of and interventions to address ~~family problems~~social determinants of health (SDOH);
  - 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 individuals 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 individuals receiving MAT services. Illicit use should be addressed in a meaningful and strength based way on the client's individualized treatment plan.~~

Block Grant Waitlist 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.

Commented [RE43]: Should this be removed?

Commented [TT44R43]: Please consult with Cammie on this item and make a determination.

Commented [CM45R43]: Recommend keeping unless Finance determines this can be removed. We have not needed this yet, but that does not mean we will not need that in the future.

Commented [TT46R43]: Resolved. Will keep for this FY and re-evaluate next year.

Individuals so contacted, will be warm transferred to a methadone assisted treatment provider of their choice to arrange for an admission appointment. Individuals 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 individuals 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. Individuals determined to meet eligibility criteria for this level of care will be directed to the provider of their choice.

For buprenorphine/naloxone assisted services: individuals 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. Individuals cannot receive buprenorphine/naloxone while on the waiting list for methadone-assisted treatment services.

~~**BUPRENORPHINE/NALOXONE ASSISTED TREATMENT**~~

~~Medically Supervised Withdrawal Treatment using buprenorphine/naloxone (Suboxone):~~

~~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 individuals will enter directly into buprenorphine/naloxone assisted treatment at the outpatient level without first receiving services through inpatient withdrawal management. 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)."~~

Commented [KF47]: Dr. Poland recommends removal of this entire section, but I am not clear why. I don't see a comment.

Commented [TT48R47]: Resolved.

DISCONTINUATION/TERMINATION/READMISSION

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

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.~~ 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 and prescribing physician agree on an appropriate tapering schedule. There is no evidence to support any mandated tapering for an individual who is successfully being treated with MOUD. A person and their prescriber should work together to taper to the lowest possible effective dose, understanding that this may be the same amount of medication, less medication, or no medication. At every step along the process of tapering a patient should be able to discontinue the taper, pause the taper or reverse the taper as clinically appropriate.

ADMINISTRATIVE DISCONTINUATION

~~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 individuals and/or staff in the treatment environment.~~ Administrative discontinuation/discharge refers to termination of medication for opioid use disorder (MOUD) due to non-compliance with treatment recommendations or engaging in activities or behaviors that impact the safety of other individuals and staff in the treatment environment.

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 individuals 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.~~ Unless there is an immediate and urgent safety concern, the provider should document efforts taken to assist individuals in continuing treatment for their OUD. If

unsuccessful in agreeing to a safe, appropriate treatment plan, a warm transfer should be attempted and facilitated to another MOUD provider.

Administrative discharge can leave the client at risk of severe withdrawal symptoms, ~~relapse~~return to illicit drug use, overdose and death. It should be a last resort when other efforts have been unsuccessful.

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).

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

It may be necessary for the OTP to refer beneficiaries who are being administratively discharged to ~~-~~another level of care. Justification for non-compliance termination must be documented in the
beneficiary's chart. An Adverse Benefit Determination (ABD) should be issued, when applicable.

INCLUDED SERVICES

Medication ~~Assisted~~ for Addiction Treatment in an outpatient setting is intended ~~for the purpose of~~ to 1) manag~~inge~~ the effects of withdrawal from opioids (prescription painkillers and heroin) and/or alcohol; 2) stabiliz~~inge~~ the client and 3) provid~~inge~~ ~~maintenance~~chronic treatment. Ancillary services such as individual therapy, group therapy, r~~R~~ecovery s~~S~~upports, acupuncture, and/or c~~C~~ase m~~M~~anagement 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~~ Use Service Programs in Michigan, include:

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

~~**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~~are required to complete an annual re-assessments for continuing care ~~and will enter re-assessment information into~~ utilizing the approved regional assessment ~~in~~ REMI.~~~~
- ~~Additional services such as medication reviews, drug screens, and actual dosing may vary depending on the service provider.~~

M~~A~~TOUD GUEST DOSING

Guest dosing is allowable between different locations of the same MAT provider. The two locations are to have an internal policy for documentation and payment.

~~**MEDICAL MARIJUANA CARD: EXPECTATION OF PROVIDERS**~~

~~*If the client 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, or MAUD, includes three FDA approved oral medications that help reduce cravings for alcohol and can be a component of MAUD~~T~~ in working with individuals 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. Any foods, beverages, products that contain alcohol or medications that contain alcohol MUST be avoided when using disulfiram. Also, many patients with other health issues may not be safe candidates for disulfiram.

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 treatment with Campral. 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, pain relief, etc.) is used to treat alcohol abuse by reducing cravings. It can help individuals 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 support for individuals 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 (DBT) 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 refill at a time and monitor 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 individuals receiving these medications as part of their substance abuse treatment.*

ATTENTION: Please note that use of gabapentin (Neurontin), carbamazepine and valproate to reduce cravings and/or to reduce the severity of withdrawal symptoms is not FDA approved. There is evidence of their effectiveness for this use, however. Any decision regarding use of these medications 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. ***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.

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 individuals receiving these medications as part of their substance abuse treatment.*

ATTENTION: Please note that use of 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.

METHAMPHETAMINE USE DISORDER AND MEDICATION ASTED TREATMENT.

Recent studies have suggested that a combination of IM naltrexone (Vivitrol) monthly combined with oral bupropion (Wellbutrin and others) may be modestly effective in reducing craving for and use of methamphetamine. Several other medications have been tried in order to diminish cravings for methamphetamine. These have shown little success. Psychosocial approaches such contingency management, CBT, group therapy, diagnosing and treating psychiatric illness and even exercise programs have shown some benefit.

MARIJUANA USE DISORDER & MEDICATION-ASSISTED TREATMENT

Medication Assisted Treatment (MAT) includes two medications that have been effective as one component of working with individuals 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 refill at a time and monitor for misuse.

2. **Acetylcysteine** (*(Brand name: Mucomyst)* - This medication, when inhaled, helps open clear 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 individuals 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 individuals 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.

Commented [KF49]: Dr. Poland recommends removal of these sections as "none of this is FDA approved and none of it has solid evidence. This is all opinion."

Commented [TT50R49]: Resolved.

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).~~

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 #63 (TIP-63), "Medications for Opioid Use Disorder", Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment (available from https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Folder3/Folder10/Folder2/Folder110/Folder1/Folder210/MAT_Guidelines_for_Opioid_Use_Disorders.pdf?rev=b8ca492ed5db460d98a17f539e32b193&hash=E766AC0B25BD9A5D66C61D80F7DB545A)

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 https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Folder4/Folder11/Folder3/Folder111/Folder2/Folder211/Folder1/Folder311/Criteria-for-Using-Methadone-for-Medication.pdf?rev=5d45b9eac48f4ec79ae2c6fd7d8243b0&hash=A9CFD1E287DD8C97D0CA780FEFE61AC6)

"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 https://store.samhsa.gov/product/medication-treatment-alcohol-use-disorder-brief-guide/sma15-4907)

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 -4th Edition (available fromhttps://www.asam.org/asam-criteria)

Waller, R.C., MD, MS. “Medication-Assisted Treatment Guidelines for Opioid Use Disorders”, (available from https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Folder3/Folder10/Folder2/Folder110/Folder1/Folder210/MAT_Guidelines_for_Opioid_Use_Disorders.pdf?rev=b8ca492ed5db460d98a17f539e32b193&hash=E766AC0B25BD9A5D66C61D80F7DB545A).

Commented [KF51]: These were all checked and updated with correct hyperlinks.

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Appendix B: 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 Substance Use, Gambling, and Epidemiology (SUGE) 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.

The Substance Abuse and Mental Health Services Administration (SAMHSA) goes on to say:

"… *Recovery housing benefits individuals in recovery by reinforcing a substance-free lifestyle and providing direct connections to other peers in recovery, mutual support groups and recovery support services. Substance-free does not prohibit prescribed medications taken as directed by a licensed prescriber, such as pharmacotherapies specifically approved by the Food and Drug Administration (FDA) for treatment of opioid use disorder as well as other medications with FDA-approved indications for the treatment of co-occurring disorders.*

(Additional information regarding recovery housing best practices can be found on the SAMHSA website located here.)

Admission Process
All recovery housing admissions will be screened through the MSHN Access Department prior to the start of services to ensure that the person meets recovery housing entrance criteria and facilitate the referral to an outpatient provider (if different from the recovery housing provider). The Access Department will complete the ~~brief screen and level of care~~screening documents in REMI and provide this information to the recovery house when approved for this service.

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 Substance Use, Gambling and Epidemiology (SUGE)'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.

Individuals residing in recovery housing must be actively engaged in formal outpatient treatment with a credentialed outpatient provider. It is the expectation that an assessment by a credentialed SUD treatment provider be completed PRIOR to admission. Information including the name and date, if known, of the provider who completed the assessment should be documented on the recovery housing Screening and Intake form. In the instance a person has successfully completed a SUD residential episode, and has met the criteria for recovery housing, but is not connected to an outpatient provider, the recovery provider will have 14 days to connect the person to an outpatient provider. (See SAMHSA "Recovery Housing Best Practices" for additional information).

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 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. Evidence of coordination of care efforts must be located in the client's file. Recovery housing must be identified in the client's treatment (with the outpatient provider) plan and the recovery plan (with the recovery provider) must also 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 and meet the continuing education requirements as outlined by MDHHS. Requirements can be found at Michigan Continuing Education Requirements link.

The provider of the recovery house will maintain a file on each individual admitted. All provided services must be formally documented on the client's individual service/recovery plan. This includes, but is not limited to, individual peer support services and, 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, and an emergency contact
- Primary Care Physician information needs to minimally include the physicians name, practice name, address, and telephone number to meet MDHHS standards.
- Evidence of enrollment with an 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 client as evidenced by the client's words
    - Goals & objectives are written using specific, measurable, attainable, realistic & time limited elements.
    - Recovery/Service Plan is signed and dated by the person in services.
- Evidence of regular care coordination with service providers
- Evidence of regular attendance with a formal outpatient provider
- 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 individuals who meet recovery criteria will be admitted to services regardless of their participation in a medication assisted treatment (MAT) program.

Length of Stay
MSHN will fund up to 90 days of recovery housing based upon determination of need. Recovery housing is limited to one admission per 12-month period. ~~Recovery housing providers should screen individuals prior to admission to determine if the person has participated in recovery housing within the last 12 months. Recovery housing providers can also contact the MSHN UM Department to confirm an individual's eligibility for MSHN-funded recovery housing services.~~ Recovery housing providers will work with each client and the client's outpatient treatment provider to develop an individualized plan identifying either alternative housing to which the client will go after discharge or alternative sources of funding to pay for the client's continued stay in recovery housing.

Utilization Patterns
Recovery housing providers will submit an authorization request in REMI for recovery housing services (H2034) for a maximum of 90 days.

MSHN requires that recovery houses be certified through MARR/NARR at a level III or higher prior to service delivery. A level III recovery house has administrative oversight and provides more structure than levels I and II and has at least one paid staff person. A level IV recovery house is highly structured and employs administrative and credentialed clinical staff. All MARR certifications are site specific and any changes in location or services must be approved by MSHN prior to services being rendered at that location.

Standards for Recovery Housing

Access – Screening: All recovery houses should have a standard screening tool which determines if the person is appropriate for recovery housing and rules out admission of individuals who may present a safety risk to self, staff, or other residents.

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.

Admission Policy: It is the expectation that all recovery housing providers have a policy and procedure in place which outlines admission criteria. This should include, but is not limited to:

- Criteria designating the amount of time a person is established in their recovery prior to admission.
- Process to ensure that a person has been connected to and receiving services from a treatment provider prior to consideration for recovery housing.
- Criteria that would preclude an individual from being admitted into recovery housing.

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. Recovery houses should consistently have Naloxone Rescue kits immediately on hand.

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~~ to the lead treatment specialist assigned to the provider ~~the Incident Review for Substance Use Disorder (SUD) Providers 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 C: Technical requirement for SUD Transportation Services

MSHN strives to reduce transportation barriers to accessing SUD treatment and recovery services, using the best quality, client-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 client's individualized treatment plan. If transportation needs arise during the course of a treatment episode, documentation of the need must be included in the client 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 client reduce barriers to transportation and must promote client 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 local MDHHS transportation assistance. Efforts to obtain other available and appropriate means of transportation must be documented in the client chart and shall be subject to MSHN confirmation. For individuals using transportation services, a transportation log must be included in the client chart. Transportation logs must include the following: date of service, signature/initials of client and program staff person(s), purpose of transportation and destination(s) with total mileage or number of bus tickets or gas cards issued.

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.

LEVEL OF CARE

Withdrawal Management& Residential Treatment
Transportation services are available to all individuals who meet medical necessity criteria for these levels of care. The withdrawal management residential service provider is responsible for determining the client'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 client's home and/or point of pick up (i.e., bus station) and destination is complete when client reaches the designated treatment center.
- Justification for using a form of transportation assistance other than least costly must be documented in the client chart. Examples of justification for using other forms of transportation include but are not limited to: the client does not reside on a public transportation route; the client has a specific physical or emotional disability which would make utilizing public transportation a hardship for that client; or the impairment caused by the client's substance use disorder poses safety concerns or high risk of relapse when using public transportation.

Routine transportation provided to the client 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).
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 individuals throughout the duration of the residential treatment episode for excessive, non-routine transportation as outlined above.
- A0100 Non-Emergency Transportation- Taxi PRIOR AUTH ONLY- This code can only be used when the auth is created by MSHN- prior authorization is required. Provider needs to rule out all other transportation options and all other closer residential/withdrawal management providers.

Outpatient
Transportation assistance is available for outpatient SUD services for Women's Specialty Individuals and their dependent children only.

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 client chart. Examples of justification for using other forms of transportation include but are not limited to: the client does not reside on a public transportation route; the client has a specific physical or emotional disability which would make utilizing public transportation a hardship for that client; or the impairment caused by the client'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; individuals may be given the number 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 client to Women's Specialty treatment services.
- T2003 Gas Card- $5.00 per unit; this code is available only for individuals who do not reside on a public transportation route. The maximum units permitted depends on individual client needs and must be clearly documented in the client chart. The provider is responsible for evaluating individual need and assisting individuals with planning.
- S0215 Mileage – IRS mileage reimbursement rate; May be used in addition to A110 if/when client requires transportation from public transportation point to treatment facility; May also be used to assist individuals 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 individuals with treatment plan goals.
- A0100 Non-Emergency Transportation- Taxi PRIOR AUTH ONLY- This code can only be used when the auth is created by MSHN- prior authorization is required. Provider needs to rule out all other transportation options and all other closer residential/withdrawal management providers.

Appendix D: MSHN Informed Consent Related to MAT

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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): _____

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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

Treatment Choice Information Sheet - 2017

Appendix E: Informational Grid on Recovery Pathways for Opioid Use Disorder
(continued)

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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**
over time to build confidence as patients re-integrate into family, work and healthier life domains.	addictive and can be hard to taper from.	help patients stay in a recovery program.	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 F: Incarcerated Services Technical Requirement (UM/Cammie)

Commented [CM53]: Complete

Purpose:
To establish requirements as the Pre-Paid Inpatient Health Plan (PIHP) for providers whose service delivery extends to providing substance use disorder (SUD) treatment in a jail/incarceration setting. Individuals with SUDs may engage in behaviors or actions that result in contact with the criminal justice system (i.e. arrest and/or incarceration). According to the SUPPORT Act Section 1003: Exploring Michigan's SUD Treatment Capacity and Access Final Project Report, justice system involvement creates barriers to assessment and treatment initiation, or disruption to continuity of MAT or other forms of SUD treatment. Once in jail, individuals have access to few services and resources which puts them at risk for relapse and death once released back into the community. Incarcerated services are a vital resource for individuals that can promote and sustain the recovery process. MSHN is supportive of services provided to individuals who are incarcerated. However, per the Medicaid Provider Manual, "Medicaid does not cover services provided to persons/children involuntarily residing in non-medical public facilities (such as jails, prisons or juvenile detention facilities)." Therefore, these services are paid for with Block Grant funds and this technical requirement will specify guidance for delivery and billing of incarcerated services.

Definitions:
Incarcerated Services are defined by MSHN as any SUD treatment services for ASAM Level of Care 0.5 and 1.0 (with or without Medication Assisted Treatment) being provided in a jail/incarceration setting. This *includes* juvenile detention facilities for adolescents and *excludes* the state and federal prison systems.

Clinical Focus of Incarcerated Treatment:
Incarcerated services funded by MSHN are a ***short-term, limited*** benefit designed to stabilize immediate needs and connect the person to appropriate services and supports in the community for ongoing treatment; it is not intended to be extensive psychotherapy. The clinical focus of treatment should include:

- Assisting the individual with exploring various recovery pathways
- Enhancing motivation and fostering readiness to engage in an ongoing program of recovery upon release
- Harm reduction and overdose prevention

Guidelines:
Across Region 5's twenty-one counties, MSHN supports services provided to individuals who are incarcerated. Providing SUD treatment services within the jail setting has barriers and complications. The provider has no control over consumer availability or knowledge of the actual release date. With MSHN's understanding of the barriers and complications involved, the following guidelines should be utilized when providing services to incarcerated consumers:

- All incarcerated services will require monthly (30 day) authorizations approved by a member of the Utilization Management (UM) Team.
- Incarcerated services are based on the consumer's medical necessity for SUD services and acknowledgement of the fact that not all ASAM LOCs can be provided in this setting.
- The SUD treatment provider will assess the consumer when the consumer presents for services and begin the process of developing a treatment plan for post-incarceration.

- Each consumer will have an individual assessment, treatment plan, and intake completed (there will be no "group intakes").
- All consumers 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 always be a possibility of early release, the individual will have all the necessary information to schedule an appointment themselves. The SUD provider will share this referral information with the incarcerated individual as soon as possible.
- It is an expectation of MSHN, if individuals are released from incarceration early, every attempt will be made by the provider of incarcerated services to contact the person to ensure a successful transition to their community SUD treatment provider is made. The attempts to contact the person should be documented in ~~the~~ their file.
- The provider of incarcerated services will secure a release to both the receiving provider and the consumer's home PIHP region, if not MSHN. If the consumer plans to live outside of the MSHN region upon discharge, please inform the MSHN SUD Care Navigator as soon as possible. The SUD Care Navigator will coordinate care with the responsible PIHP to ensure a smooth transition to an appropriate SUD treatment provider in the community where the person will be living. The SUD Care Navigator can be reached by calling 1-844-405-3095 or email Evan.Godfrey@midstatehealthnetwork.org
- All appointment dates and times will be documented in the REMI system for each consumer in his/her discharge summary. A note will be made in the discharge note section of the discharge summary in REMI stating if the consumer was released early.

Commented [CM54]: Kyle, will need to change this once we have the new number.

Medication Assisted Treatment (MAT) Specific Guidelines:

General Note: Per Mid-State Health Network, unless an existing contract is in place, effective April 1, 2023, the cost of the medication prescribed for MAT and physician/prescriber services are the responsibility of the county the jail is located in (Statute MCL 801.4-801.4a). If your agency would like to provided MAT services in an incarcerated setting, please contact your Treatment Specialist at MSHN.

MSHN has two different sets of guidelines for MAT based on whether an individual is receiving MAT at the time of incarceration or whether the person is incarcerated and then becomes interested in starting MAT.

For individuals who are receiving MAT at the time they become incarcerated, the guidelines are as follows:

- Funding for methadone daily dosing can continue while a person is incarcerated (with Block Grant only). The delivery and dosing of the medication is to be determined by the provider and the specific jail.
- Providers will need to ensure the Place of Service reflects the incarcerated status of the individual being served. This is especially important when the person's Medicaid/Health Michigan Plan is still showing active.
- Existing authorizations for methadone services can still be used and any new auths created while the person is incarcerated should include only the services being provided in the jail.
- Treatment plans are expected to stay up to date while the person is incarcerated. Jails are sometimes able to assist providers in getting plans signed by the person being served.

- If a provider is unable to get a treatment plan signed by the person served, they should still update the plan with goals related to dosing while incarcerated. In the signature line where the individual should sign, the provider will need to note that they were unable to get the signature and why.

For individuals who are incarcerated and then become interested in starting MAT, the guidelines are as follows:

- As funding for all incarcerated services is limited to 90 days, providers should initiate MAT services approximately 90 days prior to the individual's scheduled release date.

Utilization Management Guidelines:

- Please refer to the Incarcerated Services Benefit Grid located in the REMI Help menu and on the MSHN website (Policy and Procedure). The benefit grid provides detailed authorization information, including specific HCPC/CPT codes and amount of units that can be authorized for this level of care.
- Providers can submit authorization requests in REMI for a maximum of 30 days per authorization and 90 days per incarcerated treatment episode. Treatment may be authorized for more than 90 days based on individual exceptions related to medical necessity only; such as:
  - Providing MAT for pregnant individuals,
  - Initiation of MAT for individuals experiencing moderate to severe withdrawal symptoms upon admission to jail,
  - Continuation of MAT for individuals who were receiving MAT at the time they became incarcerated,
  - Complex care needs that warrant additional services to support and stabilize the individual.
- The only LOCs available for providing incarcerated services are ASAM Level of Care 0.5 and 1.0. All authorizations will be reviewed by the MSHN UM Team. If your agency would like to be considered for providing SUD treatment services in an incarcerated setting, please contact your Treatment Specialist. Any provider that has not been approved previously for incarcerated services at a specific location, will need to be supported by the MSHN SUD Treatment Team ***before*** beginning to offer supports in a new jail or juvenile detention facility.

Sources:
https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Keeping-Michigan-Healthy/BH-DD/Recovery-and-Substance-Use/SUPPORT_Act1003_Project_Final_Report.pdf?rev=19d3ff8507394f0a85504334e177a6e7&hash=E9B06444D29B91F3893212B61F09A2A8

https://www.mdch.state.mi.us/dch-medicaid/manuals/MedicaidProviderManual.pdf

http://www.legislature.mi.gov/(S(nzrpye4c0hel35t3k1ibu2qr))/mileg.aspx?page=GetMCLDocument&objectname=mcl-801-4

Appendix G: Residential Programs Food Assistance Program (FAP) Benefit Use

Mid-State Health Network (MSHN) desires the appropriate and compliant use of Food Assistance Program (FAP) benefits for beneficiaries who are receiving services from residential programs. Please review the following guidance related to the use of Food Assistance Program benefits and applies to all residential program providers:

- Residential program providers submit claims to MSHN for individuals engaged in the program using per diem rates bundled for staffing, housing, and operational expenditures. Operational costs include the cost of food for the individuals being served.
- The Michigan Department of Health and Human Services (MDHHS) Policy 615 and 617 provided valuable guidance for the utilization of FAP benefits.
    - MDHHS Policy 615 (GROUP LIVING FACILITIES (michigan.gov) states, "Unless otherwise stated in this item, a facility is not permitted to accept food assistance benefits for meals served to its residents. Clients may use their food assistance benefits for purchases at regular outlets."
    - MDHHS Policy 617 (FAP IN NONPROFIT GROUP LIVING FACILITIES (michigan.gov) states, "The SATC (Substance Abuse Treatment Center) receives and spends the food assistance benefits for food prepared by and/or served to the eligible resident and the resident's child(ren)."
- Based on Policy 615 and 617, FAP benefits are to be utilized to purchase food that will be prepared by and/or served only to the eligible resident and the resident's child(ren). Providers may receive written authorization to purchase food on behalf of an individual for their personal use to supplement the food prepared by the program, generally or as part of a special diet. Any FAP benefit use practices that do not align with Policy 615 and 617 should be discontinued. Thus, receiving authorization to purchase food on behalf of the beneficiary for food intended to feed everyone engaged in a program is not an allowable practice based on the policies.
- If residential providers have been authorized to use FAP benefits on behalf of the beneficiary, it is **expected** that a process will be in place to return the individual's FAP benefit card to them upon planned or unplanned discharge.
- If an out-of-region provider assists a beneficiary in signing up for FAP benefits, the provider must ensure the individual's county where their Medicaid is registered is not changed. A change in the individual's county can create a hardship when they return to their home community and seek continued treatment. There is also the possibility that their Medicaid Health Plan could change, and this could disrupt ongoing medical treatment with their primary care provider. Thus, providers should not engage in practices that would change an individual's Medicaid County.