



MID-STATE HEALTH NETWORK
SUBSTANCE USE DISORDER SERVICES
PROVIDER MANUAL

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Approved by: CEO, September 2025
Interim Chief Executive Officer Deputy Director, September-August 2026 ~~2025~~

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MID-STATE HEALTH NETWORK SUBSTANCE USE DISORDER SERVICES PROVIDER MANUAL

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Introduction

Welcome to the Mid-State Health Network (MSHN) substance use disorder (SUD) services provider manual. MSHN is pleased to be partnering with SUD prevention, treatment, 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, and Harm Reduction provider system. The FY24-25 plan was approved by the MSHN Board of Directors in September 2023 and extended for two more years through FY27. ~~and it~~ identifies current priorities for behavioral health services, including SUD within the region with a focus of Better Health, Better Care, Better Value, and Better Provider Systems, and Better Equity. Better equity was added to support 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, 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 (medications for opioid use disorder (MOUD), stimulant use treatment, women's specialty services (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.

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 Substance Use, Gambling and Epidemiology Section (SUGE) policies & advisories
- LARA Licensing, Certification, Training
- Medicaid Provider Manual, Chapter: Behavioral Health and Intellectual and Developmental Disability Supports and Services
- SAMHSA Treatment Guides for mental health and substance use best practice
- 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: Please visit MSHN's website and path noted above for applicable policies and procedures.

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. [A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a "clean claim" is not an ABD.](#) (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.

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, 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. (Please note, ASAM Criteria 4 Edition does not include Early Intervention as a separate level of care. ~~MSHN MDHHS will be maintaining this level of care for FY27. reference in FY26 until more is known during implementation in FY26.~~)

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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.

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.

Expedited Appeal is the expeditious review of an Adverse Benefit Determination, requested by the enrollee or the enrollee's provider, when the appropriate party determines that taking the time for a standard resolution could seriously jeopardize the enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function. If the enrollee requests the expedited review, the PIHP determines if the request is warranted. If the enrollee's provider makes the request, or supports the enrollee's request, the PIHP must grant the request. (42 CFR 438.410(a); 42 CFR 438.210)

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

Grievance is 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))

Grievance and Appeal System is the processes implemented to handle appeals of adverse benefit determinations and grievances, as well as the processes to collect and track information about them. 42 CFR 438.400.

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 \(hhs.gov\)](https://www.hhs.gov/overdose-prevention)

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.

Limited English Proficiency (LEP) means being limited in the ability or unable to speak, read, and/or write the English language well enough to understand and be understood without the aid of an interpreter.

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 [metrics for domains for](#) access to care, ~~adequacy and appropriateness of services provided, efficiency, and outcomes~~ as required by MDHHS.

Commented [KL2]: Please note that as of FY27, only access to care domain will be collected for SUD providers

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 their substance use and/or mental health problems and the adverse consequences, as well as the presence of specific readiness to change personal patterns.~~

Commented [CM3]: This is no longer a dimension but evaluated as part of each dimension for the ASAM 5

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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 their 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.

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Service Authorization is the process of requesting an initial and/or continued authorization of services, either approving or denying as requested or authorizing in an amount, duration, or scope less than requested, all as required under applicable law, including but not limited to 42 CFR 438.210.

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 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 Cases 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 to enhance the relationship between the client and the provider. This includes orienting new individuals to the available services and benefits, including how to access them, helping individuals with all problems and questions regarding benefits, effectively and efficiently handling client complaints and grievances, 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 clients and other community representatives or citizens' informational needs. Customer Services is responsible for providing support and resources to meet client and provider needs, including but not limited to resource information and referrals. Provider must 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.

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 in 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 as they occur. 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. All required information shall be provided in a manner and format that may be easily understood and readily accessible by members and potential members. 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.

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Provider Service Animal Obligation

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The Americans with Disabilities Act (ADA) is a federal civil rights law that prohibits discrimination against individuals with disabilities and ensures equal access. Under the ADA, a person with a disability is an individual who has a physical or mental impairment that substantially limits one or more major life activities, or has a record of such an impairment, or is regarded as having such an impairment. Individuals with an ADA-covered disability may use a service animal during treatment. Under the ADA, a service animal is defined as a dog (or miniature horse) that is trained to perform tasks for an individual with a disability. The work or tasks performed by the service animal must be directly related to the person's disability.

Examples of disability related tasks may be:

- Navigating an individual who is blind or has low vision
- Pulling a wheelchair
- Opening doors or operating light switches
- Detecting the onset of a seizure and helping the person remain safe during the seizure
- Alerting to oncoming allergic reactions
- Interrupting self-harm behaviors or a dissociative episode
- Leading someone with PTSD to a safe location during an anxiety attack;
- Creating a physical barrier between the handler and others in crowded spaces

When an individual with a service animal seeks admission for services, staff may ask **only two questions** (and only if it is not readily apparent that the dog is a service animal):

- Is the dog a service animal required because of a disability?
- What work or task has the dog been trained to perform?

That's it. **No other questions are permitted.**

Providers **may not**:

- Ask about the nature or extent of the person's disability
- Require medical documentation or proof of disability
- Require documentation, certification, or identification for the service animal
- Require the service animal to wear a vest, tag, or special identification
- Ask the service animal to demonstrate its trained tasks
- Require proof of training or graduation from a service animal program
- Ask where the animal was trained or who trained it

Providers may request certain health and safety information:

- Vaccination records — For state/local public health compliance (standard for all dogs)
- Veterinary contact information — For safety planning in case the handler is incapacitated
- Emergency contact person — To care for the animal if the handler cannot
- Dietary needs and medication information — To assist in an emergency

These are not service animal documentation; they are standard responsible pet ownership and public health requirements that apply to all dogs, service animals or not.

Service Animal Standards

Animals that perform the following tasks would **not** qualify as a service animal under ADA:

- Emotional support alone
- Comfort or companionship only
- Crime deterrent by presence
- Animals other than dogs or miniature horses (Cats, birds, reptiles, rabbits, etc.)
- Therapy animals used in a therapeutic setting

Service animals must meet the following behavioral standards:

- Must be housebroken — Reliably trained not to urinate or defecate indoors and eliminates only in designated, appropriate locations
- Must always be under handler's control — through leash, harness, voice, or signal.
 - Note: Handler's disability may prevent the use of physical devices, but they must maintain control through voice commands, signals, or other effective means
- Must not be disruptive — No excessive barking, running around, jumping on people
- Must not be aggressive — No biting, lunging, growling at people or other animals
- Must not pose a direct threat — Cannot threaten the health or safety of others.
 - Note: Allergies to dogs and fear of dogs are **not** valid reasons to deny access or refuse service to people using service animals. Accommodations for others should be explored if an allergy or fear is expressed.

A service animal may be required to leave the premises **only** in two circumstances:

- The dog is out of control, and the handler does not take effective action to control it
- The dog is not housebroken

Before requiring the removal of a service animal, staff should:

- Give the handler an opportunity to regain control — Allow time for the handler to correct the behavior
- Document the specific behavior concern — Write an incident report with date, time, and specific behaviors observed
- Consult with supervisor or administrator — Do not make a unilateral decision
- Provide notice to handler — Explain specific behavioral concern and give opportunity to remedy if possible

Even if the service animal must be removed, the person with a disability must still be offered the opportunity to obtain services without the service animal.

Responsibilities:

- The individual with the service animal is responsible for:

- Care and Supervision: feeding, grooming, veterinary care, vaccinations, and licensing
- Sanitation: cleaning up after the animal (indoors and outdoors), disposing of waste, cleaning up "accident"
- Damage and Liability: Responsibility for any damage caused by the service animal beyond normal wear and tear, payment for repairs or cleaning caused by the animal, and liability for any injuries caused by the animal
- Behavior Management: control the animal if it becomes disruptive, removing the animal when disruptive/cannot be controlled, notifying staff immediately of behavioral issues or incidents
- The provider must:
 - Accommodations: permit service animals in all areas where clients are normally allowed, provide designated outdoor relief areas for service animals, make waste disposal receptacles available and accessible, and designate a feeding area that maintains sanitation standards
 - Note: Service animals may be restricted from specific areas such as sterile medical procedure rooms, food preparation areas, areas that would fundamentally alter the nature of services, or areas that would be a threat to the health or safety of the individual.
 - Train all staff on ADA service animal requirements, educate staff on proper interaction with service animals, and provide training on the two permissible questions and documentation prohibitions
 - Non Discrimination: **not** isolate the person with a service animal from other residents/clients, **not** treat the person less favorably than others, **not** charge fees, deposits, or surcharges for service animals, and **not** restrict the handler to "pet-friendly" areas or outdoor spaces only
 - Conflict Resolution: address conflicts (allergies, fears, complaints) through individualized assessments, balance the needs of all individuals involved, and document decisions and rationale

How to Interact with Service Animals

DO:

- Talk to the person, not the animal
- Treat the person with the same respect as all other clients
- Ignore the service animal (it is working)
- Ask the handler for permission before petting or interacting with the animal
- Direct questions to the handler, not about the animal
- Treat the service animal as medical equipment, not as a pet

DON'T:

- Pet, feed, or distract the service animal without explicit permission
- Make eye contact with the service animal or use "dog voice."
- Offer food or treats to a service animal

- ~~Call the animal or make sounds to get its attention~~
- ~~Separate the handler from their service animal~~
- ~~Ask to see the animal perform tasks~~

Remember: ~~A service animal is medical equipment, similar to a wheelchair, a cane, or an oxygen tank. You would not touch or interact with someone's wheelchair without permission—apply the same standard to service animals.~~

Resources:

- ~~<https://www.ada.gov/topics/service-animals/>~~
- ~~<https://www.michigan.gov/mdcr/divisions/ada-compliance/service-animals>~~
- ~~[Midstatehealthnetwork.org](https://www.midstatehealthnetwork.org) → [Provider Network](#) → [Provider Trainings](#) → [Provider Service Animal Training](#)~~

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 of those rights, and to expect a resolution. The recipient rights process establishes a method by which, if a client believes their 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 Regional 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

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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. When there is suspected fraud, waste or abuse, please contact the MSHN Compliance Officer for guidance and direction. 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 are required to report such wrongdoing to the MSHN Compliance Officer or to the Provider Compliance Officer. The Provider Compliance Officer will immediately report potential fraud, waste, or abuse 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. Refer to the MSHN Compliance Consent to Share Information Policy and the MSHN Compliance Confidentiality and Notice of Privacy Policy for more information.

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.

Kim Zimmerman, Chief Compliance & Quality Officer, Privacy Officer
Office: 517-657-3018 | Fax: 517-253-7552
kim.zimmerman@midstatehealthnetwork.org

Steve Grulke, Chief Information Officer, Security Officer
Office: 517-253-7671 | Fax: 517-253-7552
steve.grulke@midstatehealthnetwork.org

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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 Quality Assessment and Improvement Program (QAPI) as required by the Michigan Department of Health and Human Services. The QAPI Plan can be found on the MSHN Website: Stakeholders → Quality & Compliance → [Quality Assessment Performance Improvement Program Plan](#). The purpose of the MSHN QAPI 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. The scope of MSHN's Quality Assessment Performance Improvement Program is inclusive of all Substance Use Disorder Providers, CMHSP Participants and their respective provider networks. Performance monitoring covers all organizational functions, aspects of care and service delivery systems, and 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's safety, and feedback, as outlined in the QAPI Plan.

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Sentinel Events

MSHN Residential Treatment Providers are contractually responsible for reviewing all critical incidents as identified by MDHHS and MSHN to determine if a sentinel event has occurred. Details related to the process for reporting can be found under the [Quality Chapter of MSHN policies](#). The following events should be reviewed to determine if the event meets the criteria for a sentinel event:

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- Death of a recipient
- Accidents or serious illness requiring emergency room visits and/or admissions to a hospital (includes overdose)
- Alleged cause of abuse or neglect
- Arrest and/or conviction
- Serious challenging behaviors
- Medication errors
- Medication Assisted Treatment (MAT) Medication Errors

A sentinel event is a Patient Safety Event that reaches a patient and results in any of the following:

- Death
- Permanent harm
- Severe temporary harm and intervention required to sustain life

An event can also be considered a sentinel event even if the outcome was not death, permanent harm, or severe temporary harm and intervention required to sustain life. Additional information relating to these events can be found under the MSHN policy [Critical Incidents - SUD Only](#).

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

¹ Special Provisions Treatment. Performance/Progress Report Requirements-Sentinel Event Reporting requirements.

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 through the provider portal in REMI.

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 Satisfaction Surveys

MSHN treatment providers shall conduct 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 satisfaction surveys. 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 individuals actively in treatment or those that have been discharged from services 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 identify systemic areas of dissatisfaction which must be used in the development of a Performance Improvement plan to make programmatic changes to address those areas of dissatisfaction and improve services.

Performance Management Standards –

MSHN is contractually responsible for meeting performance standards as defined by MDHHS. Performance standards include but are not limited to timeliness standards (for individuals with Medicaid and the Healthy Michigan Plan), and the Performance Bonus Incentive Pool (PBIP) Metrics. The following performance measures include individuals with a substance use disorder (please note that the following are subject to change with updated MDHHS requirements):

- MMBPIS Indicator 2e: 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 (Benchmark standard = 75.3%).

² Michigan Department of Health and Human Services Quality assessment Performance Improvement Programs for Specialty Prepaid Inpatient Health Plan Section VIII A-D.

³ [Michigan Department of Health and Human Services Event Notification](#).

⁴ Special Provisions-Treatment Satisfaction Surveys

- ~~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 (Benchmark 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.
 - Two rates are reported:
 - The percentage of ED visits for which the member received follow-up within 30 days of the ED visit.
 - The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days).
- Initiation and Engagement of Substance Use Disorder Treatment (IET-AOD): 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.

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Treatment providers who do not meet the standards set by MDHHS and/or MSHN will be subject to a quality improvement or a performance improvement plan. The quality improvement plan must 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.

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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:
Kara Laferty, Quality Manager
 Office:
 (517) 299-0750, extension 884
 | Fax: 517-253-7552
kara.laferty@midstatehealthnetwork.org

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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 three 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 ~~liability insurance meets the requirement as outlined in the contract language. 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.~~

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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 [MDHHS Behavioral Health Code Charts and Provider Qualifications Chart](#)s and [MDHHS Substance Use Disorder Credentialing and Staff Qualifications](#) policy. 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 and verification of staff qualifications 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, financial and Medicaid event verification, staff qualifications and credentialing, 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/medication for opioid use disorder, 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 their 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's Chief Financial Officer Leslie Thomas at leslie.thomas@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.



User Manuals

 [Provider Portal Dashboard](#)

How-To Videos

 [60. How to Use the Provider 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@midstatehealthnetwork.org mailbox.~~

Commented [AD12]: Recommend removal. This form has been exhausted for several years now.

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 MDHHS SUGE Prevention Policy #2: *Addressing Communicable Disease Issues in the Substance Abuse Service Network* available on the [MDHHS SUGE website](#). 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 ~~MDHHS SUGE Policy~~~~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 for Michigan's behavioral health workforce. 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 reviews.

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, performance enhancement 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 Leslie Thomas, Chief Financial Officer 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.

Commented [A113]: Leslie - Do you want to be the contact for all of these areas? Seems appeals, site reviews, and credentialing would fall under Compliance. Recommend delete this section.

PREVENTION PROVIDERS

MSHN's Prevention Specialists are available to assist with SUD Prevention and Community Recovery 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
Cari Patrick: Cari.Patrick@midstatehealthnetwork.org
Sarah Surna: Sarah.Surna@midstatehealthnetwork.org

Field Code Changed

Field Code Changed

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 [MSHN](#) 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 Certifications](#)). 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 5600 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 annually. 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 is recommended to be completed within one (1) year of hire. This training is recommended 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 ([MDHHS Guidance for Evidence-Based Implementation of SUD Prevention](#)). 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 ten percent (10%) of total direct services/units can be in the Federal Strategy of Information Dissemination and services under this category and 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 the 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 business days once submitted to MDHHS.

Prevention 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. <https://www.samhsa.gov/grants/gpra-measurement-tools>

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 met? 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.

Commented [SA14]: We will add a hyperlink when the manual is uploaded to the new MPDS system

Activity data must be entered into the MPDS on a monthly basis. Failure to enter activity data by the 10th of the month following the date of service may result in delayed payment by MSHN. MSHN Prevention Specialists are available to provide MPDS related technical assistance and training to Contracted Prevention Providers upon request. Please consult the MPDS User Manual prior to contacting your MSHN Prevention Specialist for assistance.

Designated Youth Tobacco Use Representatives (DYTURs)

The federal [Synar Amendment](#) requires states to have laws in place prohibiting the sale and distribution of tobacco products to persons under 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.
- [Participate in the Coverage Study if a community in your county is selected by MDHHS. The Coverage Study occurs every three years, usually following the formal Synar period. This requires a team of two people to visit a select number of businesses in a specific geographic area chosen by MDHHS to verify if they sell tobacco products. Instructions and reporting templates will be supplied to all selected DYTURs.](#)

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. [Tracking of any vendors with a "21+ Only" sign on their door is also required.](#)
- **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. [It is strongly recommended DYTURs do Vendor Education with 100% of vendors in their county.](#)
- **Formal Synar Compliance Check Forms; and**
- **Youth Access to Tobacco Activity Report and**
- **[Coverage Study Reporting Forms if applicable](#)**

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 [Master Retailer List updates](#), 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 each month.

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

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
Sherrie Donnelly	sherrie.donnelly@midstatehealthnetwork.org
Jodie Smith	jodie.smith@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 ~~(Kate)~~

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 provider's 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 ~~(Kate)~~

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. All provider ASAM designations for the agency will need to be supported through the home/host PIHP, even if provider offices are geographically located in other PIHP regions. 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 willmay also need to be updated as well as the LARA SUD license.

ASAM Continuum Training Process ~~(Kate)~~

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 will then submit the certificate to your MSHN Treatment Specialist to activate that user's account and be granted access to CONTINUUM® through REMI.

Commented [KF15]: This section may need to be updated pending outcome of updates to the ASAM-C for transition to ASAM-4 criteria.

Commented [AI16R15]: Dani ?

Commented [TT17R15]: No updates yet. The State has not provided any new info as the ASAM C update is not slotted to be done until 10-1-26.

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 have 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

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".

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

III. A downloadable certificate of completion will become available after you complete the module(s).

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.

ASAM Continuum FAQ Document available on the MSHN website:

[MSHN ASAM Continuum FAQ 7-18-24.docx \(live.com\)](#)

ASAM Continuum Access Process for REMI:

When ASAM Continuum training is complete, please contact your agency lead treatment specialist to request the person be given access to the ASAM Continuum in REMI. The provider will first need to ensure the staff person has been added to your agency with an account in REMI. This can be supported by the provider through the provider portal.

When sending the request for access to ASAM Continuum in REMI to your lead treatment specialist, please provide the following information:

- Person's first and last name
- Person's education, qualifications/credentials
- Person's active email address to receive REMI log-in instructions
- Certificate of Completion for the ASAM Continuum training (above)

Please note, requests for access to the ASAM Continuum ~~in~~ REMI can take up to 72 hours, so please plan accordingly.

Auricular Acupuncture ~~(Jodie)~~

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 ~~(Sherrie)~~

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/MOUD providers shall not mandate or require behavioral contracts for any of their individuals receiving MAT/MOUD services. Illicit use should be addressed in a meaningful and strength-based way on the client's individualized treatment plan.

Biopsychosocial Assessment ~~(Kate)~~

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 the 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. If your agency needs to register a staff member for training for the GAIN I Core, please email your lead treatment specialist with the following information:

- Staff member's full name
- Staff member's credentials
- Staff member's email address

Per the LARA SUD Administrative Rules that went into effect as of 6-26-2023, the guideline for Assessments & Treatment Plans (i.e. 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 person's needs in treatment and recovery services and assist with informing the annual treatment plan, as needed. *(Please note, for anyone in services over 12-months, they will also need an updated BHTEDS record known as an "s" record to be completed.)*

The MSHN Standardized Assessment policy can be located on the MSHN website [here](#).

The ASAM Continuum FAQ document is available on the MSHN website: [here](#)

Co-Occurring Mental Health and Substance Use Disorders ~~(Jodie)~~

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. All programs should be co-occurring capable by 10-01-2026 with the implementation of ASAM 4 criteria. 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. 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) ~~(Kate)~~

As stated in the [MSHN Provider Contract Non-compliance procedure](#), a provider may receive support through either a Corrective Action Plan (CAP), 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 prescriptive 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: a provider may receive support through either a Corrective Action Plan (CAP), 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 prescriptive direction to the provider of steps to be taken to address the quality and compliance issues in concrete and measurable approaches. Utilization of the

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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 the Contract Remedies and Sanctions section of the 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 ~~(Sherrie)~~

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 people 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. The MSHN Cultural Competency Policy can be accessed [here](#) on the MSHN website.

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 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 organization's 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 ~~(Jodie)~~

Accurate documentation is necessary to maintain the best care for the 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 persons served in the group.

Evidence-Based Practices ~~(Jodie)~~

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-based 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](https://midstatehealthnetwork.org/application/files/5117/3151/2211/Service_Delivery_System_Evidence_Based_Practices_Policy062024.pdf) ~~HYPERLINK~~
"https://midstatehealthnetwork.org/application/files/5117/3151/2211/Service_Delivery_System_Evidence_Based_Practices_Policy062024.pdf":

Commented [JS23]: Link appears to just take to main page its not showing the EBP policy page

Commented [KF24R23]: "here" took me to the policy. If this was updated, you can delete the hyperlink and text after it.

Gambling Disorder Protocol ~~(Sherrie)~~

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

During Admissions process:

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

During Treatment Planning process and ongoing during treatment:

1. If there is a GD diagnosis, 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 ~~(Kate)~~

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 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](#)

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Harm Reduction ~~(Sherrie)~~

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](#) [Harm Reduction Framework/SAMHSA](#).

Harm reduction resources can be found on the MSHN website [here](#). ~~here~~[here](#).

Individualized Treatment Planning ~~(Sherrie)~~

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.

Per the LARA SUD Administrative Rules implemented on 6-26-2023, standard R325.1363 outlines expectations for service plans (i.e. 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: [Treatment Policy 06 Individualized Treatment and Recovery Planning](#)

Integrated Coordination of Care ~~(Jodie)~~

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~~ 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.

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The MSHN Service Philosophy & Treatment policy can be accessed on the MSHN website [here](https://midstatehealthnetwork.org/application/files/4117/5751/9631/Service_Delivery_System_Service_Philosophy_Policy.pdf)
https://midstatehealthnetwork.org/application/files/4117/5751/9631/Service_Delivery_System_Service_Philosophy_Policy.pdf

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MDOC Priority Population Technical Requirements ~~(Christina/Cammie)~~

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. 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 SUD Treatment contract between MSHN and the SUD Provider Network, MSHN has delegated to providers the responsibility for access to outpatient services and any direct SUD treatment services.

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Referrals, Screening, & Assessment: ~~(Christina/Cammie)~~

Individuals under MDOC supervision are considered a priority population for assessment and admission ~~for to substance use disorder treatment SUD 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.

Commented [CR29R28]: Through the current MSHN SUD Treatment contract between MSHN and the SUD Provider Network, MSHN delegates responsibility for direct outpatient substance use disorder treatment services to our contracted providers. Responsibility for withdrawal management and residential treatment services remains with Mid-State Health Network and is not delegated.

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

Withdrawal Management and Residential Referrals Only: ~~(Christina/Cammie/Rusmira)~~

If an individual has not been receiving any SUD treatment services, and the supervising agent would like to refer the person to withdrawal management and/or residential treatment, the supervising agent will send the CFJ-306 (MDOC referral form) and the MDHHS 5515 (release of information) to the SUD Care Navigator using the MDOCreferrals@midstatehealthnetwork.org email. The referral documents will be reviewed and a preliminary referral recommendation provided. If those services are recommended, the client will call MSHN Access line (844-405-3095) and be transferred to an appropriate residential provider after a complete Level of Care Determination has been made by MSHN Access. For individuals not currently receiving SUD treatment services, the supervising agent can submit a referral to the SUD Care Navigator through MDOCreferrals@midstatehealthnetwork.org or the secure online referral portal. All referrals must include a CFJ-306 and signed MDHHS 5515. Referral documentation is reviewed and the SUD Care Navigator contacts the referred individual and/or supervising agent for completion of a Level of Care Determination. Following the determination, the Navigator coordinates referral to a provider offering the most appropriate level of treatment consistent with the individual's assessed needs and clinical recommendations.

Commented [CR30]: For individuals not currently receiving SUD treatment services and who are being referred for withdrawal management and/or residential treatment, the supervising agent can submit a referral to the SUD Care Navigator through MDOCreferrals@midstatehealthnetwork.org. All referrals must include a CFJ-306 and signed MDHHS 5515. Referral documentation is reviewed and the SUD Care Navigator contacts the referred individual and/or supervising agent for completion of a Level of Care Determination. Following the determination, the Navigator coordinates referral to a provider offering the most appropriate level of treatment consistent with the individual's assessed needs and clinical recommendations.

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

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MSHN Access. MSHN Access staff will review the clinical documentation and determine if the referral is appropriate. All MDOC residential referrals must originate from MSHN Access Department. If an MDOC client contacts a residential treatment provider directly to request services, the residential treatment provider should contact the MSHN Access Department to ensure that the referral has been approved. If an individual is already receiving outpatient SUD treatment services, but it is determined they need residential treatment or withdrawal management, the current SUD treatment provider can make the referral directly to MSHN SUD Care Navigator or MSHN Access. MSHN staff will review the clinical documentation, complete or update the Level of Care Determination as needed, and determine whether referral to residential treatment is appropriate based on the individual's assessed needs. All MDOC residential and withdrawal management referrals must originate through the MSHN Access Department. If an MDOC-referred individual contacts a residential treatment provider directly seeking admission, the provider should assist the person with a warm transfer to the MSHN Access Department (844-405-3095).

Commented [CR31]: If an individual is already receiving outpatient SUD treatment services, but it is determined they need residential treatment or withdrawal management, the current SUD treatment provider can make the referral directly to MSHN SUD Care Navigator or MSHN Access. MSHN staff will review the clinical documentation, complete or update the Level of Care Determination as needed, and determine whether referral to residential treatment is appropriate based on the individual's assessed needs. All MDOC residential referrals must originate through the MSHN Access Department. If an MDOC-referred individual contacts a residential treatment provider directly seeking admission, the provider must contact the MSHN Access Department to verify the referral has been approved prior to admission.

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.

Commented [CR32]: Supervising agents should submit the CFJ-306 (MDOC referral form) and signed MDHHS 5515 directly to the receiving provider; without both required documents, the referral is not recognized as MDOC priority population status per MSHN.

Supervising agents should submit the CFJ-306 (MDOC referral form) and signed MDHHS 5515 directly to the receiving provider; without both required documents, the referral is not recognized as 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 recommendation to withdrawal management and/or residential, the outpatient provider will refer the client to the MSHN Access Department for referral to the most appropriate residential program. Both providers will work to ensure the full assessment gets transferred to the receiving provider (with appropriate release).

If the individual is not recommended for any SUD treatment services, the provider will offer information regarding community resources such as AA/NA or other support groups to the individual.

Individuals referred through MDOC for SUD treatment must receive an in-person assessment and may not be denied based on a phone screening alone. Assessments should consider presenting symptoms, substance use history prior to and during incarceration, and treatment history while incarcerated. If the assessment determines the need for withdrawal management and/or residential treatment, the outpatient provider will refer the individual to MSHN Access or the SUD Care Navigator. Referring and receiving providers are responsible for coordinating transfer of the full assessment and related clinical information, with appropriate releases in place. If the individual is accepted for treatment, the provider must maintain communication with the referring agent, consistent with the signed MDHHS 5515, including informing the agent of treatment recommendations and, if admitted, completing and sending the MDOC Monthly Progress Report.

If the assessment does not support a recommendation for SUD treatment services, the provider should offer information on community resources, including mutual support groups and other recovery supports. Admission and treatment decisions for level or duration of care, will be based on ASAM criteria and medical necessity for treatment; MSHN and/or providers are not required to honor supervising agent requests regarding level or duration of care. 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.

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 prescriptions 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 FY276 treatment contract to view full reporting requirements.

REMI Documentation: ~~(Christina/Cammie)~~

Please see the Help Menu in REMI for or the Provider Training section on priority populations for additional information on MDOC documentation.

The MSHN point of contact for MDOC related questions is the SUD Care Navigator, Christina Romero. Christina is able to assist with questions regarding referral, screening, assessment, and training needs. Christina can be reached by email at Christina.Romero@midstatehealthnetwork.org.

Medication Assisted Treatment & Medication for Opioid Use Disorders (MOUD) ~~(Jodie)~~

MSHN adheres to requirements described in all MDHHS/SUGE policies related to Medication Assisted Treatment (MAT) and its subset of Medication for Opioid Use Disorder (MOUD) treatment.

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 #4 5 and #56*, 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) and its subset of Medication for Opioid Use Disorder (MOUD) treatment that are determined to be medically necessary for the individualized needs of that client. Per SAMHSA, exclusion of individuals who are on MAT or MOUD 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 \(SAMHSA\)](#)

Commented [CR33]: Individuals referred through Michigan Department of Corrections for substance use disorder treatment must receive an in-person assessment and may not be denied based on phone screening alone. Assessments should consider presenting symptoms, substance use history prior to and during incarceration, and treatment history while incarcerated. *If the assessment determines the need for withdrawal management and/or residential treatment, the outpatient provider will refer the individual to MSHN Access or the SUD Care Navigator.* Referring and receiving providers are responsible for coordinating transfer of the full assessment and related clinical information, with appropriate releases in place. If the individual is accepted for treatment, the provider must maintain communication with the referring agent, consistent with the signed MDHHS 5515, including informing the agent of treatment recommendations and, if admitted, completing and sending the MDOC Monthly Progress Report (insert link to MSHN-Provider Trainings). If the assessment does not support a recommendation for SUD treatment services, the provider should offer information on community resources, including mutual support groups and other recovery supports. Admission and treatment decisions for level or duration of care, will be based on ASAM criteria and medical necessity for treatment; MSHN and/or providers are not required to honor supervising agent requests regarding level or duration of care.

Commented [CR34]: Individuals referred through Michigan Department of Corrections for substance use disorder treatment must receive an in-person assessment and may not be denied based on phone screening alone. Assessments should consider presenting symptoms, substance use history prior to and during incarceration, and treatment history while incarcerated. *If the assessment determines the need for withdrawal management and/or residential treatment, the outpatient provider will refer the individual to MSHN Access or the SUD Care Navigator.* Referring and receiving providers are responsible for

Commented [CR35]: Or MSHN's Provider Training section on Priority Population

Commented [CR36]: is the SUD Care Navigator, Christina Romero.

Commented [KF37]: This is the individualized treatment plan policy. Should this be #4, which is about off-site dosing?

Commented [JS38R37]: updated

Commented [KF39R37]: Trisha - I think this should list TP #4 and #5 as they are the two that are relevant to MAT/MOUD. I'm not sure why #6 is included as it relates to treatment planning. Thoughts?

Commented [KF40]: Is this the most recent version of this document?

Commented [JS41R40]: checked it is

MSHN-contracted SUD treatment providers are expected to adopt a MAT/MOUD-inclusive treatment philosophy in which 1) the provider demonstrates willingness to serve all eligible treatment-seeking individuals, including those who are using MOUD 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 MOUD either with individuals or in the public domain. The MSHN SUD Services – Medications for Opioid Use Disorder (MOUD) 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 for opioid use disorders 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 C) that attests that the client was informed in an objective and non-judgmental way about other treatment options including MOUD, 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 D).
- When a client already on MOUD (or considering MOUD) 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 MOUD 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 their chosen recovery pathway that includes MOUD.
- Providers' policies will include language that prohibits delegitimizing, and/or stigmatizing of MOUD (e.g., using either oral or written language that frames MOUD as "substituting one addiction for another") either verbally with the individual, in written materials for individuals or for public consumption, or in the public domain.

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

SAMHSA Extranet Requirement for Opioid Treatment Programs: For Opioid Treatment Programs (OTPs), the provider must be registered in the SAMHSA Extranet system and be utilizing it as necessary. "Failure to submit the Form SMA-168 exception request and obtain approval from the [state opioid treatment authority](#) AND the SAMHSA prior to providing care that deviates from the federal opioid treatment standards constitutes a serious regulatory violation.

Commented [JS42]: How does this work with the Treatment Policy #8 new details

Commented [KF43R42]: Can you say more about this?

Commented [JS44R42]: I confused this with take home policy items. Scratch that

This type of violation may threaten an OTP's accreditation and certification and bring it out of compliance with state and federal regulations." If a program has consulted the text of the federal opioid treatment standards in 42 CFR 8 and is unsure if the care it intends to provide for a patient is in compliance, then the program should submit a Form SMA-168 exception request on the [SAMHSA OTP Extranet website](#). All Opioid Treatment Programs that are:

- Licensed by the Department of Licensing and Regulatory Affairs,
- Certified by the Drug Enforcement Administration, and
- Registered by the Substance Abuse and Mental Health Services Administration (having been approved by the State Opioid Treatment Authority), are required to submit requests to the extranet system.

Substance Use Disorder Health Home

[The Michigan Department of Health and Human Services \(MDHHS\) Substance Use Disorder Health Home \(SUDHH\) program provides comprehensive care management and coordination services for Medicaid beneficiaries diagnosed with qualifying ICD-10 alcohol, stimulant, or opioid use disorders. Eligible beneficiaries must also be at risk for developing co-occurring conditions such as mental health disorders, asthma, diabetes, heart disease, elevated BMI, or COPD.](#)

[SUDHH services deliver integrated, person-centered care designed to address complex physical and behavioral health needs. Beneficiaries must meet geographic eligibility requirements and be enrolled in Medicaid, the Healthy Michigan Plan, Freedom to Work, Healthy Kids Expansion, or MICHild.](#)

[The SUDHH model includes six core services:](#)

- [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 Service](#)

[SUDHH is structured as a partnership between a Lead Entity \(LE\) and Health Home Partners \(HHPs\) to ensure effective service delivery. The LE is defined as a regional entity under Michigan's Mental Health Code \(330.1204b\). HHPs must be enrolled in Michigan Medicaid, comply with all program requirements, and maintain a contract or memorandum of understanding with the LE. While HHPs may be physically located outside the LE's region, they must serve beneficiaries residing within the LE's region.](#)

[The SUDHH workforce includes Behavioral Health Specialists, Nurse Care Managers, Peer Recovery Coaches, Community Health Workers, Medical Consultants, Psychiatric Consultants, and Addictionologist Medical Physicians. HHPs are also responsible for coordinating care with beneficiaries' natural supports and community providers such as primary care physicians,](#)

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dentists, dietitians, nutritionists, pharmacists, peer support specialists, diabetes educators, school staff, and other relevant partners.

Providers interested in becoming a Health Home Partner may contact Liz Philpott, Integrated Health Administrator, at elizabeth.philpott@midstatehealthnetwork.org.

According to the Michigan Department of Health and Human Services' (MDHHS) Substance Use Disorder Health Home Handbook, the Substance Use Disorder Health Home will provide comprehensive care management and coordination services to Medicaid beneficiaries with an opioid use disorder. Michigan's SUDHH 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 MOUD.

Substance Use Disorder 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 qualifying ICD-10 code diagnosis related to alcohol, stimulant or opioid use disorder.

The HHP will employ the following: Behavioral Health Specialist, Nurse Care Manager, Peer Recovery Coach, Community Health Worker, 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 SUDHH 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

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6. Referral to Community and Social Support Services

Providers interested in exploring becoming a Health Home Partner should contact Liz Philpott, Integrated Health Administrator at elizabeth.philpott@midstatehealthnetwork.org for more information.

Prohibition on Provision of Hypodermic Needles (Sherrie)

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 (Sherrie)

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 Request for Service was completed by the provider prior to the Project ASSERT Screening/LOC, data collected in the Request for Service 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 (Sherrie)

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](https://midstatehealthnetwork.org/application/files/8417/3642/8778/Service_Delivery_System_BH_ROSC.pdf).
[here](https://midstatehealthnetwork.org/application/files/8417/3642/8778/Service_Delivery_System_BH_ROSC.pdf)HYPERLINK
"https://midstatehealthnetwork.org/application/files/8417/3642/8778/Service_Delivery_System_BH_ROSC.pdf":
https://midstatehealthnetwork.org/application/files/8417/3642/8778/Service_Delivery_System_BH_ROSC.pdf

Commented [SD45]: updated ROSC policy link

MSHN wants to ensure that this process represents a broad range of stakeholder viewpoints.

- a. Providers will act consistent with collaboration and cooperation of efforts in order to effect positive change in communities/counties.
- b. Providers support a process of community change that engages critical thinking and collaboration with community partners.
- c. Providers support a continuum of improved health and functioning in which there are a variety of diverse roles for all involved to provide input. These roles include prevention and treatment Provider, 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 local~~ ROSC meetings. Participation can be defined as in person, by phone, videoconference, or connection through email list-serve.

Commented [KF46]: Should this be updated? I'm not sure if this is still accurate or if the language needs to change based on changes being made to workgroups. Thoughts?

Commented [SD47R46]: done

Supervision ~~(Kate)~~

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 \(samhsa.gov\)](#)
- [SAMHSA: Competencies for Supervision in Substance Use Disorder Treatment - An Overview](#)
- [SAMHSA: The SUD Counseling Competency Framework - An Overview](#)

Transfer ~~(Jodie)~~

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 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 next provider to continue care seamlessly.

Trauma Informed Care ~~(Sherrie)~~

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~~ *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 ~~(Sherrie)~~

Trauma-specific services include prevention, intervention, or treatment services that address traumatic stress as well as any co-occurring disorders that develop 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.

Commented [JS48]: Does it need to be specified where this is documented at?

Commented [KF49R48]: Minimally, it should be documented in the client record. They could also note it in the provider comments in REMI, but that is not a requirement to complete the discharge. It's preferred if they add it though.

Commented [JS50R48]: ok

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- *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~~) Trauma Policy) [https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Folder3/Folder88/Folder2/Folder188/Folder1/Folder288/Trauma Policy.pdf?rev=928ce68949f640cfbdce418cd872cdfb&hash=A693774D4330D5C2390E590F872B9F49](https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Folder3/Folder88/Folder2/Folder188/Folder1/Folder288/Trauma%20Policy.pdf?rev=928ce68949f640cfbdce418cd872cdfb&hash=A693774D4330D5C2390E590F872B9F49) and and [MSHN Trauma Informed Systems of Care Policy. https://midstatehealthnetwork.org/application/files/8117/3151/2478/Service_Delivery_System_Trauma_Policy_062024.pdf.org/application/files/8117/3151/2478/Service_Delivery_System_Trauma_Policy_062024.pdf](https://midstatehealthnetwork.org/application/files/8117/3151/2478/Service_Delivery_System_Trauma_Policy_062024.pdf.org/application/files/8117/3151/2478/Service_Delivery_System_Trauma_Policy_062024.pdf)

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~~Veteran Services (Tammy)~~

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 \(va.gov\)](https://va.gov/locations/)

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 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
 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 ~~(Jodie)~~

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 their 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 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 should ask the client if it is okay to transfer them and explains the reasoning for the transfer. This allows the client to understand they are 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 they have 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.” Should be documented in client's record.

Women’s Specialty Services (WSS) & Enhanced Women’s Specialty Services (EWSS)

MSHN-designated Women’s Specialty Services (WSS) and Enhanced Women’s Specialty Services (EWSS) providers shall comply with all applicable federal and state requirements, including 45 CFR Part 96, Subpart L; MDHHS Women’s Treatment Services Policy P-T-12; MDHHS Enhanced Women’s Services Technical Advisory TA-T-08; MDHHS Fetal Alcohol Spectrum Disorders (FASD) Treatment Policy #11; MDHHS SUD Case Management Policy P-T-08; and applicable MSHN contractual requirements.

A. Priority Population Identification and Access: Providers shall identify, document, track, and prioritize access and admission for applicable SUD priority populations consistent with federal and MDHHS requirements, including:

- Pregnant injecting drug users;
- Pregnant individuals with a substance use disorder;
- Injecting drug users;
- Parents/guardians at risk of losing custody of children due to substance use; and
- Other priority populations established by MDHHS requirements.

Pregnant women and parenting women who meet applicable priority-population criteria shall be clearly distinguished and documented as priority populations within screening, assessment, clinical records, and applicable reporting systems.

Providers shall ensure required screening, referral, admission, interim services, and linkage to care within applicable federal and MDHHS access standards.

B. Required Women’s Specialty Services: Consistent with 45 CFR 96.124(c) and (e), providers receiving funding from the state-administered funds set aside for pregnant and postpartum women and women with dependent children must provide or arrange for the following five (5) types of services:

1. Primary medical care, including referral for prenatal care and, while the women are receiving such services, childcare.
2. Primary pediatric care, including immunizations, for their children.
3. Gender-specific substance abuse treatment and other therapeutic interventions for women, which may address issues of relationships, sexual and physical abuse, and parenting, and childcare while the women are receiving such services.
4. Therapeutic interventions for children in the custody of women in treatment, which may, among other things, address their developmental needs, their issues of sexual and physical abuse, and neglect.
5. Sufficient case management and transportation to ensure that women and their children have access to the services provided.

Providers shall ensure WSS are gender-responsive, trauma-informed, family-centered, culturally responsive, strength-based, and recovery-oriented. Services shall address the individual and

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family's identified strengths and needs, including, as applicable, parenting and family functioning, relationships, trauma and abuse, child development, physical and behavioral health, recovery supports, and barriers to treatment.

C. Assessment, Documentation, and Service Coordination: Assessment shall be an ongoing, strength-based process that considers the individual within the family context. Providers shall document, as applicable;

- Priority-population and parenting status;
- Individual strengths and identified needs;
- Dependent children and their developmental, behavioral, medical, and therapeutic needs;
- Family functioning and natural/community supports;
- Trauma, abuse, violence, and safety needs;
- Physical and behavioral health needs;
- Childcare and transportation needs;
- Referrals, linkages, and care-coordination activities;
- Interim services when immediate admission is unavailable; and
- Progress and changes in needs throughout the treatment episode.

Providers shall coordinate services across systems as needed and document referrals and outcomes. WSS requirements for arranging medical/pediatric care and transportation are considered care coordination and may also be delivered within an appropriately established SUD case management program.

D. Enhanced Women's Specialty Services: EWSS provides enhanced, long-term, community-based case management and advocacy in addition to required WSS services. Providers shall follow MDHHS TA-T-08 regarding eligibility, enrollment, service intensity, peer advocate requirements, community-based service delivery, transportation, engagement/re-engagement, coordination with family and other providers, and other program requirements.

EWSS shall provide case management services for eligible individuals for up to three (3) years postpartum, as applicable under MDHHS requirements. Documentation shall demonstrate ongoing engagement and outreach, care coordination, recovery-support linkage, reassessment of needs, and other required EWSS activities throughout the period of service.

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E. FASD Prevention, Screening, and Referral: Providers serving women shall incorporate FASD prevention and education consistent with MDHHS Treatment Policy #11. When providers have contact with children during their mother's/primary caregivers treatment episode, required FASD prescreening shall be completed and appropriate referrals made for further diagnostic evaluation and services when indicated.

F. Staff Training and Documentation: Providers shall ensure staff delivering WSS/EWSS services meet applicable MDHHS gender-specific education, training, supervision, and competency requirements. Providers shall maintain documentation of required education, training, supervised experience, and/or other approved qualifications in personnel files.

Training and competency areas shall include applicable requirements related to gender-responsive treatment, trauma-informed care, relationships, parenting and child development, cultural responsiveness, women and addiction, FASD, recovery-oriented engagement, and other requirements established by MDHHS policy or technical advisory.

Training documentation shall be maintained and made available to MSHN and MDHHS upon request.

G. Interim Services: When immediate admission is unavailable, providers shall provide or arrange required interim services within applicable federal and MDHHS timelines. Interim services shall be based on priority-population requirements and may include early intervention clinical services; HIV and tuberculosis education; education regarding risks associated with injection drug use and transmission to partners or infants; education regarding the effects of alcohol and drug use during pregnancy; prenatal care referral; and other required engagement and linkage activities.

Related MDHHS Resources: Women's Treatment Services Policy P-T-12; Enhanced Women's Services Technical Advisory TA-T-08; FASD Treatment Policy #11; and SUD Case Management Policy P-T-08. MDHHS SUD Treatment Policies to support WSS/EWS can be found here.

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FINANCE AND CLAIMS

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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 \$1,000,000 in a fiscal year.

Medicaid Verification/Reimbursement

The provider, upon admitting a client record into the REMI system, is responsible for determining 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, 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 Stacey Lehmann, Data and Grant Coordinator at Stacey.Lehmann@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 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: Evan.Godfrey@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: 844-405-3095/217-4005
E-mail: um@midstatehealthnetwork.org

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, 1.5, 1.7, 2.1, 2.5, and 2.7) 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 outpatient providers are required to utilize the [Request for Services \(RFS\)](#) and the [Level of Care Screening Determination](#) 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.

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Individuals seeking SUD treatment services have the right to choose their preferred treatment provider from the available options. When outpatient providers or MSHN Access Staff perform a 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. 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:~~ Medical necessity and level of care determinations shall align with the latest version of the ASAM Criteria and reflect current clinical standards.
 - 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.

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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:

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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: 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 recommended timeframes for submitting authorizations are within 3 business days of admission for all outpatient authorizations. 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 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 7~~14~~ days of the date the authorization request was submitted. If an authorization decision is not reached within 14~~7~~ 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. 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 Access 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 reflect 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 <https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/reporting> in the REMI Help menu). 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~~ The discharge form in REMI should reflect 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@midstatehealthnetwork.org

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

MSHN Access Assistant: Amanda, Lewis, Amanda.lewis@midstatehealthnetwork.org

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

MSHN Access Assistant: Jasmine Washington, Jasmine.Washington@midstatehealthnetwork.org

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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

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MSHN Access Process/Procedure:

MSHN has implemented partial centralization of access for withdrawal management, residential treatment, and recovery housing services to improve operational efficiency and enhance the overall experience for individuals seeking care.

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New Access Procedures

Individuals seeking withdrawal management, residential treatment, and recovery housing services must contact the MSHN SUD Access Department at **(844) 405-3095**.

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Providers must direct all requests for withdrawal management, residential treatment, and recovery housing services to MSHN Access. Providers are required to obtain prior authorization from the MSHN SUD Access Department before admitting individuals to withdrawal management, residential treatment, or recovery housing services.

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Access procedures for outpatient levels of care (ASAM 1.0 and 2.1 Levels of Care) remain unchanged. Individuals seeking these services may continue to connect directly with the SUD provider network and/or local Community Mental Health Service Programs (CMHSPs), as appropriate.

If an individual receiving SUD outpatient services requires recovery housing, they must contact the MSHN Access Team for assistance. If a higher level of care is needed, including withdrawal management or residential treatment, the outpatient provider may assist with the referral process.

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

A. Emergency and After-Hours Access to Services

If 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
- After-hours calls for residential treatment, withdrawal management, and recovery housing services are supported through MSHN's designated after-hours coverage provider. The after-hours contact number remains (844) 405-3095, which connects callers to immediate assistance.
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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, they are 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 they receive a bill from the provider or have any other concerns or questions regarding the denial of payment for services process.

Providers are first encouraged to contact a MSHN UM Specialist before 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, 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 receiving 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.

Appendix A: Recovery Housing Technical Requirement ~~(Sherrie)~~

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~~ → here)

Admission Process

All recovery housing admissions will be screened through the REMI Request for Service and Level of Care tabs by the provider. Provider will then send a message in REMI to Access the Recovery Housing distribution list 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). Information in the REMI ~~email to Access~~ message must include:

- Person's name
- Date of birth
- Any recent treatment reported by the person
- Typical use pattern
- Last date of use
- Proposed admission date.

Commented [KF62]: This link needs to be updated.

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Commented [CM64]: Cammie will update this- working on a finalized version.

The ~~Access~~Utilization Management (UM) Department will review the information in REMI and provide an authorization to the recovery house if the person is 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"](#) ~~Recovery Housing Best Practices~~ for additional information).

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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](#).

Commented [KF67]: Is this the most updated version? It's from 2022.

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Commented [SD69]: Added needs assessment language

The provider of the recovery house will maintain a file on each individual admitted. A needs assessment should be completed upon admission to the recovery house which should identify strengths and areas for improvement that will drive the individualized recovery plan. 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. 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 physician's 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 -Request for Service completed in REMI
- Signed client acknowledgement of discussion and receipt of recovery housing rules and expectations
- Needs assessment
- 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

Commented [SD70]: Added Needs Assessment

It is the expectation of MSHN that individuals who meet recovery criteria will be admitted to services regardless of their participation in a MAT/MOUD 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 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.

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Utilization Patterns

Recovery housing providers will submit-receive 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.

Peer Recovery Support Services (PRSS) will be billed in REMI using the H0038 for those who are State Certified Peer Coaches and T1012 codes for those coaches not meeting the State Certification criteria, but who are CCAR certified.

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.
- Discharge Policy

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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/MOUD-inclusion: MAT/MOUD treatment is another vital resource needed by many individuals, particularly those with an opioid use disorder. MOUD 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/MOUD. 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/MOUD to the SAMHSA "Know Your Rights" brochure <https://narronline.org/wp-content/uploads/2018/06/Know-Your-Rights-Brochure-0110.pdf> <https://narronline.org/wp-content/uploads/2018/06/Know-Your-Rights-Brochure-0110.pdf> NARR- Know Your Rights in https://www.samhsa.gov/sites/default/files/programs_campaigns/medication-assisted/Know-Your-Rights-Brochure.pdf SAMHSA Know Your Rights 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 MAT/MOUD. If technical assistance is needed regarding how to integrate people on MAT/MOUD 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 to the lead treatment specialist assigned to the provider 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:

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- 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>)
- [http://www.midstatehealthnetwork.org/provider-network/docs/Finance - Income Eligibility 10-08-2015.pdf](http://www.midstatehealthnetwork.org/provider-network/docs/Finance_-_Income_Eligibility_10-08-2015.pdf) SUD Treatment- Income Eligibility & Fee Determination
[https://midstatehealthnetwork.org/application/files/8415/3021/4996/Finance-SUD Income Eligibility and Fee Determination Procedure 2.0 Clean.pdf](https://midstatehealthnetwork.org/application/files/8415/3021/4996/Finance-SUD_Income_Eligibility_and_Fee_Determination_Procedure_2.0_Clean.pdf)
- Mid-State Health Network Substance Use Disorder Provider Manual
[https://midstatehealthnetwork.org/application/files/8717/3808/0822/FY25 SUD Provider Manual 10.1.24.pdf](https://midstatehealthnetwork.org/application/files/8717/3808/0822/FY25_SUD_Provider_Manual_10.1.24.pdf) MSHN Provider Manual
- Michigan Association of Recovery Residences (<https://narronline.org/cm-business/michigan-association-of-recovery-residences/>) MARR

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Appendix B: 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.



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)					
Opioid Maintenance Medication (Buprenorphine/Methadone)		Opioid Blocking Medication Vivitrol (Naltrexone)		Abstinence-Based Treatment	
Benefits	Risks/Limitations	Benefits	Risks/Limitations	Benefits	Risks/Limitations
1. Medications are safe when used as prescribed by a medical professional. 2. Medications can reduce use of illicit drugs and other criminal activity. 3. Medications can help patients stay in treatment longer (which is the best indicator of successful recovery).	1. Patients don't always take medications as prescribed. 2. Medications can have side effects. 3. Medications can be expensive.	1. Medications block the "high" associated with opioid use. 2. Patient makes a commitment each month to the naltrexone and their MAT. 3. No injection or withdrawal associated with naltrexone.	1. Some patients are not comfortable with injections. 2. Might be associated with depression in a low percentage of patients. 3. A patient must wait a week or longer from last opioid use to start naltrexone.	1. Some patients don't take their medications. 2. Abstinence allows a person to travel and not be tied to their MAT (medication) source. 3. Many 12-Step fellowships encourage abstinence. 4. Recovery programs for professionals (like pilots and doctors) for whom job safety is critical are often abstinence-based and often successful. 5. There is less stigma associated with an	1. Detoxification without and cravings make relapse a higher probability. 2. Patients are left without potential protection from overdose. 3. Abstinence-based programs require a strong ongoing commitment that may falter or be unattainable to some who could easily experience overdose & death. 4. Such professional recovery programs are often expensive and out of reach of most people with OUD. 5. High quality, long term abstinence based programs offering continuity of care with
4. Medications can stabilize patients and reduce craving. 5. Medications can reduce relapse.	4. There is stigma associated with taking medication. 5. Some medications, when combined with other non-prescribed	4. Successfully reduces cravings and relapses in many patients. 5. Can protect patients by blocking potential	4. Will block the effect of opioid medications to treat pain. 5. A high enough dose of Vivitrol or other opioids might override the		

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



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 (Mavixone)		Benefits	Risks/Limitations
Benefits Over time to build confidence as patients re-integrate into family, work and together the therapies.	Risks/Limitations Addictive and can be hard to taper from.	Benefits Help patients stay in a recovery program.	Risks/Limitations Patients with severe liver disease.		
8. Buprenorphine binds tightly to opioid receptors and if used correctly may protect against opioid overdose.	8. Buprenorphine will not protect against overdosing on drugs or 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 degree of opioid withdrawal or it may irritate the entire wall.	9. The full form of maintenance is less expensive and can be used both before and after a course of the extended form.	9. If the full form is used a commitment to recovery must be made daily and use of the full form needs 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 buprenorphine to provide breakable relief.	10. With injury or pain management, physicians might have to be inpatient in the hospital by physicians to provide take 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 D: Incarcerated Services Technical Requirement ~~(Kate, Cammie,~~ Christina)

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 or Medication for Opioid Use Disorders) 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 regular authorizations approved by a member of the Utilization Management (UM) Team. Please see the current Incarcerated Services Benefit Plans located in the REMI Help Menu.
- 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 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 Christina.Romero@midstatehealthnetwork.org
- All appointment dates and times will be documented in the REMI system for each consumer in their 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.

Medication Assisted Treatment & Medications for Opioid Use Disorders Treatment (MOUD) Specific Guidelines: ~~-(Kate)~~

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/MOUD 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 provide MAT/MOUD services in an incarcerated setting, please contact your Treatment Specialist at MSHN.

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

For individuals who are receiving MAT/MOUD 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 authorizations 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/MOUD, the guidelines are as follows:

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

Utilization Management Guidelines: ~~(Cammie)~~

- Please refer to the Incarcerated Services Benefit Plan located in the REMI Help menu and on the MSHN website. The benefit plan provides detailed authorization information, including specific HCPC/CPT codes and number of units that can be authorized for this level of care.
- Providers can submit authorization requests in REMI for a maximum of 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/MOUD for pregnant individuals,
 - Initiation of MAT/MOUD for individuals experiencing moderate to severe withdrawal symptoms upon admission to jail,
 - Continuation of MAT/MOUD for individuals who were receiving MAT/MOUD 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.

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Sources:

[MDHHS: SUPPORT Act Section 1003: Exploring Michigan's SUD Treatment Capacity & Access](#)

[Medicaid Provider Manual](#)

[Michigan Legislature](#)

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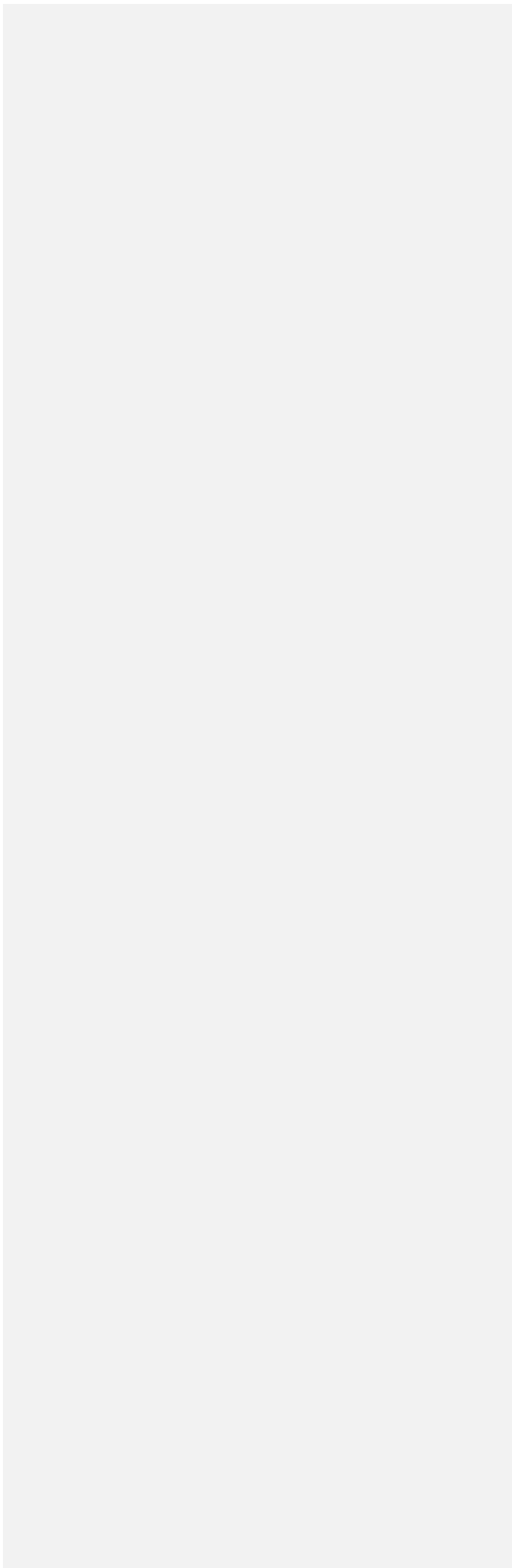
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Appendix E: Residential Programs Food Assistance Program (FAP) Benefit Use (Kate/Dan)

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.
- Community substance abuse treatment agencies **MUST** apply to be Title 19-compliant certified substance abuse treatment facilities able to handle food stamps to utilize a member's FAP benefits. Agencies must apply to be a food stamp retailer. Information can be found at: <https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/drugcontrol/treatment> under *Certifying Substance Abuse Treatment Facilities as Title XIX Compliant*.
- Title 19-compliant certified substance abuse treatment facilities should follow 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.
- Title 19-compliant facilities authorized to use FAP benefits are **expected** to have a process 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.

Appendix F: Non-Emergency Medical Transportation (PLACEHOLDER)

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Appendix G: Culturally Effective Organizational Self-Assessment (PLACEHOLDER)

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