INCLUSION PRACTICE GUIDELINE

Normalization: means rendering services in an environment and under conditions that are culturally normative. This approach not only maximizes an individual's opportunities to learn, grow and function within generally accepted patterns of human behavior but it also serves to mitigate social stigma and foster inclusion.

Self-determination: means the right of a recipient to exercise his or her own free will in deciding to accept or reject, in whole or in part, the services which are being offered. Individuals cannot develop a sense of dignity unless they are afforded the freedom and respect that comes from exercising opportunities for self-determination.

Self-representation: means encouraging recipients, including those who have guardians or employ the services of advocates, to express their own point of view and have input regarding the services that are being planned or provided by the RMHA.

V. STANDARDS

a. Responsible PIHPs and CMHSPs shall design their programs and services to be congruent with the norms of their community.

   This includes giving first consideration to using a community's established conventional resources before attempting to develop new ones that exclusively or predominantly serve only mental health recipients.

   Some of the resources which can be used to foster inclusion, integration and acceptance include the use of the community's public transportation services, leisure and recreation facilities, general health care services, employment opportunities (real work for real pay), and traditional housing resources.

b. PIHPs and CMHSPs shall organizationally promote inclusion by establishing internal mechanisms that:
   i. assure all recipients of mental health services will be treated with dignity and respect.
   ii. assure all recipients, including those who have advocates or guardians, have genuine opportunities for consumer choice and self-representation.
   iii. provide for a review of recipient outcomes.
   iv. provide opportunities for representation and membership on planning committees, work groups, and agency service evaluation committees.
   v. invite and encourage recipient participation in sponsored events and activities of their choice.

INCLUSION PRACTICE GUIDELINE

c. PIHPs and CMHSPs shall establish policies and procedures that support the principle of normalization through delivery of clinical services and supports that:
   i. address the social, chronological, cultural, and ethnic aspects of services and outcomes of treatment.
   ii. help recipients gain social integration skills and become more self reliant.
   iii. encourage and assist adult recipients to obtain and maintain integrated, remunerative employment in the labor market(s) of their communities, irrespective of their disabilities. Such assistance may include but is not limited to helping them develop relationships with co-workers both at work and in non-work situations. It also includes making use of assistive technology to obtain or maintain employment.
   iv. assist adult recipients to obtain/ maintain permanent, individual housing integrated in residential neighborhoods.
   v. help families develop and utilize both informal interpersonal and community based networks of supports and resources.
   vi. provide children with treatment services which preserve, support and, in some instances, create by means of adoption, a permanent, stable family.

d. PIHP and CMHSPs shall establish procedures and mechanisms to provide recipients with the information and counsel they need to make informed treatment choices. This includes helping recipients examine and weigh their treatment and support options, financial resources, housing options, education and employment options. In some instances, this may also include helping recipients:
   i. learn how to make their own decisions and take responsibility for them.
   ii. understand his or her social obligations.

VI. **REFERENCES AND LEGAL AUTHORITY**

MCL 330.116, et seq. MCL 330.1704, et seq.

HOUSING PRACTICE GUIDELINE

NOTE: Replicated from the MDHHS Housing Guideline as included in the Public Mental Health Manual, Volume III, Section 1708, Subject GL-05, Chapter 07-C, Dated 2/14/95.

I. SUMMARY

This guideline establishes policy and procedure for ensuring that the provision of mental health services and supports are not affected by where consumers choose to live: their own home, the home of another or in a licensed setting. In those instances when public money helps subsidize a consumer's living arrangement, the housing unit selected by the consumer shall comply with applicable occupancy standards.

II. APPLICATION

a. Psychiatric hospitals operated by the Michigan Department of Health and Human Services (MDHHS).
b. Special facilities operated by MDHHS.
c. Prepaid Inpatient Health Plans (PIHPs) and Community Mental Health Services Programs (CMHSPs) as specified in their contracts with MDHHS.

III. POLICY

The Michigan Department of Health and Human Services recognizes housing to be a basic need and affirms the right of all consumers of public mental health services to pursue housing options of their choice. Just as consumers living in licensed dependent settings may require many different types of services and supports, persons living in their own homes or sharing their household with another may have similar service needs. RHMAs shall foster the provision of services and supports independent of where the consumer resides.

When requested, RHMAs shall educate consumers about the housing options and supports available, and assist consumers in locating habitable, safe, and affordable housing. The process of locating suitable housing shall be directed by the consumer's interests, involvement and informed choice. Independent housing arrangements in which the cost of housing is subsidized by the PIHP and CMHSP are to be secured with a lease or deed in the consumer's name.

This policy is not intended to subvert or prohibit occupancy in or participation with community based treatment settings such as an adult foster care home when needed by an individual recipient.

IV. DEFINITIONS

Affordable: is a condition that exists when an individual's means or the combined household income of several individuals is sufficient to pay for food, basic clothing, health care, and personal needs and still have enough left to cover all housing related costs including rent/mortgage, utilities, maintenance, repairs, insurance and property taxes. In situations

where there are insufficient resources to cover both housing costs and basic living costs, individual housing subsidies may be used to bridge the gap when they are available.

Habitable and safe: means those housing standards established in each community that define and require basic conditions for tenant/resident health, security, and safety.

Housing: refers to dwellings that are typical of those sought out and occupied by members of a community. The choices a consumer of mental health services makes in meeting his or her housing needs are not to be linked in any way to any specific program or support service needs he or she may have.

Responsible Mental Health Agency (RMHA): means the MDHHS hospital, center, PIHP or CMHSP responsible for providing and contracting for mental health services and/or arranging and coordinating the provision of other services to meet the consumer's needs.

V. **STANDARDS**

RMHAs shall develop policies and create mechanisms that give predominant consideration to consumers' choice in selecting where and with whom they live. These policies and mechanisms shall also:

A. Ensure that RMHA-supported housing blends into the community. Supported housing units are to be scattered throughout a building, a complex, or the community in order to achieve community integration when possible. Use of self-contained campuses or otherwise segregated buildings as service sites is not the preferred mode.

B. Promote and support home ownership, individual choice, and autonomy. The number of people who live together in RMHA-supported housing shall not exceed the community's norms for comparable living settings.

C. Assure that any housing arranged or subsidized by the RMHA is accessible to the consumer and in compliance with applicable state and local standards for occupancy, health, and safety.

D. Be sensitive to the consumer's cultural and ethnic preferences and give consideration to them.

E. Encourage and support the consumer's self-sufficiency.

F. Provide for ongoing assessment of the consumer's housing needs.

G. Provide assistance to consumers in coordinating available resources to meet their basic housing needs. RMHAs may give consideration to the use of housing subsidies when

consumers have a need for housing that cannot be met by the other resources which are available to them.

VI. **REFERENCES AND LEGAL AUTHORITY**

MCL 330.1116(j)

VII. **EXHIBITS**

Federal Housing Subsidy Quality Standards based on 24 CFR § 882.10

CONSUMERISM PRACTICE GUIDELINE

I. SUMMARY

This guideline sets policy and standards for consumer inclusion in the service delivery design and delivery process for all public mental health services. This guideline ensures the goals of a consumer-driven system which gives consumers choices and decision-making roles. It is based on the active participation by primary consumers, family members and advocates in gathering consumer responses to meet these goals.

This participation by consumers, family members and advocates is the basis of a provider's evaluation. Evaluation also includes how this information guides improvements.

II. APPLICATION

A. Psychiatric hospitals operated by the Michigan Department of Health and Human Services (MDHHS).
B. Centers for persons with developmental disabilities and community placement agencies operated by the MDHHS.
C. Children's psychiatric hospitals operated by the MDHHS.
D. Special facilities operated by the MDHHS.
E. Community Mental Health Services Programs (CMHSPs) and Prepaid Inpatient Health Plans under contract with MDHHS.
F. All providers of mental health services who receive public funds, either directly or by contract, grant, third party payers, including managed care organizations or other reimbursements.

III. POLICY

This policy supports services that advocate for and promote the needs, interests, and well-being of primary consumers. It is essential that consumers become partners in creating and evaluating these programs and services. Involvement in treatment planning is also essential.

Services need to be consumer-driven and may also be consumer-run. This policy supports the broadest range of options and choices for consumers in services. It also supports consumer-run programs which empower consumers in decision-making of their own services.

All consumers need opportunities and choices to reach their fullest potential and live independently. They also have the rights to be included and involved in all aspects of society.

Accommodations shall be made available and tailored to the needs of consumers as specified by consumers for their full and active participation as required by this guideline.

IV. DEFINITIONS

Informed Choice: means that an individual receives information and understands his or her options.

Primary Consumer: means an individual who receives services from the Michigan Department of Health and Human Services , Prepaid Inpatient Health Plan or a Community Mental Health Services Program. It also means a person who has received the equivalent mental health services from the private sector.

Consumerism: means active promotion of the interests, service needs, and rights of mental health consumers.

Consumer-Driven: means any program or service focused and directed by participation from consumers.

Consumer-Run: refers to any program or service operated and controlled exclusively by consumers.

Family Member: means a parent, stepparent, spouse, sibling, child, or grandparent of a primary consumer. It is also any individual upon whom a primary consumer depends for 50 percent or more of his or her financial support.

Minor: means an individual under the age of 18 years.

Family Centered Services: means services for families with minors which emphasize family needs and desires with goals and outcomes defined. Services are based on families' strengths and competencies with active participation in decision-making roles.

Person-Centered Planning: means the process for planning and supporting the individual receiving services. It builds upon the individual's capacity to engage in activities that promote community life. It honors the individual's preferences, choices, and abilities.

Person-First Language: refers to a person first before any description of disability.

Recovery: means the process of personal change in developing a life of purpose, hope, and contribution. The emphasis is on abilities and potentials. Recovery includes positive expectations for all consumers. Learning self-responsibility is a major element to recovery.

V. STANDARDS

A. All services shall be designed to include ways to accomplish each of these standards.

1. "Person-First Language" shall be utilized in all publications, formal communications, and daily discussions.
2. Provide informed choice through information about available options.
3. Respond to an individual's ethnic and cultural diversities. This includes the availability of staff and services that reflect the ethnic and cultural makeup of the service area. Interpreters needed in communicating with non-English and limited-English-speaking persons shall be provided.

4. Promote the efforts and achievements of consumers through special recognition of consumers.
5. Through customer satisfaction surveys and other appropriate consumer related methods, gather ideas and responses from consumers concerning their experiences with services.
6. Involve consumers and family members in evaluating the quality and effectiveness of service. Administrative mechanisms used to establish service must also be evaluated. The evaluation is based upon what is important to consumers, as reported in customer satisfaction surveys.
7. Advance the employment of consumers within the mental health system and in the community at all levels of positions, including mental health service provision roles.

B. Services, programs, and contracts concerning persons with mental illness and related disorders shall actively strive to accomplish these goals.

1. Provide information to reduce the stigma of mental illness that exists within communities, service agencies, and among consumers.
2. Create environments for all consumers in which the process of "recovery" can occur. This is shown by an expressed awareness of recovery by consumers and staff.
3. Provide basic information about mental illness, recovery, and wellness to consumers and the public.

C. Services, programs, and contracts concerning persons with developmental disabilities shall be based upon these elements.

1. Provide personal preferences and meaningful choices with consumers in control over the choice of services and supports.
2. Through educational strategies: promote inclusion, both personal and in the community; strive to relieve disabling circumstances; actively work to prevent occurrence of increased disability; and promote individuals in exercising their abilities to their highest potentials.
3. Provide roles for consumers to make decisions in polices, programs, and services that affect their lives including person-centered planning processes.

D. Services, programs, and contracts concerning minors and their families shall be based upon these elements:

1. Services shall be delivered in a family-centered approach, implementing comprehensive services that address the needs of the minor and his/her family.
2. Services shall be individualized and respectful of the minor and family's choice of services and supports.
3. Roles for families to make decisions in policies, programs and services that affect their lives and their minor's life.

E. Consumer-run programs shall receive the same consideration as all other providers of mental health services. This includes these considerations:

1. Clear contract performance standards.
2. Fiscal resources to meet performance expectations.
3. A contract liaison person to address the concerns of either party.
4. Inclusion in provider coordination meetings and planning processes.
5. Access to information and supports to ensure sound business decisions.

F. Current and former consumers, family members, and advocates must be invited to participate in implementing this guideline. Provider organizations must develop collaborative approaches for ensuring continued participation.

Organizations' compliance with this guideline shall be locally evaluated. Foremost, this must involve consumers, family members, and advocates. Providers, professionals, and administrators must be also included. The CMHSP shall provide technical assistance. Evaluation methods shall provide constructive feedback about improving the use of this guideline. This guideline requires that it be part of the organizations' Continuous Quality Improvement.

VI. REFERENCES AND LEGAL AUTHORITY

Act 258, Section 116(e), Public Acts of 1974 as amended, being MCL 330.1116, 1704, 1708.

PERSONAL CARE IN NON-SPECIALIZED RESIDENTIAL SETTINGS TECHNICAL REQUIREMENT

NOTE: Replicated from the MDHHS Personal Care in Non-Specialized Residential Settings Guideline as included in the Public Mental Health Manual, Volume 01-C, Section 11 16(j), Subject GL-00, Chapter 01, Dated 10/9/96.

I. SUMMARY

This guideline establishes operational policy; program and clinical documentation requirements for issuing payments through the Adult Services Automated Payment (ASAP) (formerly Model Payment Program) program for mental health recipients who need personal care services when placed in a non-specialized residential foster care setting.

II. APPLICATION

A. Community Mental Health Services Programs (CMHSPs) and Prepaid Inpatient Health Plans (PIHPs) as specified in their contracts with the Michigan Department of Health and Human Services (MDHHS).

B. Psychiatric Hospitals and Centers operated by, or under contract with the MDHHS.

C. Special facilities operated by the MDHHS.

D. Children's units operated by the MDHHS.

III. POLICY

Upon placement of a mental health recipient into a non-specialized residential foster care setting, the Responsible Mental Health Agency (RMHA) shall insure that any need for personal care services are identified in their plan is addressed in keeping with Medicaid (MA) standards. In addition, RMHA shall take the required action(s) to further insure that payment(s) for personal care services are issued, and all payment problems are resolved.

IV. DEFINITIONS

Client Services Management: a related set of activities which link the recipient to the public mental health system and which staff coordinate to achieve a successful outcome.

Family Member: means a parent or step-parent of a minor child or spouse.

Individual Plan of Service (IPS): a written plan which identifies mental health services; as defined in Section 712, Act 290 of the Public Acts of 1995.

Medicaid (MA) Designated Case Manager: case manager must be either a qualified mental retardation professional (QMRP) as defined in 42 CFR 483.430, or a qualified mental health professional (QMHP) as defined in Michigan's Medicaid Provider Manual.

Non-Specialized Residential Foster Care Setting: a licensed dependent living arrangement which provides room, board and supervision, but does not provide in-home specialized mental health services.

Personal Care Services: services provided in accordance with an individualized plan of service that assist a recipient by hands-on assistance, guiding, directing, or prompting of Personal Activities of Daily Living (PADL) in at least one of the following activities:

A. EATING/FEEDING: the process of getting food by any means from the receptacle(plate, cup, glass) into the body. This item describes the process of eating after food is placed in front of an individual.

B. TOILETING: the process of getting to and from the toilet room for elimination of feces and urine, transferring on and off the toilet, cleansing self after elimination, and adjusting clothes.

C. BATHING: the process of washing the body or body parts, including getting to or obtaining the bathing water and or equipment, whether this is in bed, shower or tub.

D. GROOMING: the activities associated with maintaining personal hygiene and keeping one's appearance neat, including care of teeth, hair, nails, skin, etc.

E. DRESSING: the process of putting on, fastening and taking off all items of clothing, braces and artificial limbs that are worn daily by the individual, including obtaining and replacing the items from their storage area in the immediate environment. Clothing refers to the clothing usually worn daily by the individual.

F. TRANSFERRING: the process of moving horizontally and or vertically between the bed, chair, wheelchair and or stretcher.

G. AMBULATION: the process of moving about on foot or by means of a device with wheels.

H. ASSISTANCE WITH SELF-ADMINISTERED MEDICATION: the process of assisting the client with medications that are ordinarily self-administered, when ordered by the client's physician.

V. STANDARDS

A. Recipient must be Medicaid active during effective dates of service.

B. Providers of non-specialized residential services must be licensed and meet minimum requirements of the Michigan Department of Human Services (MDHS) and MDHHS as defined and contained therein, Act 117, Public Acts of 1973, as amended and Act 2 18, Public Acts of 1979, as amended, for non-specialized residential settings such as: homes for the aged, adult foster care family home, adult foster care small group home, adult foster care large group home, adult foster care congregate facility, foster family home, foster family group home, and child caring institutions.

C. Personal care services are covered when ordered by a physician or Medicaid (MA) designated case manager based upon face to face contact with recipient, and in accordance an Individual Plan of Service (IPS) and rendered by a qualified person who is not a member of the individual family.

D. Supervision of personal care services is required, and may be provided by a registered nurse, physician assistant, a MA designated case manager supervisor or a MA designated case manager other than the case manager who ordered services. Supervision of personal care services is a two-part/sign-off process which includes:

1. Approval of covered personal care services, occurs after a Medicaid designated case manager or physician has ordered personal care services, which must be either written in the IPS or on a program approved form.

2. A re-evaluation or review of personal care services must occur within a calendar year of the last plan for personal care services or last re-evaluation or review whichever occurred last, based upon either a face-to-face contact with recipient or an administrative review of plan of service. A Medicaid designated case manager shall initiate a re-evaluation or review on a program approved form.

E. Provider of service must maintain a service log that documents specific days on which personal care services were delivered consistent with the recipients individual plan of services.

F. Compliance with the Personal Care/Adult Services Automated Payment standards of MDHHS.

VI. REFERENCES AND LEGAL AUTHORITY

A. Social Security Act, Section 1905(a) (17).
B. 42 CFR 440.170 and 42 CFR 483.430.
C. Act 258 of the Public Acts of 1974 (MCLA -330.1 116) and Act 290 of the Public Acts of 1995 (MCLA -330.1712).
D. Michigan's Medicaid' state provisions for Title XIX of the Social Security Act.
E. Michigan Department of Health & Human Services, Service Manual, Adult and Family Services Item -314 and 372. Home Help Adult, Community Placement and Personal Care Services. Adults Foster Care (AFC) and Homes for the Aged (HA), Personal Care/Supplemental Payments.

F. Michigan Department of Health and Human Services, Personal Care/Adult Services Automated Payment Manual, 1996.

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES (MDHHS) BEHAVIORAL HEALTH & DEVELOPMENTAL DISABILITIES ADMINISTRATION FAMILY-DRIVEN AND YOUTH-GUIDED POLICY AND PRACTICE GUIDELINE

A. Summary/Background

The purpose of this policy guideline is to establish standards for the Prepaid Inpatient Health Plans (PIHPs), Community Mental Health Services Programs (CMHSPs) and their contract agencies regarding the delivery of family-driven and youth-guided services and supports for children and their families. This policy guideline will outline essential elements of family-driven and youth-guided policy and practice at the child and family level, system level and peer-delivered level.

Person-centered planning is the method for individuals served by the community mental health system to plan how they will work toward and achieve personally defined outcomes in their own lives. The Michigan Mental Health Code established the right for all individuals to develop individual plans of services through a person-centered planning process regardless of disability or residential setting.

For children and families, the Person-Centered Planning Policy Guideline states: "The Michigan Department of Health and Human Services (MDHHS) has advocated and supported a family-driven and youth-guided approach to service delivery for children and their families. A family-driven and youth-guided approach recognizes that services and supports impact the entire family; not just the identified youth receiving mental health services. In the case of minors, the child and family is the focus of service planning, and family members are integral to a successful planning process. The wants and needs of the child and his/her family are considered in the development of the Individual Plan of Service." As the child matures toward transition age, services and supports should become more youth-guided.

As a result of the effort to develop family-driven and youth-guided services, the Substance Abuse and Mental Health Administration (SAMSHA) in partnership with the Federation of Families for Children's Mental Health, has developed a set principles (described in section C of this policy) which serve as the basis for the delivery of family-driven and youth-guided services. These principles comprise the standards which should guide the delivery of services to children and their families and are essential to development of an effective system of care.

This policy is consistent with the "Application for Renewal and Recommitment (ARR) to Quality and Community in the Michigan Public Mental Health System," as issued by MDHHS on February 1, 2009. The ARR formally introduced new and enhanced

expectations of performance and revitalized MDHHS's commitment to excellence in partnership with PIHPs and CMHSPs.

While agencies are expected to collaborate, they are not intended to be the primary decision-makers on behalf of a child or family. It is important for systems to actively engage families in leading all decisions about the care of their child. Similarly, as appropriate, based on their age and functioning, youth should have opportunities to make decisions about their own care. Family and youth involvement is also important on a broader level, with an expectation that they are active participants in system-level governance and planning (Wilder Foundation, Snapshot: Mental Health Systems of Care for Children, August 2009).

B. Policy

It is the policy of MDHHS that all publicly-supported mental health agencies and their contact agencies shall engage in family-driven and youth-guided approaches to services with children and families and will engage family members and youth at the governance, evaluation, and service delivery levels as key stakeholders.

How this policy will be supported:

- MDHHS staff in partnership with the family organizations will work with PIHPs, CMHSPs, and contract agencies to support successful implementation of the family-driven and youth-driven policy guideline.
- MDHHS will work with other system partners at the state level to ensure PIHPs, CMHSPs and contract agencies can build an effective system of care.\
- Through ARR progress reviews, updates and technical assistance. The different sections of the ARR have applicability to family-driven and youth-guided care, e.g., stakeholder involvement, developing an effective system of care, improving the quality of services and supports, assuring active engagement, etc.

C. Family-Driven and Youth-Guided Principles

Family-driven and youth-guided principles should be measured at several different levels: the child and family level, the system level and the peer-to-peer level. These principles incorporate all levels, and will be detailed under section D: Essential Elements.

- Families and youth, providers and administrators share decision-making and responsibility for outcomes.
- Parents, caregivers and youth are given accurate, understandable, and complete information necessary to set goals and to make informed decisions and choices about the right services and supports for individual children and their family as a whole.
- All children, youth and families (parents) have a biological, adoptive, foster, or surrogate family voice advocating on their behalf.

- Families and family-run organizations engage in peer support activities to reduce isolation, gather and disseminate accurate information, and strengthen the family voice.
- Families and family-run organizations provide direction for decisions that impact funding for services, treatments, and supports and advocate for families and youth to have choices.
- Providers take the initiative to change policy and practice from provider-driven to family-driven and youth-guided.
- Administrators allocate staff, training, support and resources to make family-driven and youth-guided practice work at the point where services and supports are delivered to children, youth and families.
- Community attitude change efforts focus on removing barriers and discrimination crated by stigma.
- Communities and public and private agencies embrace, value, and celebrate the diverse cultures of their children, youth, and families and work to eliminate mental health disparities.
- Everyone who connects with children, youth, and families continually advances their own cultural and linguistic responsiveness as the population served changes so that the needs of diverse populations are appropriately addressed.

D. Essential Elements for Family-Driven and Youth-Guided Care

1. "Family-driven" means that families have a primary decision-making role in the care of their own children as well as the policies and procedures governing care for all children in their community. This includes
    - Being given the necessary information to make informed decisions regarding the care of their children
    - Choosing culturally and linguistically competent supports, services, and providers
    - Setting goals
    - Designing, implementing and evaluating programs
    - Monitoring outcomes
    - Partnering in funding decisions.
2. "Youth-guided" means that young people have the right to be empowered, educated, and given a decision-making role in their own care as well as the policies and procedures governing the care of all youth in the community, state, and nation. A youth-guided approach views youth as experts and considers them equal partners in creating system change at the individual, state, and national level (SAMHSA).
3. "Family-run organization" means advocacy and support organizations that are led by family members with lived experience raising children with SED and/or DD thus creating a level of expertise. These organizations provide peer-to-peer support, education, advocacy, and information/referral services to reduce isolation for family members,

gather and disseminate accurate information so families can partner with providers and make informed decisions, and strengthen the family voice at the child and family level, and systems level.

4. Child and Family-Level Action Strategies:
    - Strength and Culture Discovery – Children, youth and family strengths will be identified and linked to treatment strategies within the plan of service
    - Cultural Preferences – The plan of service will incorporate the cultural preference unique to each youth and family.
    - Access – Children, youth and families are provided usable information to make informed choices regarding services and supports and have a voice in determining the services they receive. Services and supports are delivered in the home and community whenever possible.
    - Voice – Children, youth and families are active participants in the treatment process, their voice is solicited and respected, and their needs/wants are written into the plan in language that indicates their ownership.
    - Ownership – The plan compliments the strengths, culture and prioritized needs of the child, youth and family.
    - Outcome-based – Plans are developed to produce results that the youth and family identify. All services, supports and interventions support outcomes achievement.
    - Parent/Youth/Professional Partnerships – Parents and youth are recognized for having expertise, are engaged as partners in the treatment process, and share accountability for outcomes.
    - Increase Confidence and Resiliency – The plan will identify specific interventions that maximize the strengths of the child, youth, and family, increase the skills of the youth to live independently and advocate for self, and equip the family with skills to successfully navigate systems and manage the needs of their child and family.
    - Participation in Planning Meetings – Youth and families determine who participates in the planning meetings.
    - Crisis and Safety Planning – Crisis and safety plans should be developed to decrease safety risks, increase confidence of the youth and family, and respect the needs/wants of the youth and family.

5. System-level Action Strategies:
    - Agencies have policies that ensure that all providers of services to children, youth, and families incorporate parent/caregivers and youth on decision-making groups. boards and committees that support family-driven and youth-guided practice.

- Agencies have policies that ensure training, support, and compensation for parents and youth who participate on decision-making groups, boards and committees and serve as co-facilitators/trainers.
- Policies are in place within the agency to support employment of youth and parents.
- Youth and parents are part of the program and service design, evaluation, and implementation of services and supports.
- Children, youth and families are provided opportunities to participate in and co-facilitate training and education opportunities.
- Services are delivered where the children, youth and family feel most comfortable and in a way that is relevant to the family culture.
- All stakeholder groups include diverse membership including youth and family members who represent the population the agency/community serves.

6. Peer-delivered Action Strategies:
    - Parents/caregivers, youth who have first-hand experience with the public mental health system are recruited, trained and supported in their role as parent/peer support partners.
    - Family Organizations are involved in the recruiting, supporting, and training of family members and youth peer-to-peer support partners. They may also serve as the contract employers of the parent support partners.
    - Peer-to-peer support models approved by MDHHS for parents and youth are available.

E. Biography

National Technical Assistance and Evaluation Center. A Closer Look: Family Involvement in Public Child Welfare Driven Systems of Care. February 2008

https://www.childwelfare.gov/pubs/acloserlook/familyinvolvement/familyinvolvement.pdf

http://www.samhsa.gov/

ACMH Youth Advisory Council Focus Group (January 16, 2010)

ACMH Staff Retreat (December 14, 2009)

June 7, 2011,

TO: Executive Directors of Prepaid Inpatient Health Plans (PIHPs) and Community Mental Health Services Programs (CMHSPs)

FROM: Cynthia Kelly, Director, Bureau of State Hospitals & Behavioral Health Administrative Operations

SUBJECT: *Employment Works!* Policy

MDHHS recognizes that employment is an essential element of quality of life for most people, including individuals with a serious mental illness or a developmental disability; including persons with the most significant disability. Therefore, it is the policy of MDHHS that:

Each eligible working age individual over 14 years old (to correlate with transition planning and related MDHHS policy 1915(b)/(c) Waiver Program Attachment P.7.10.4.1) and ongoing to the age of their chosen retirement-generally seen as around 65 years old) will be supported to pursue his or her own unique path to work and a career. All individuals will be afforded the opportunity to pursue competitive, integrated work. MDHHS shall define "competitive employment" and "integrated setting" using the definitions of those terms listed in title 34, Code of Federal Regulations, section 361".

- (11) Competitive employment means work-
  - (i) In the competitive labor market that is performed on a full-time or part-time basis in an integrated setting; and
  - (ii) For which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals who are not disabled.

- (33) Integrated setting,--
  - (i) With respect to the provision of services, means a setting typically found in the community in which applicants or eligible individuals interact with non-disabled individuals other than non-disabled individuals who are providing services to those applicants or eligible individuals;
  - (ii) With respect to an employment outcome, means a setting typically found in the community in which applicants or eligible individuals interact with non-disabled individuals, other than non-disabled individuals who are providing services to those applicants or eligible individuals, to the same extent that non-disabled individuals in comparable positions interact with other persons.

Each time a pre-planning meeting is held to prepare for a person's plan of service (at least annually); a person's options for work will be encouraged as noted in Contract Attachment P 4.4.1.1 and will be documented during the pre-planning meeting. After exploration of competitive employment options, it is recognized that some individuals may choose other work options such as Ability One contracts, integrated community group employment, self-employment, transitional employment, volunteering, education/training, or unpaid internships as a means leading to future competitive, integrated work.

In the case of employment for persons with mental illness, MDHHS has adopted the evidence-based practice of Individual Placement and Support (IPS). The definition for the outcome of competitive employment for this specific population remains; individual jobs that anyone can apply for rather than jobs created specifically for people with disabilities. These jobs pay at least minimum wage or the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals who are not disabled. Further, the jobs do not have artificial time limits imposed by the social service agency.

This proposed policy shall support persons with serious mental illness and developmental disabilities to receive services and supports to achieve and maintain competitive employment. It is imperative that this *Employment Works!* Policy be shared and reinforced as an expectation with staff responsible for employment services and outcomes and with all supports coordinators and case managers.

In order to measure employment outcomes, MDHHS will compare baseline numbers for all competitive, integrated employment-both individual and group. Additionally, MDHHS will measure facility-based employment each year. It is expected that the total percentage of individuals competitively employed in integrated settings will increase-both individual, integrated employment and group, integrated employment. It is also expected that as both of these types of employment increase, the percentage of individuals in facility-based employment will decrease. This policy supports the incentive for increased competitive, integrated employment for people with disabilities, as written into contract language.

Expectations for MDHHS:

- Establish a permanent state-level staff member who has responsibility for further development and overseeing its implementation of the *Employment Works!* Policy.
- Provide technical assistance to the field for program implementation and sustainability and to also provide opportunities for training and development.
- Review existing employment data sources, and establish a strategy for collecting and sharing accurate employment outcome data with stakeholders.
- Establish specific employment goals for the PIHP/CMHSP system data.
- Strengthen the strategy and agreements with Michigan Rehabilitation Services (MRS) and the Michigan Commission for the Blind (MCB) to improve the consistency of MRS/MCB supports for PIHP/CMHSP consumers.
- Encourage and promote the use of best employment practices, including employment practices recognized in the most current Medicaid Provider Manual under Supported Employment Services. (Examples include the evidence based supported employment, customized employment, self-employment, etc.)
- Identify CMHSPs with best employment outcomes, learn from their successes, and highlight these practices.
- Assist PIHPs/CMHSPs in developing expertise in benefits planning.
- Strengthen the role of existing employment working group(s) by establishing a standing employment leadership team.

Expectations for PIHPs/CMHSPs:

- Designate a local staff member who shall be responsible for implementation of the *Employment Works!* Policy. Designate this staff member and an alternate to participate in a standing employment leadership team.
- Provide timely and accurate employment outcome data to MDHHS to review and determine employment strategies at least annually.
- Achieve established employment goals/increases.
- Establish strategies and enhance cash match agreements, partnership plus and/or other strategies with MRS and MCB to improve consistency of MRS/MCB supports for PIHP/CMHSP consumers.
- Embrace and promote the use of best employment practices, including EBP SE.
- Share local best employment practices across the PIHP/CMHSP network through conferences, webinars, conference calls, newsletters, cross-agency presentations, etc.
- Designate at least one (preferably two) staff with proven expertise in benefits planning or clear capacity to access timely and accurate information to address immediate employment interests of persons with disabilities.

Adult Jail Diversion Policy Practice Guideline
February 2005

I. Statement of Purpose

There is a general consensus with the principle that the needs of the community and society at large are better served if persons with serious mental illness, serious emotional disturbance or developmental disability who commit crimes are provided effective and humane treatment in the mental health system rather than be incarcerated by the criminal justice system. It is recognized that many people with serious mental illness have a co-occurring substance disorder.

This practice guideline reflects a commitment to this principle and conveys Michigan Department of Health and Human Services (MDHHS) jail diversion policy and resources for Community Mental Health Services Programs (CMHSPs). The guideline is provided as required under the authority of the Michigan Mental Health Code, PA 258 of 1974, Sec. 330.1207 - Diversion from jail incarceration (Add. 1995, Act 290, Effective March 28, 1996).

Section 207 of the Code states:

> "Each community mental health service program shall provide services designed to divert persons with serious mental illness, serious emotional disturbance, or developmental disability from possible jail incarceration when appropriate. These services shall be consistent with policy established by the department."

The guideline outlines CMHSP responsibilities for providing jail diversion programs to prevent incarceration of individuals with serious mental illness or developmental disability who come into contact with the criminal justice system. A separate practice guideline will address Juvenile Diversion of children with serious emotional disturbance.

Jail diversion programs are intended for individuals alleged to have committed misdemeanors or certain, usually non-violent, felonies and who voluntarily agree to participate in the diversion program.

II. Definitions

The following terms and definitions are utilized in this Practice Guideline:

Arraignment: The stage in the court process where the person is formally charged and enters a plea of guilty or not guilty.

Booking: The stage in the law enforcement custody process following arrest, when the individual is processed for formal admission to jail.

CMHSP: Community Mental Health Services Program. A program operated under Chapter 2 of the Mental Health Code as a county mental health agency, a community mental health organization or a community mental health authority.

Co-Occurring Disorder: A dual diagnosis of a mental health disorder and a substance disorder.

MDHHS: Michigan Department of Health and Human Services.

GAINS Center: The National GAINS Center for People with Co-Occurring Disorders in the Justice System is a national center for the collection and dissemination of information about effective mental health and substance abuse services for people with co-occurring disorders who come in contact with the justice system. The GAINS Center is operated by Policy Research Inc. (PRI), through a cooperative agreement administered by the National Institute of Corrections (NIC). (GAINS Center website at www.gainsctr.com).

In-jail Services: Programs and activities provided in the jail to address the needs of people with serious mental illness, including those with a co-occurring substance disorder, or a developmental disability. These programs or activities vary across the state and may include crisis intervention, screening, assessment, diagnosis, evaluation, case management, psychiatric consultation, treatment, medication monitoring, therapy, education and training. Services delivered are based on formal or informal agreements with the justice system.

Jail Diversion Training: Cross training of law enforcement, court, substance abuse and mental health personnel on the diversion system and how to recognize and treat individuals exhibiting behavior warranting jail diversion intervention.

Jail Diversion Program: A program that diverts individuals with serious mental illness (and often co-occurring substance disorder) or developmental disability in contact with the justice system from custody and/or jail and provide linkages to community-based treatment and support services. The individual thus avoids or spends a significantly reduced time period in jail and/or lockups on the current charge. Depending on the point of contact with the justice system at which diversion occurs, the program may be either a **pre-booking or post-booking** diversion program. Jail diversion programs are intended for individuals alleged to have committed misdemeanors or certain, usually non-violent, felonies and who voluntarily agree to participate in the diversion program.

Post-booking Diversion program: Diversion occurs after the individual has been booked and is in jail, out on bond, or in court for arraignment. Often located in local jails or arraignment courts, post- booking jail diversion programs staff work with stakeholders such as prosecutors, attorneys, community corrections, parole and probation officers, community-based mental health and substance abuse providers and the courts to develop and implement a plan that will produce a disposition outside the jail. The individual is then linked to an appropriate array of community-based mental health and substance abuse treatment services.

Pre-booking Diversion Program: Diversion occurs at the point of the individual's contact with law enforcement officers before formal charges are brought and relies heavily on effective interactions between law enforcement officers and community mental health and substance abuse services. Most pre-booking programs are characterized by specialized training for law enforcement officers. Some model programs include a 24-hour crisis drop-off center with a no-refusal policy that is available to receive persons brought in by the law enforcement officers. The individual is then linked to an appropriate array of community-based mental health and substance abuse treatment services.

Screening: Evaluating a person involved with the criminal justice system to determine whether the person has a serious mental illness, co-occurring substance disorder, or a developmental

disability, and would benefit from mental health services and supports in accordance with established standards and local jail diversion agreements.

TAPA Center for Jail Diversion: The Technical Assistance and Policy Analysis Center is a branch of the National GAINS Center focusing on the needs of communities in developing programs to divert people with mental illness from jail into community-based treatment and supports. (TAPA website at www.tapacenter.org).

III. **Background Summary**

During the 1990s, CMHSPs and MDHHS focused resources on development of in-jail and in-detention services. In-jail services provided by most community mental health services program (CMHSPs) included services ranging from crisis intervention, assessment, counseling, consultation, and other mental health services. Some CMHSPs provided similar services in detention centers. An effective prototype for adults using the Assertive Community Treatment (ACT) model for persons exiting state prison, county jail or an alternative treatment program was also developed. These programs are important for assuring that individuals with mental health needs receive services while incarcerated and are linked to appropriate services and supports upon release. While in-jail services are an important part of the comprehensive service array provided by CMHSPs, they **are not** considered to constitute a jail diversion program, **unless** they have been specifically designed as part of a "fast track" release to community treatment within a post-booking diversion program.

Some individuals with serious mental illness or developmental disability must be held in jail because of the seriousness of the offense and should receive mental health treatment within the jail. However, other individuals who have been arrested may be more appropriately diverted to community-based mental health programs. In response to views of consumers, advocates and policy makers, the requirement for a jail diversion program in each CMHSP was included in the 1996 amendments to the Michigan Mental Health Code, P.A. 258 of 1974.

The first MDHHS Jail Diversion Best Practice Guideline was promulgated as an administrative directive in 1998. The directive defined the department's jail diversion procedures and set forth conditions for establishing and implementing an integrated and coordinated program as required by the 1996 Code amendments. New information has been used to update the guideline and to incorporate suggestions for improving current practice.

Effective programs support cross-system collaboration and recognize that all sectors of the criminal justice system need to have access to training. Training should be available to police officers, sheriffs, jail personnel, parole and probation officers, judges, prosecutors, and the defense bar.

The availability of a comprehensive, community-based service array is essential for jail diversion programs to be effective, and may allow many individuals to avoid criminal justice contact altogether. People who receive appropriate mental health treatment in the community usually have a better long-term prognosis and less chance of returning to jail for a similar offense.

The National GAINS Center for People with Co-Occurring Disorders in the Justice System is a national locus for the collection and dissemination of information about effective mental health and substance abuse services for people with co-occurring disorders who come in contact with

the justice system. The Center gathers information designed to influence the range and scope of mental health and substance abuse services provided in the justice system, tailors these materials to the specific needs of localities, and provides technical assistance to help them plan, implement, and operate appropriate, cost-effective programs. The GAINS Center is a federal partnership between two centers of the Substance Abuse and Mental Health Services Administration-the Center for Substance Abuse Treatment and the Center for Mental Health Services-and the National Institute of Corrections (NIC). More recently, this federal partnership has expanded to include the Office of Justice Programs and the Office of Juvenile Justice and Delinquency Prevention. The Center is operated by Policy Research, Inc. of Delmar, New York in collaboration with the Louis de la Parte Florida Mental Health Institute.

Based on the results of field research and program evaluations, the National GAINS Center asserts that the "best diversion programs see detainees as citizens of the community who require a broad array of services, including mental health care, substance abuse treatment, housing and social services. They recognize that some individuals come into contact with the criminal justice system as a result of fragmented services, the nature of their illnesses and lack of social supports and other resources. They know that people should not be detained in jail simply because they are mentally ill. Only through diversion programs that fix this fragmentation by integrating an array of mental health and other support services, including case management and housing, can the unproductive cycle of decompensation, disturbance and arrest be broken."

Strategies for creating effective diversion programs are also highlighted in the report from the "New Freedom Commission on Criminal Justice" published in June 2004. This report was published as part of the President's New Freedom Commission on Mental Health.

Several key factors are recognized as being important components of an effective jail diversion program. An effective program should:

- Recognize the complex and different needs of the population; be designed to meet the different needs of various groups within the population (such as individuals with a co-occurring substance disorder); **and** be culturally sensitive.
- Integrate all the services individuals need at the community level, including corrections, the courts, mental health care, substance abuse treatment, and social services (such as housing and entitlements), with a high level of cooperation among all parties.
- Incorporate regular meetings among the key players to encourage coordination services and sharing of information. Meetings should begin in the early stages of planning and implementing the diversion program, and should continue regularly.
- Utilize liaisons to bridge the barriers between the mental health and criminal justice systems and to manage the interactions between corrections, mental health, and judicial staff. These individuals need to have the trust and recognition of key players from each of the systems to be able to effectively coordinate the diversion effort.
- Have a strong leader with good communication skills and an understanding of the systems involved and the informal networks needed to put the necessary pieces in place.
- Provide for early identification of individuals with mental health treatment needs who meet the diversion program's criteria. This is done through the initial screening and evaluation that usually takes place in the arraignment court, at the jail, or in the

community for individuals out on bond. It is important to have a process in place that assures that people with mental illness are screened in the first 24 to 48 hours of detention.

- Utilize case managers who have experience in both the mental health and justice systems and who are culturally and racially similar to the clients they serve. An effective case management program is one of the most important components of successful diversion. Such a program features a high level of contact between clients and case managers, in places where clients live and work, to insure that clients will not get lost along the way.

IV. Essential Elements for Michigan CMHSPs

A. CMHSPs shall provide a pre-booking and a post-booking jail diversion program intended for individuals:
   1. alleged to have committed misdemeanors or certain, usually non-violent, felonies, and,
   2. who voluntarily agree to participate in the diversion program.

B. Offenses considered appropriate for diversion shall be negotiated at the local level.

C. Pre-booking jail diversion programs shall:
   1. Restrict eligibility to individuals who have or are suspected of having a serious mental illness, including those with a co-occurring substance disorder, or a developmental disability who have committed a minor or serious offense that would likely lead to arrest, or have been removed from a situation that could potentially lead to arrest.
   2. Have a diversion mechanism or process that clearly describes the means by which an individual is identified at some point in the arrest process and diverted into mental health services. Specific pathways of the pre-booking diversion programs are defined and described in an interagency agreement for diversion.
   3. Assign specific staff to the pre-booking program to serve as liaisons to bridge the gap between the mental health, substance abuse, and criminal justice systems, and to manage interactions between these systems. It is important to have a strong leader with good communication skills and understanding of the systems involved and the informal networks needed to put the necessary pieces in place.
   4. Provide cross training for, and actively promote attendance of, law enforcement and mental health personnel on the pre-booking jail diversion program, including but not limited to: target group for diversion; specific pathways for diversion; key players and their responsibilities; data collection requirements; and other information necessary to facilitate an effective diversion program.
   5. Maintain a management information system that is HIPAA compliant and that can identify individuals brought or referred to the mental health agency as a result of a pre-booking diversion. Include the unique consumer ID as assigned by the CMHSP and the date of diversion, the type of crime, and the diagnosis. The unique ID can be used to link to the encounter data to obtain information regarding services. The CMHSP must be prepared to share its jail diversion data with the department upon request.

6. Outline the program and processes in a written inter-agency agreement, or document efforts to establish an inter-agency agreement, with every law enforcement entity in the service area. Inter-agency agreements shall include but not be limited to the following information: identification of the target population for pre-booking jail diversion; identification of staff and their responsibilities; plan for continuous cross-training of mental health and criminal justice staff; specific pathways for the diversion process; description of specific responsibilities/services of the participating agencies at each point in the pathway; data collection and reporting requirements; and process for regular communications including regularly scheduled meetings.

D. Post-booking jail diversion programs shall:

1. Restrict eligibility to individuals who have or are suspected of having a serious mental illness, including those with a co-occurring substance disorder, or a developmental disability who have been arrested for the commission of a crime.

2. Have a clearly described mechanism or process for screening jail detainees for the presence of a serious mental illness, co-occurring substance disorder, or developmental disability within the first 24 to 48 hours of detention. The process shall include:
   - Evaluating eligibility for the program;
   - Obtaining necessary approval to divert;
   - Linking eligible jail detainees to the array of community-based mental health and substance abuse services.

3. Assign specific staff to program including liaisons to bridge the barriers between the mental health, substance abuse and criminal justice systems, and to manage interactions between these systems. It is important to have a strong leader with good communication skills and understanding of the systems involved and the informal networks needed to put the necessary pieces in place.

4. Establish regular meetings among the key players, including police/sheriffs, court personnel, prosecuting attorneys, judges, and CMHSP representatives to encourage coordination of services and the sharing of information.

5. Include case managers and other clinical staff who have experience in both the mental health and criminal justice systems whenever possible. If this is not possible, documentation of recruitment efforts must be documented, and an intensive training program with specific criminal justice focus must be in place for case managers. Case managers and other clinical staff must provide care in a culturally competent manner.

6. Provide cross training for, and actively promote attendance of, law enforcement and mental health personnel on the post-booking jail diversion program, including but not limited to: target group for diversion; specific pathways for diversion; key players and their responsibilities; data collection requirements; and other information necessary to facilitate an effective diversion program.

7. Maintain a management information system that is HIPAA compliant and that can identify individuals brought or referred to the mental health agency as a result of a post-booking diversion. Include the unique consumer ID as assigned by the CMHSP and the date of diversion, the type of crime, and the diagnosis. The unique ID can be used to link to the encounter data to obtain information regarding services. The CMHSP must be prepared to share its jail diversion data with the department upon request.

8. Outline the program and processes in a written inter-agency agreement, or document efforts to establish an inter-agency agreement, with every law enforcement entity in the service area. Inter-agency agreements shall include but not be limited to the following information: identification of the target population for post-booking jail diversion; identification of staff and their responsibilities; plan for continuous cross-training of mental health and criminal justice staff: specific pathways for the diversion process, description of specific responsibilities/services of the participating agencies at each point in the pathway; data collection and reporting requirements; and process for regular communications including regularly scheduled meetings.

V. **Resources**

Council of State Governments Criminal Justice/Mental Health Consensus Project Report, June 2002
www.consensusproject.org/infocenter

The National GAINS Center for People with Co-Occurring Disorders in the Justice System
www.gainsctr.com

The President's New Freedom Commission on Mental Health Achieving the Promise: Transforming Mental Health Care in America Final Report, July 2003
www.mentalhealthcommission.gov/reports/FinalReport

The Technical Assistance and Policy Analysis Center for Jail Diversion (TAPA)
www.tapacenter.org

SPECIAL EDUCATION-TO-COMMUNITY TRANSITION PLANNING PRACTICE RECOMMENDATION GUIDELINE

I. Statement of Purpose

The purpose of this practice recommendation guideline is to provide community mental health service programs (CMHSPs) direction and guidance in planning for the transition of students with disabilities from special education programs to adult life as required by the MI Mental Health Code Section 330.1227, School-to-Community Transition Services. Section 330.1100d(11) of the MI Mental Health Code states: "Transition services means a coordinated set of activities for a special education student designed within an outcome-oriented process that promotes movement from school to post-school activities, including post-secondary education, vocational training, integrated employment including supported employment, continuing and adult education, adult services, independent living, or community participation." This practice guideline provides information about state and federal statutes relevant to school services and the CMHSPs responsibilities. In addition, information is being provided regarding key elements of school programs which appear to better prepare students with disabilities for transition from special education to adult life.

Although this guideline focuses only on special education to community transition, it is important to note CMHSP responsibilities described in Section 208 of the Mental Health Code: "(1) Services provided by a community mental health service program shall be directed to individuals who have a serious mental illness, serious emotional disturbance, or developmental disability. (3) Priority shall be given to the provision of services to persons with the most severe forms of serious mental illness, serious emotional disturbance, and developmental disability." In addition, any Medicaid recipient requiring medically necessary services must also be served.

Children meeting the criteria described above, but not in special education, also face issues of transition to adult life. These may include sub-populations of youth such as runaway youth, children with emotional disturbance at risk of expulsion from school, and youth who "age out" of: 1) the DSM diagnosis for which they are receiving mental health services; 2) Children's Waiver; 3) Children's Special Health Care Services plan; and 4) foster care placement, making them at risk for being homeless. The Michigan Department of Health and Human Services (MDHHS) recognizes the importance of these issues and is seeking service models to assist CMHSPs to meet the needs of this population. For example, Dr. Hewitt "Rusty" Clark of the Florida Mental Health Institute, a national expert on transition, has presented and discussed issues regarding transition to independent living for youth and young adults with emotional and behavioral disturbances with department staff and Michigan stakeholders. In addition, the MDHHS funded three interagency transition services pilot programs targeted at this population in FY 99. While it is recognized that these are important issues which need attention and guidance, they are not the focus of this transition guideline document.

II. Summary

The completion of school is the beginning of adult life. Entitlement to public education ends, and young people and their families are faced with many options and decisions about the future. The most common choices for the future are pursuing vocational training or further academic education, getting a job, and living independently.

The Michigan Mental Health Code requires: "Each community mental health service program shall participate in the development of school-to-community transition services for individuals with serious mental illness, serious emotional disturbance, or developmental disability. This planning and development shall be done in conjunction with the individual's local school district or intermediate school district as appropriate and shall begin not later than the school year in which the individual student reaches 16 years of age. These services shall be individualized. This section is not intended to

increase or decrease the fiscal responsibility of school districts, community mental health services programs, or any other agency or organization with respect to individuals described in this section."

The effectiveness of primary and secondary school programming for students with disabilities directly affects services and financial planning of CMHSPs. Schools that best prepare students with disabilities to live and work in the community and to access generic community services such as transportation and recreation create fewer demands on the adult services system and foster better community participation for individuals with disabilities. It is important for CMHSPs to develop a knowledge base of the federal statutes underlying school programming in order to assess whether students with mental health-related disabilities are receiving school services that will lead to independence, employment, and community participation when their school experience ends.

CMHSPs have a responsibility to provide information about eligibility requirements, types of services, and person-centered planning in the public mental health system to students, families, caregivers, and school systems.

III. Development

For the past two years, the MDHHS has been involved in activities to increase the knowledge base and to become more familiar with the issues of transition. Activities have included:

1. Membership on the Transition Network Team, a statewide project comprised of representatives from state agencies, selected school systems, Social Security Administration and advocacy groups. The goal of the Transition Network Team is to resolve policy issues and barriers so that community partners can work collaboratively.

2. Review of the Transition Initiative findings with the project evaluator. The Transition Initiative was a five-year, federally-funded grant to the State of Michigan focused on transition services.

3. Attendance at a training program on the Individuals with Disabilities Education Act (IDEA) amendments of 1997, sponsored by CAUSE and provided by the Center for Law and Education of Boston, Massachusetts.

4. Attendance at annual School-To-Work conferences.

5. Attendance at the Michigan Association of Transition Services Personnel conference.

In July1999, the MDHHS convened a work group consisting of department staff and representatives of seven CMHSPs with experience in planning and facilitating transition initiatives in their local communities. The work group presented and discussed current field practices and reviewed articles and research related to transition.

IV. Practice

A. Current CMHSP Involvement

There is a broad range of CMHSP involvement with schools around transition services. Generally, CMHSPs are concerned with knowing the number of students who will be completing their school program and who are projected to need services from the CMHSP, such as case management (resource coordination), housing, therapy(ies), employment (placement and/or supports), and social/recreational opportunities. To a lesser degree, CMHSPs participate in the final Individual Educational Program (IEP) prior to the student completing their school program.

Some CMHSPs actively participate with the schools and other community services providers. In a few communities, employment services are well coordinated with the student maintaining the same community job after completion of their school program. A few of these individuals keep

the same vocational services provider. In addition, there may be social and recreational programs that are available to persons with disabilities who are still in school, as well as for those who are out of school. There is a need for more CMHSP involvement to promote: 1) Local school systems implementing the values of IDEA, with particular focus on integration, early vocational exploration and community-based work experiences; and 2) CMHSPs becoming more knowledgeable regarding desirable components of school programs which appear to lead to students with disabilities being more successful in their transition to adult life.

For CMHSPs to know if local school systems are providing appropriate programming, CMHSPs must have some knowledge of the applicable laws and must have knowledge of local school programming. CMHSPs also have a responsibility to provide students, caregivers and school systems information regarding eligibility for services from the public mental health system. Clearly part of that responsibility involves presenting the mental health service principles of person-centered planning, self-determination, inclusion and recovery.

B. Major Federal Legislation Regarding Transition

1. Education of the Handicapped Act (EHA) The EHA, Public Law (P.L.) 94-142, is the primary legislation which guides school services. This Act, passed in 1975, is better known through its latest amendments, as the Individuals with Disabilities Education Act (IDEA).

   P.L. 94-142 established the concept of a free and appropriate (public) education for all children. The following points are presented to show that the public laws guiding school services for students with disabilities match up well with Michigan Mental Health Code principles:

   - All children with disabilities, regardless of the severity of their disability will receive a Free (and) Appropriate Public Education (FAPE) at public expense.
   - Education of children and youth with disabilities will be based on a complete and individual evaluation and assessment of the specific, unique needs of each child.
   - An Individualized Education Program (IEP), or an Individualized Family Services Plan (IFSP), will be drawn up for every child or youth found eligible for special education or early intervention services, stating precisely what kinds of special education and related services, or the types of early intervention services, each infant, toddler, preschooler, child or youth will receive.
   - To the maximum extent appropriate, all children and youth with disabilities will be educated in the regular education environment.
   - Children and youth receiving special education have the right to receive the related services necessary to benefit from special education instruction. Related services include: Transportation and such developmental, corrective, and other supportive services as are required to assist a child with a disability to benefit from special education that includes speech pathology and audiology, psychological services, physical and occupational therapy, recreation (including therapeutic recreation), early identification and assessment of disabilities in children, counseling services (including rehabilitation counseling), and medical services for diagnostic or evaluation purposes. The term also includes school health services, social work services in schools, and parent counseling and training.

2. P.L. 98-524, the Vocational Education Act of 1984 (the Carl D. Perkins Act)
   The Perkins Act has a goal to improve the access of students with disabilities to vocational education. The Act requires vocational education be provided for students with disabilities.
3. P.L. 93-112, the Rehabilitation Act of 1973

The Rehabilitation Act of 1973 is primarily important because of Section 504. Section 504 states no person shall be excluded from participation in, denied the benefits of, or subjected to discrimination under any program or activity receiving federal financial assistance by means of a disability.

The full history of the related Public Laws is available through the National Information Center for Children and Youth with Disabilities (NICHCY). Their web site is a good source of past and current information (http://www.aed/nichcy).

C. Review of the Literature

A publication by the Transition Research Institute, University of Illinois at Urbana-Champaign, authored by Paula D. Kohler, Ph.D. and Saul Chapman, Ph.D., dated March 1999 and updated in April 1999, reviewed 106 studies which have attempted to empirically validate transition practices used by school systems. The report indicates that a "rigorous screening" narrowed the field to 20 studies for further review. The report found that there were many problems with the studies reviewed, including: Not enough information about specific interventions and practices; specific practices not directly tested making it difficult to establish specific outcomes to specific practices; studies focused on higher functioning students; lack of random sampling; lack of baseline data; too many subjects lost during the studies, and lack of use of appropriate evaluation methods. A conclusion from this report states "...there is some evidence to support various practices but also that no strong body of evidence exists that unequivocally confirms any particular approach to transition, nor is there any strong evidence to support individual practices."

The NICHCY publishes a variety of resources on transition. The resources include ideas and information on how students, families, school personnel, service providers and others can work together to help students make a smooth transition. In particular, the focus is on creative transition planning and services that use all of the resources that exist in communities, not just agencies that have traditionally been involved.

These practice guidelines incorporate certain practices and models which, while not empirically validated, are consistent with MDHHS values and principles. These practices and models are being utilized across the country by many schools and these schools consider these practices to be positive. It appears that many transition practices for students with disabilities are practices being utilized as part of the School-To-Work services for all students. Simply assuring that students with disabilities are included in the broader programming at the same time as other students is a positive practice.

V. Philosophy and Values

The MDHHS deems that CMHSP transition services must be based on values that reflect person-centered planning, and services and supports that promote individuals to be:

- empowered to exercise choice and control over all aspects of their lives
- involved in meaningful relationships with family and friends
- supported to live with family while children and independently as adults
- engaged in daily activities that are meaningful, such as school, work, social, recreational, and volunteering
- fully included in community life and activities

VI. Essential Elements

MI Mental Health Code 330.1227, Sec 227 requires that "transition planning begin no later than the school year in which the individual student reaches 16 years of age." CMHSPs, however, should be involved with schools early enough to develop a mutual relationship based on the principles of

inclusion, self-determination and age appropriateness which underlie both IDEA and the MI Mental Health Code. The practice(s) that would lead to the most consistent relationships between schools and CMHSPs for students under 16 years of age, or more than two years away from graduation, are:

A. **Early and Active Involvement with the Schools.**

1. Current federal regulation requires that IEP (transition) planning for students with disabilities must begin at age 14. IEPs must be held once a year plus when there is a significant change in programming. Rather than attending each IEP, particularly early in an individual student's educational career, a better strategy for CMHSPs would be to look more broadly at the type of programming each individual school system is providing to students with disabilities.
2. Key questions to consider when reviewing school programming for students with disabilities include: Are all students with disabilities being included with all students in School-To-Work (STW) activities? Are all students with disabilities being given opportunities to experience community-based work and independent living activities? Are all students with disabilities being experientially taught how to access generic community services? Are all students with disabilities learning about making choices as they move into adulthood?
3. Examples of STW activities in school systems are career days, job shadowing, student portfolios of work and educational achievements, summer work experiences, student internships, and student co-op experiences. All students with disabilities should be participating in these activities simultaneously with other students their own age.
4. All available community resources should be pursued, particularly for out-of-school and summer programming. The Michigan Department of Career Development, Rehabilitation Services (DCD-RS) is very active in many parts of the state working with students with disabilities. The DCD-RS is a particularly valuable resource for career/employment-related services for students exiting secondary schools.

B. **Participating in IEP Meetings and Sharing Information with Schools**

While CMHSPs need not attend all IEP meetings, they do need to ensure that schools, students, families and caregivers have basic knowledge of what CMHSPs can provide to persons with disabilities and eligibility criteria for those services. It is also important that

CMHSPs provide information on the MDHHS requirement that all CMHSP services be based on a person-centered plan. There are a variety of mechanisms available to CMHSPs for providing information. Brochures, community information events, direct mailings, special group presentations, local media, etc. Based on CMHSP experience to date, no one or two methods will be adequate.

CMHSPs shall provide schools with the following information through the CMHSP customer services efforts:

1. Values governing public mental health services including:
    - Recovery
    - Self-determination
    - Full community inclusion
    - Person-centered planning

2. Eligibility criteria
    - MI Mental Health Code priority populations
    - Medicaid
    - Specialty medically necessary services (including the boundary with the Qualified Health Plans)

- Children's Waiver
- Local service selection guidelines/protocols/etc.

3. Local service array for both adult and child service providers
4. The name and telephone number for a CMHSP liaison to the school for systemic service-related issues

C. **Providing Information about CMHSP Service Populations** CMHSPs have the responsibility to provide information to appropriate local school staff about specific conditions which would indicate the likelihood that a student would need assessment and/or service from the CMHSP upon graduation.

Students classified under the school system as Severely Multiply Impaired (SXI), Trainable Multiply Impaired (TMI), Severely Mentally Impaired (SMI) and Educable Mentally Impaired (EMI) are generally eligible for CMHSP services. Other student classifications would indicate a closer look by CMHSPs to determine eligibility for adult services from the CMHSP. The classification of Autistically Impaired (AI) covers students with a very broad range of skills and abilities often necessitating further assessment to determine eligibility for CMHSP services. Students classified as Emotionally Impaired (EI) would have to be assessed for eligibility for adult services from the CMHSP. In the mental health system, Emotional Impairment, by definition, ends at the age of 18. Students classified as EI as well as Learning Disabled (LD) and Physically or Otherwise Health Impaired (POHI) would need to assessed for an appropriate developmental disability or mental illness diagnosis. Where the school diagnosis is not appropriate, it is the responsibility of the CMHSP to provide an assessment. CMHSPs must look at factors in addition to diagnosis. Other factors include: risk for expulsion from school, need for assistance in multiple life domains, or absence of a stable natural support network.

D. **Using Local Councils and Committees**
CMHSPs can also use Multi-Purpose Collaborative Bodies (MPCBs) to address issues regarding the systemic implementation of transition services and to identify additional community resources for transition services. Regional Inter-Agency Coordination Committees (RICC) and Transition Councils are additional local bodies which may be used for the same purpose.

The following are the practice protocols that would lead to the most consistent relationship between CMHSPs and the schools for students 16 years of age, or two years away from completion of their school program.

For students within two years of completing their school program, or for students where the CMHSP is already providing or arranging services, the CMHSP shall:

E. **Request Information from Schools**
It is expected that CMHSPs will need the following from the schools to determine future needs and manage available resources including, but not limited to, information for each student age 16 or older who is expected to receive a diploma more than two years from the present:

- special education classification
- whether or not it is expected the student will need assistance in multiple life domains
- the stability of the student's natural support system
- any transition services currently being provided
- any mental health related services being provided by the school (e.g. school based Medicaid services)
- post-graduation goals, if identified

Based on this information and the CMHSP's knowledge of, and relationship with, the school district, the CMHSP may decide to initiate contact with the school for specific students.

F. **Initiate Transition Planning**

1. The CMHSP shall identify for the school, the student and his/her family a contact person at the CMHSP to act as a contact for the student's transition plan.

2. The CMHSP shall initiate CMHSP transition planning as part of each student's IEP. In the event that the student/family does not want the CMHSP to have a representative present, the CMHSP shall work with the school district to assure that the CMHSP has input into the student's transition plan and to obtain the necessary information (such as that outlined in E above) so that future services can be projected. CMHSPs shall plan to participate in individual IEP meetings for students who meet the eligibility criteria in section E above, and those students who may need assessment or services from the CMHSP as they near completion of their school program. Attendance or other active participation at IEP meetings the last two years will ensure that the student and the CMHSP have sufficient time to prepare for transition.

3. The CMHSP shall provide mental health services as part of a comprehensive transition plan which promotes movement from school to the community, including: vocational training, integrated employment including supported employment, continuing and adult education, adult services, independent living or community participation. It should be noted that the CMHSP does not have sole responsibility for any of these post-school activities and it may not use its state or federal funds to supplant the responsibility of another state agency. It is highly recommended that CMHSPs look at cooperative agreements and the pooling of resources to develop the best services possible for students with disabilities.

VII. **Definitions**

Carl D. Perkins Act, P.L. 98-524, the Vocational Education Act of 1984, also known as the Carl D. Perkins Act--The Perkins Act has a goal to improve the access of students with disabilities to vocational education. The Act requires that vocational education be made available as appropriate for students with disabilities.

CAUSE - Citizens Alliance to Uphold Special Education--A statewide parent training and information center for special education-related activities.

CMHSP - Community Mental Health Service Program

EHA - Education of the Handicapped Act, P. L. 94-142--The primary legislation which guides school services for students with disabilities. Passed in 1975, it is better known as IDEA, based on later amendments labeled as the "Individuals with Disabilities Education Act."

EI - Emotionally Impaired--An impairment determined through manifestation of behavioral problems primarily in the affective domain, over an extended period of time, which adversely affect the person's education to the extent that the person cannot profit from regular learning experiences without special education support.

EMI - Educable Mentally Impaired--An impairment which is manifested through all of the following characteristics:

- Development at a rate approximately two to three standard deviations below the mean as determined through intellectual assessment

- Lack of development primarily in the cognitive domain
- Impairment of adaptive behavior

FAPE - Free and Appropriate Public Education

IDEA -See EHA

IEP - Individualized Education Program--A program developed by an individualized educational planning committee which shall be reviewed (at least) annually.

IEPT - Individualized Educational Planning Team--A committee of persons appointed and invited by the superintendent to determine a person's eligibility for special education programs and services and, if eligible, to develop an individualized education program.

Inclusion - A MDHHS value which directs funding organizations and service providers to enable persons with disabilities to participate in the community, i.e., use community transportation, work in real paid jobs, access generic community social and recreation opportunities and live in their own apartments and houses. Inclusion includes the availability of flexible professional and natural supports that reinforce the individual's own strengths, and expands their opportunities and choices.

NICHCY - National Information Center for Children and Youth with Disabilities

Multi-Purpose Collaborative Body - An inclusive planning and implementation body of stakeholders at the county or multi-county level, focused on a shared vision and mission to improve outcomes for children and families

Person-Centered Planning - A highly individualized process designed to respond to the expressed needs/desires of the individual. The Michigan Mental Health Code establishes the right for all individuals to have their Individual Plan of Service developed through a person-centered planning process regardless of age, disability or residential setting. Person-centered planning is based on the following values and principles:

- Each individual has strengths, and the ability to express preferences and to make choices.
- The individual's choices and preferences shall always be considered if not always granted. Professionally trained staff will play a role in the planning delivery of treatment and may play a role in the planning and delivery supports. Their involvement occurs if the individual has expressed or demonstrated a need that could be met by professional intervention.
- Treatment and supports identified through the process shall be provided in environments that promote maximum independence, community connections and quality of life.
- A person's cultural background shall be recognized and valued in the decision-making process.

Recovery - Recovery is the nonlinear process of living with psychiatric disability in movement toward a quality life. The Recovery model for individuals involves the movement from anguish, awakening, insight action plan and determined commitment for wellness. The external factors influencing recovery are support, collaboration, building trust, respect, and choice and control. The development of hope provided by caregivers and generated from within the individual is a base for transformation into well-being and recovery.

The concept of recovery was introduced in the lay writings of consumers beginning in the 1980s. It was inspired by consumers who had themselves recovered to the extent that they were able to write about their experiences of coping with symptoms, getting better, and gaining an identity. Recovery also was fueled by longitudinal research uncovering a more positive course for a significant number of patients with severe mental illness. Recovery is variously called a process, an outlook, a vision, a guiding principle.

There is neither a single agreed-upon definition of recovery nor a single way to measure it. But the overarching message is that hope and restoration of a meaningful life are possible, despite serious mental illness. Instead of focusing primarily on symptom relief, as the medical model dictates, recovery casts a much wider spotlight on restoration of self-esteem and identity, and on attaining meaningful roles in society.

Self-Determination - Self-determination incorporates a set of concepts and values which underscore a core belief that people who require support from the public mental health system as a result of a disability should be able to define what they need in terms of the life they seek, should have access to meaningful choices, and control over their lives. Within Michigan's public mental health system, self-determination involves accomplishing major system change which can assure that services and supports for people are not only person-centered, but person-defined and person-controlled. Self-determination is based on the following four principles:

- FREEDOM The ability for individuals, with assistance from their allies (chosen family and/or friends), to plan a life based on acquiring necessary supports in desirable ways, rather than purchase a program.
- AUTHORITY The assurance for a person with a disability to control a certain sum of dollars in order to purchase these supports, with the backing of their allies, as needed.
- SUPPORT The arranging of resources and personnel, both formal and informal, to assist the person to live their desired life in the community, rich in community associations and contributions.
- RESPONSIBILITY The acceptance of a valued role by the person in their community through employment, affiliations, spiritual development, and caring for others, as well as accountability for spending public dollars in ways that are life-enhancing.

A hallmark of self-determination is assuring a person the opportunity to control a fixed sum of dollars which is derived from the person-centered planning process and called an individual budget. The person, together with their allies controls the use of the resources in their individual budget, determining themselves which services and supports they will purchase from whom, and under what circumstances.

SMI - Severely Mentally Impaired--An impairment manifested through all of the following behavioral characteristics:

1. Development at a rate approximately four and one-half or more standard deviations below the mean as determined through intellectual assessment
2. Lack of development primarily in the cognitive domain
3. Impairment of adaptive behavior

Supported Employment - Competitive work in integrated settings for persons with the most significant disabilities for whom competitive work has not traditionally occurred or has been interrupted as a result of a significant disability.

SXI - Severely Multiply Impaired--An impairment determined through the manifestation of either of the following:

1. Development at a rate of two to three standard deviations below the mean and two or more of the following conditions:
    - a hearing impairment so severe that the auditory channel is not the primary means of developing speech and language skills
    - a visual impairment so severe that the visual channel is not sufficient to guide independent mobility
    - a physical impairment so severe that activities of daily living cannot be achieved without assistance
    - a health impairment so severe that the student is medically at risk

2. Development at a rate of three or more standard deviations below the mean, or students for whom evaluation instruments do not provide a valid measure of cognitive ability and one or more of the following conditions:
    - a hearing impairment so severe that the auditory channel is not the primary means of developing speech and language skills
    - a visual impairment so severe that the visual channel is not sufficient to guide independent mobility
    - a physical impairment so severe that activities of daily living cannot be achieved without assistance
    - a health impairment so severe that the student is medically at risk

TMI - Trainable Mentally Impaired--An impairment manifested through all of the following behavioral characteristics: 1) Development at a rate approximately three to four and one-half standard deviations below the mean as determined through intellectual assessment 2) Lack of development primarily in the cognitive domain 3) Impairment of adaptive behavior

Transition Services - A coordinated set of activities for a student which is designed within an outcome-oriented process and which promotes movement from school to post-school activities, including: Post-secondary education; vocational training; integrated employment including supported employment; continuing and adult education; adult services; independent living; or community participation. The coordinated set of activities shall be based on the individual student's needs and shall take into account the student's preferences and interests, and shall include needed activities in all of the following areas: 1) Instruction 2) Community experiences 3) Development of employment and other post-school adult living objectives 4) If appropriate, acquisition of daily living skills and functional vocational evaluation

VIII. Literature and Resources

ARTICLES AND PAPERS

Clark, H.B. Transition to Independence Process (TIP): TIP System Development and Operations Manual Florida Mental Health Institute, University of South Florida, 1998 (Revised)

Clark, H.B. & Foster-Johnson Serving Youth in Transition into Adulthood (pp.533-551 In B.A. Stroul (Ed.), Children's Mental Health: Creating Systems of Care in a Changing Society Baltimore, MD Paul H. Brookes Publishing Co., Inc. 1996

Dague, Bryan, Van Dusen, Roy, Burns, Wendy Transition: The 10 Year Plan Presentation at the Association for Persons in Supported Employment Conference Chicago, IL July 1999

Deschenes, Nicole, Clark, Hewitt B. Seven Best Practices in Transition Programs for Youth Reaching Today's Youth Summer 1998

Everson, Jane M., Moon, M. Sherril Transition Services for Young Adults with Severe Disabilities: Defining Professional and Parental Roles and Responsibilities Virginia Commonwealth University Reprinted in September 1987 from the Journal of the Association of Persons with Severe Handicaps (JASH)

Halpern, A.S. Transition: Is It Time for Another Rebottling? Paper presented at the 1999 Annual OSEP Project Director's Meeting Washington D.C. June 1999

Kohler, Paula D. Ph.D. Facilitating Successful Student Transitions from School to Adult Life An analysis of Oklahoma Policy and Systems Support Strategies March 1999

Sale, P., Metzler, H.D., Everson, J.M., Moon, M.S. Quality Indicators of Successful Transition Programs Journal of Vocational Rehabilitation: 1(4): 47-63

NEWSLETTERS

C.E.N. Newsline Eaton Intermediate School District 1790 East Packard Highway Charlotte, MI 48813

Networks National Technical Assistance Center for State Mental Health Planning 66 Canal Center Plaza, Suite 302 Alexandria, VA 22314

Special Education Mediation Reporters Michigan Special Education Mediation Program SCAO 309 N. Washington Square, P.O. Box 30048 Lansing, MI 48909

Transition The College of Education & Human Development Transition Technical Assistance Project Institute on Community Integration University of Minnesota 109 Pattee Hall, 150 Pillsbury Dr., S.E. Minnesota, MN 55455

Transitions Michigan Transition Services Association John Murphy, Charlevoix-Emmet ISD 08568 Mercer Blvd. Charlevoix, Michigan 49720

UCP Pathways United Cerebral Palsy Association of Michigan, Inc. 320 N. Washington Sq., Suite #60 Lansing, MI 48933

WEB SITES

http://www.ed.wuc.edu/sped/tri/institute.html
Transition Research Institute at Illinois, NTA Headquarters 117 Children's Research Center, 51 Gerty Drive Champaign, IL 61820

http://www.ici.coled.umn.edu/schooltowork/profiles.html
School-to-Work Outreach Project Institute on Community Integration (UAP), University of Minnesota 111 Pattee Hall, 150 Pillsbury Drive SE Minneapolis, MN 55455

http://www.mde.state.mi.us/off/sped/index.html
Michigan Department of Education Office of Special Education and Early Intervention Services
P.O. Box 30008, Lansing, MI 48909

http://www.nichcy.org
National Information Center for Children and Youth with Disabilities
P.O. Box 1492 Washington, D.C. 20013-1492

http://www.vcu.edu/rrteweb/facts
Virginia Commonwealth University, Rehabilitation Research and Training Center on Supported Employment

IX. Authority

Mental Health Code, Act 258 MI, Sec. 330.1208 - Individuals to which service directed; priorities; denial of service prohibited

Mental Health Code, Act 258 MI, Sec.330.1227 - School-to-Community Transition (1974 & Supp 1996)

Mental Health Code, Act 258 MI, Sec. 330.1712 - Individualized written plan of service (1974 & Am. 1996)

CONTRACT FINANCING

1. **Insert Milliman Rate Certification letter for the time period covered by the contract.**

2. **Insert Milliman Paid Rate letter for the time period covered by the contract.**

3. **Insert 428 Schedule**

4. **Insert SUD Community Grant Authorization**

SUD COMMUNITY GRANT AGREEMENT AMOUNT

The total amount of this agreement is $_____. The Department under the terms of this agreement will provide funding not to exceed $_____. The federal funding provided by the Department is $_____, as follows:

Federal Program Title	Catalog of Federal Domestic Assistance (CFDA)	CFDA #	Federal Agency Name	Federal Grant Award Number	Award Phase	Amount
SAPT Block Grant	Block Grant for Prevention & TX of Substance Abuse	93.959	Department of Health & Human Services/SAMHSA	13 B1 MI SAPT	2018	
					Total FY 2018 Federal Funding	

_____sub-recipient relationship; or
_____vendor relationship.

The grant agreement is designated as:
_____Research and development project; or
_____Not a research and development project

INTERNAL SERVICE FUND TECHNICAL REQUIREMENT

Purpose

The establishment of an Internal Service Fund (ISF) is one method for securing funds as part of the overall strategy for covering risk exposure under the MDHHS/PIHP Medicaid Managed Specialty Supports and Services Contract (MDHHS/PIHP Contract). The ISF should be kept at a minimum to assure that the overall level of PIHP funds are directed toward consumer services. General provisions and restrictions for establishing an ISF are outlined below:

General Provisions

A. PIHPs may establish an ISF for risk corridor financing in accordance with shared risk provisions contained in the MDHHS/PIHP Contract with the Michigan Department of Health and Human Services .

B. An ISF may be established for the purpose of securing funds necessary to meet expected risk corridor financing requirements under the MDHHS/PIHP Contract.

C. When establishing an ISF, the PIHP may apply any method it considers appropriate to determine the amounts to be charged to the various funds covered by the ISF provided that:

   The total amount charged to the various funds does not exceed the amount of the estimated liability determined pursuant to Governmental Accounting Standards Board (GASB) Statement No.10, *General Principles of Liability Recognition*, or such other authoritative guidance as issued by the American Institute of Certified Public Accountants (AICPA); and

D. Non-compliance with the provisions of GASB Statement No. 10 and 2 CFR 200 Subpart E Cost Principles relative to any applicable matter herein will cause the ISF charges to be unallowable for purposes of the MDHHS/CMHSP Contract.

E. The ISF shall not be used to finance any activities or costs other than ISF eligible expenses.

F. All programs exposed to the risk corridor shall be charged their proper share of the ISF charges to the extent that those programs are covered for the risk of financial loss. Such charges must be allocated to the various programs/cost categories based on the relative proportion of the total contractual obligation, actual historical cost experience, or reasonable historical cost assumptions. If actual historical cost experiences or reasonable historical cost assumptions are used, they must cover, at a minimum, the most recent two years in which the books are closed.

G. A set of self-balancing accounts shall be maintained for the ISF in compliance with generally accepted accounting principles (GAAP).

H. The PIHP shall restrict the use of the ISF to the defined purpose.

I. The amount of funds paid to the ISF shall be determined in compliance with reserve requirements as defined by GAAP and applicable federal and state financing provisions contained in the MDHHS/PIHP Contract.

J. To establish an adequate funding level to cover risk corridor requirements, the PIHP may make payments up to the lesser of: (1) the total potential liability relative to the risk corridor and the overall risk management strategy of the PIHP's operating budget; or (2) the risk reserve requirements determined under paragraph C above and the applicable financing provisions contained in the MDHHS/PIHP Contract.

K. The PIHP shall establish a policy and procedure for increasing payments to the ISF in the event that it becomes inadequate to cover future losses and related expenses.

L. Payments to the ISF shall be based on either actuarial principles, actual historical cost experiences, or reasonable historical cost assumptions, pursuant to the provisions of OMB Circular A-87, Attachment B, paragraph 2 2(d)(3). If actual historical cost experiences or reasonable historical cost assumptions are utilized, they must cover, at a minimum, the most recent two years in which the books have been closed.

M. Payments and funding levels of the ISF shall be analyzed and updated at least biannually pursuant to the provisions of 2 CFR 200 Subpart E Cost Principles.

N. If the ISF becomes over-funded, it shall be reduced within one fiscal year through the abatement of current charges or, if such abatements are inadequate to reduce the ISF to the appropriate level, it shall be reduced through refunds in accordance with 2 CFR 200 Subpart E Cost Principles.

O. Upon contract cancelation or expiration, any funds remaining in the ISF and all of the related claims and liabilities shall be transferred to the new PIHP that encompasses the existing PIHPs region. When existing PIHPs geographic regions overlap more than one new PIHP region MDHHS will provide the percentage allocation to each new PIHP.

General Restrictions

Use of funds held in the ISF shall be restricted to the following:

A. The PIHP shall restrict the use of the ISF to the defined purpose. The defined purpose of the ISF is to secure funds necessary to meet expected future risk corridor requirements established in accordance with the MDHHS/PIHP Contract between the PIHP and the Michigan Department of Health and Human Services . All expenses, for the purpose intended to be financed from the ISF, shall be made from the ISF. No expenses from this fund will be match able--only the payments to the ISF will be match able. No other expenses may be paid from the ISF.

B. Payment of the PIHP's risk corridor obligation.

C. The PIHP may invest ISF funds in accordance with statutes regarding investments (e.g., *Mental Health Code* 330.1205, Sec. 205(g). The earnings from the investment of ISF funds

shall be used to fund the risk reserve requirements of the ISF in accordance with 2 CFR 200 Subpart E Cost Principles.

D. The ISF may not loan or advance funds to any departments, agencies, governmental funds, or other entities in accordance with 2 CFR 200 Subpart E.

E. Funds paid to the ISF shall not be used to meet federal cost sharing or used to match federal or state funds pursuant to 2 CFR 200 Subpart E.

F. State funds paid to the ISF shall retain its character as state funds in accordance with the Mental Health Code and shall not be used as local funds.

General Accounting Standards

The ISF shall be established and accounted for in compliance with the following standards:

A. Generally accepted accounting principles (GAAP).

B. GASB Statement No. 10, *Accounting and Financial Reporting for Risk Financing and Related Insurance Issues*, or other current standards.

C. Financial Accounting Standards Board (FASB) Statement No. 60, *Accounting and Reporting by Insurance Enterprises*, or other current standards.

D. FASB Statement No.5, *Accounting for Contingencies*, or other current standards.

E. 2 CFR 200 Subpart E, *Cost Principles*, or other current standards.

F. Other financing provisions contained in the MDHHS/PIHP Contract.

G. The financial requirements set forth in the HCFA Federal 1915(b) waiver.

REGION#

2013 Application for Participation

For Specialty Prepaid Inpatient Health Plans

Michigan Department of Health & Human Services Behavioral Health & Developmental Disabilities Administration
2/6/2013

Table of Contents

A. INTRODUCTION

The purpose of the Michigan Department of Health & Human Services (MDHHS) 2013 Application for Participation (AFP) for re-procurement of Medicaid Specialty Prepaid Inpatient Health Plans (PIHPs) is to describe the necessary information and documentation that will be required from the applicant to determine whether the Urban Cooperation Act (UCA) formed entity or the Regional Entity applicant, (jointly governed by the sponsoring Community Mental Health Services Programs(CMHSPs)), meets the MDCH requirements for selection to be certified to Center for Medicare and Medicaid Services as a PIHP effective January 1, 2014.

The AFP is the official vehicle which begins solicitation and selection for the PIHPs for the state-defined regions. Specifically, the AFP identifies the plan for meeting the required functions of the PIHP, including identification of functions that are to be direct-operated, delegated and/or contracted within and outside the sponsoring CMHSPs.

The AFP requires response in the following areas: Governance, Administrative Functions including general management and financial, Information Systems Management, Provider Network Management, Utilization Management, Customer Service, Quality Management, Accreditation, External Quality Review, and Public Policy initiatives including crisis response capacity, health and welfare, Olmstead compliance, substance abuse prevention and treatment capacity, and recovery.

In recognition of the short timeframe between issuance of this AFP and the April 1st due date for the response, MDHHS will allow an extended response time, up to 5 p.m. on July 1st, for some items so noted in this document. However, an application is not considered complete until all items requested in the AFP are submitted.

Similar to the 2002 Application for Participation, this AFP is targeted first exclusively to entities comprised of Michigan CMHSPs in compliance with Michigan's application for renewal of its 1915(b) Specialty Services and Supports Waiver. In the waiver application, Michigan proposed that a first opportunity should be afforded to CMHSPs since these entities have the necessary expertise with the target populations and strong coordination linkages with other community agencies; control other resource streams (e.g., state funds); sustain local systems of care; have already made durable investments in specialized care management strategies and unique service/support arrangements; and have statutorily prescribed protection, equity and justice functions important to individuals, policymakers and Michigan's citizens.

This AFP is intended to re-procure the PIHPs based on new regional boundaries drawn by the MDHHS. There will be one PIHP selected per region, and that PIHP will manage the Medicaid specialty benefit for the entire region defined by the MDHHS. The PIHP will contract with CMHSPs and other providers within the region to deliver services. It is relevant to note that beginning October 1, 2013, plans for merging Coordinating Agency functions within the CMHSP system must be developed and initiated, with full compliance (merger of functions) with the law (P.A. 500 and 501) by October 1, 2014. This application response will supply information regarding the activities aimed at reaching these goals, and expected roles and timeframes, as much as they are known to the applicant and member CMHSPs at the time of response.

The only acceptable legal arrangements for affiliation going forward will be either UCA agreements or creation of a regional entity under Section 1204b of the Mental Health Code. In either case, such intergovernmental affiliation formations result in the creation of a new legal entity jointly "owned" and governed by the sponsoring CMHSPs. It is this entity that will be considered, recognized and designated as the PIHP (for a region consisting of more than one CMHSP).

As described in the November 26, 2012, "Discussion Draft", the key objective of this new management entity is to balance and obtain the best two opposites while avoiding the limits of each. The new regional structure must consolidate authority and core functions, while simultaneously promoting local responsiveness. (Please reference the "Discussion Draft-Version 2, November 26, 2012, for further details).

Policies and procedures for "Provider Network Services," "Provider Procurement," "Provider Credentialing" and "Customer Services" must be maintained by the regional entity, with common provider application processes throughout the region. The processes and functions MAY be decentralized among more than one entity or CMHSP, but each decentralized unit will be acting under the common policies and procedures of the UCA/Regional Entity. A provider then, moving from one CMHSP to another to provide service should not experience repeated and different application and procurement processes to become a Medicaid provider in a new CMHSP within the same regional entity.

The regional entity policies and procedures for Provider Services need to include the full breadth of what may be needed by any single CMHSP to respond to local need and to take advantage of increasing opportunity for participating in accountable and integrated systems of care with local partners. An individual CMHSP should not be hindered from participating in opportunities to provide integrated and accountable care to serve the Medicaid population in its catchment area. The objective of this new entity is to balance and obtain the best of both opposites (local control/responsiveness and regional standards/consistency), while avoiding the limits of each.

As with the original AFP, this application process differs from typical request for proposal processes because a) the bid does not include pricing; and b) the process is not competitive at this stage. Applicants are indicating their capacity and commitment to performance in a variety of areas. Pricing is determined by the MDHHS in compliance with Medicaid regulations, the 1915(b) waiver, and state appropriations and will be shared with applicants prior to contract negotiations to commence in the Spring of 2013.

Other significant MDHHS policy decisions impacting applicants that need to be considered are as follows:

1. Capitation Payments and Data Files

   The base capitation rates and methodology are currently under evaluation by actuaries. The MDHHS intends to re-develop rate structures, methodologies and adjusters that increase the percentage of the ratio reflecting morbidity and decrease the percentage that is based on history/geography. In the 2012-2013 year, the ratio is 50/50 morbidity/geography. MDHHS will be increasing the percentage of the ratio that reflects morbidity each year. Ultimately, MDHHS will be moving to methodologies that are built on a common statewide rate structure where adjusters are entirely based on morbidity differences or cost of living methodologies common to other areas of health care. MDHHS will utilize common actuarial methodologies statewide, as approved by CMS. The concurrent 1915(c) Habilitation Supports Waiver allocation of certificates will also be adjusted based on factors such as the number of people with developmental disabilities served within the region, thus moving away from current historical allocation.

   The data files distributed will be a single file for each consolidated service area. This file will be available only to the PIHP. The PIHP must have the capacity to provide information to and collect information from the individual CMHSPs within the region in compliant, efficient and helpful formats for use by the CMHSPs in understanding the broad scope of enrollees, trends and utilization of the individual CMHSP and as it compares to the other members within the region.

   Single CMHSP PIHPs will be required to report both the administrative cost of PIHP functions borne directly by the PIHP and those PIHP functions carried out by the CMHSP, CMHSP core providers, and managed comprehensive provider networks (MCPNs). To promote full transparency of PIHP and administrative costs, MDHHS will require reporting of administrative costs of both the PIHP itself, and administrative costs for direct services for the CMHSP. MDHHS intends to place a cap on the administrative cost percentage for CMHSP direct services.

2. Sub-capitation

An applicant may sub-capitate for shared risk with its provider network, including CMHSPs, MCPNs, and core providers. The actuarially-sound methodology and rates for sub-capitation, by contractor, must be submitted to MDHHS. MDHHS retains the right to disapprove any sub-capitation arrangement that is determined not to be actuarially sound or where the arrangement has a high probability to adversely impact the State's risk-sharing. Sub-capitation rates shall be reasonable when compared to other service rates for similar services. Sub-capitation shall not contribute to risk reserve accumulation that exceeds seven and one-half percent (7.5 percent) of annual per eligible/per month, or an amount consistent with Governmental Accounting Standards Board Statement 10, whichever is less, within the applicant's region.

3. Internal Service Fund (ISF)

The ISF risk reserves that exist on December 31, 2013, for PIHPs whose geographically boundaries have not changed may be continued under the new contract, up to the level justifiable by Governmental Accounting Standards Board Statement 10 and the current ISF Technical Requirement (MDHHS/PIHP Contract Attachment 7.7.4.1). For PIHP regions where the geography has changed, (such as individual CMHSPs entering and exiting PIHP regions and PIHP regions combining), MDHHS will work with actuaries to determine the percentage of the ISF that shall move to the new PIHP for purpose of servicing the enrollees that move to the new PIHP region. It is expected that the actuarially-determined amount of the ISF to be transferred to the new PIHP will be based on prior fiscal years enrollee data, summarized by diagnoses for those belonging to the exiting CMHSP.

4. Integrated Care

All PIHPS will be required to have and provide upon request, signed agreements with all the Medicaid Health Plans (MHPs) in the region. The PIHPs and MHPs shall use the model coordination agreement provided in the contract as a foundational template. The Medicaid Health Plan contracts will contain the same requirement to have signed agreements with the PIHPs. Over the period of the upcoming waiver renewal cycle, new opportunities for integration with physical health care may become available in Michigan. MDHHS is exploring options such as Medicaid Health Homes (ACA section 2703) and Integrated Care Dual Eligible Demonstrations (Medicare/Medicaid). Four of the new PIHP regions have been selected as the Dual Eligible Demonstration sites: Regions 1, 4, 7 and 9; others may be selected to participate in the integrated care opportunities. If approved by CMS, both the dual eligible and Medicaid Health Home opportunities will require contract amendments for PIHP regions selected to participate. The PIHPs in the Dual Eligibles regions will also require contracts with the Integrated Care Organizations in order to accomplish the Care Bridge functions and desired outcomes of integrated Medicare and Medicaid-funded behavioral health and physical health care.

5. Performance Monitoring and Incentives

MDHHS will be implementing a performance incentive structure for the Medicaid PIHPs. During each contract year, MDHHS will withhold a portion of the approved capitation payment from each PIHP (range to be determined, but likely to be between .02 and .015). These funds will be used for the PIHP performance incentive awards. These awards will be made to PIHPs according to criteria pre-established by MDHHS. The criteria will include assessment of performance from areas such as: access, health and welfare, and compliance with the Balanced Budget Act (BBA) per External Quality Review, including performance measure data validation. In 2014, the two areas of focus will be PIHP proper and complete reporting of monetary amounts and billing/rendering provider; and completeness of Quality Improvement health conditions and developmental disabilities characteristics data.

6. Program Integrity and Compliance

A strong compliance and program integrity system is critical to all managed care systems. All PIHPs shall comply with 42 CFR 438.608 Program Integrity requirements. This includes key functions to be owned by the PIHP such as: designation of a compliance officer for the PIHP, region wide policies and procedures showing commitment to comply with federal and state laws, training and education for the compliance officer and employees, clear lines of communication with the compliance officer, discipline and enforcement, internal monitoring and auditing and prompt response to detected offenses. The state is seeking more detail on program integrity and compliance programs than has been required in past applications.

7. Sanctions

MDHHS will utilize a variety of means to assure compliance with applicable requirements. MDHHS will pursue remedial actions and possibly sanctions, including intermediate sanctions as described in 42 CFR 438.700, as needed, to resolve outstanding contract violations and performance concerns. The use of remedies and sanctions will typically follow a progressive approach, but MDHHS reserves the right to deviate from the progression, as needed, to seek correction of serious, repeated, or patterns of substantial non-compliance or performance problems. The application of remedies and sanctions shall be a matter of public record.

The range of contract remedies and sanctions MDHHS will utilize include:

A. Issuing a notice of the contract violation and conditions to the PIHP with copies to the Board.

B. Requiring a plan of correction and status reports that becomes a contract performance objective.

C. Imposing a direct dollar penalty, making it a non-matchable PIHP administrative expense and reducing earned savings from that fiscal year by the same dollar amount.

D. Imposing intermediate sanctions (as described in 42 CFR 438.700) that may include the following civil monetary penalties:

- A maximum of $25,000 for each determination of failure to provide services; misrepresentation or false statements to beneficiaries or health care providers.
- A maximum of $100,000 for each determination of discrimination or misrepresentation or false statements to CMS or the State.

E. For sanctions related to reporting compliance issues, MDHHS may delay up to 25% of scheduled payment amount to the PIHP until after compliance is achieved. MDHHS may add time to the delay on subsequent uses of this provision. (Note: MDHHS may apply this sanction in a subsequent payment cycle and will give prior written notice to the PIHP.)
F. Initiate contract termination.

The following are examples of compliance or performance problems for which remedial actions, including sanctions, can be applied to address repeated or substantial breaches, or reflect a pattern of non-compliance or substantial poor performance. This listing is not meant to be exhaustive, but only representative.

A. Reporting timeliness, quality and accuracy.
B. Performance Indicator Standards.
C. Repeated Site-Review non-compliance (repeated failure on same item).
D. Failure to complete or achieve contractual performance objectives.
E. Substantial inappropriate denial of services required by this contract or substantial services not corresponding to condition. Substantial can be a pattern, large volume or small volume but severe impact.
F. Repeated failure to honor appeals/grievance assurances.
G. Substantial or repeated health and/or safety negligence.

8. Transition To State Defined Regions:

The applications submitted in response to the AFP must demonstrate that the PIHPs are able to meet, or have viable plans with specified dates for completion of requirements. Because of the complexity and transition time needed to move some functions from single CMHSPs as PIHPs to fewer and regional entities as PIHPs, this AFP allows the applicant to specify target dates beyond April 1, 2013, for some of the functions.

MDHHS reserves the right to require the milestone target dates be adjusted in order for a conditional (or provisional) award to be granted. Should the milestone target dates not be met, MDHHS reserves the right to notify CMS the PIHP no longer meets requirements for continuing to function as the PIHP. MDHHS may then give notice of termination of the contract and proceed to seek another entity to manage the PIHP functions for that region. A new managing entity could be either a neighboring PIHP or a non-CMHSP-governed entity selected to manage the region through a competitive process (with assurances to maintain the statutory purposes the local CMHSP).

B. INSTRUCTIONS

Since 2002, the PIHPs have managed Medicaid specialty services and supports and carried out their responsibilities for ensuring beneficiary freedom, opportunities for achievement, equity, and participation consistent with the history and mission of CMHSPs. MDHHS has been responsible for assuring that PIHPs are in compliance with federal laws and regulations, state Medicaid policy, the Michigan Mental Health Code and Administrative Rules, and the contract between MDHHS and the PIHPs. To that end, MDHHS will use the results of performance and contract monitoring and external quality reviews for existing PIHP (where the new entity adopts the policies of an existing PIHP) and, as applicable, for CMHPs to inform its review of an applicant's suitability to become a new PIHP.
In 2009, MDHHS and the PIHPs engaged in a comprehensive quality improvement effort called "Focusing a Partnership for Renewal and Recommitment to Quality and Community in the Michigan Public Mental Health System" referred to as the ARR). The ARR addressed updated (from 2002) public policy considerations. PIHPs with the assistance of community stakeholders, performed environmental scans and developed plans for improvement where they found the need. MDHHS and PIHP staff worked together as PIHPs made progress in achieving their own goals.

The 2002 AFP and the 2008 ARR are the foundation of the Medicaid Specialty Supports and Services program and the vision and values, and public policy they addressed – such as person-centered planning and self-determination, and culture of gentleness– are still highly regarded, and while not addressed in this AFP, will continue to be part of the contracts between MDHHS and the new PIHPs to fulfill provider network adequacy and capacity requirements for the covered specialty services.

This 2013 AFP is also built upon documents that have been the foundation of the Specialty Services and Supports Program since 2002: the FY'12-13 amended 1915(b) Waiver for Specialty Services and Supports, and the FY'13 MDHHS/PIHP contracts and the attachments. Finally, it is expected that the applicants are compliant or are able to become compliant with the 1997 Balanced Budget Act, 42 CFR Part 438, and the External Quality Review Protocols.

This 2013 AFP addresses primarily those public policy areas that are new or evolving; and raises expectations for certain administrative capabilities that a mature specialty managed care system such as Michigan's should be able to demonstrate. This AFP solicits applicant information in the following: Governance; Administrative Functions including General Management, Financial Management, Information Systems Management, Provider Network Management, Utilization Management, Customer Service, Quality Management; Accreditation Status; External Quality Review; and the following Public Policy initiatives: Crisis Response Capacity, Health and Welfare, ADA/Olmstead Compliance, Substance Use Disorder Prevention and Treatment, and Recovery.

We have placed links to documents referred to on this page and other helpful resources identified throughout this AFP on the MDHHS web site's Mental Health and Substance Abuse page.

Responses to this AFP shall be entered in the electronic version of this document in the boxes, tables and spaces provided. Supplementary information shall be attached as instructed and labeled with the requested Attachment number.

Certain items in the application may be submitted subsequent to the April 1st due date but **no later than 5 p.m. on July 1, 2013. However, the applicant is cautioned that an application will not be considered complete until all items requested have been submitted.** An incomplete application as of July 2, 2013, will result in loss of first opportunity to CMHSPs in the region (through Urban Cooperation Act or Regional Entities). The state will then proceed to open the region to competitive bid.

Please adhere to the page count limitation specified for text boxes and use no smaller than 12-point font. Some text boxes have limits on the number of characters that can be inserted.

Label each attachment with the Region number and item number, save all attachments in PDF into one document, and submit as instructed below.

Responses must be submitted electronically to Marlene Simon at SimonM4@michigan.gov by 5 p.m. on April 1, 2013. Items submitted electronically between April 1, 2013 and July 1, 2013 are to be labeled with the applicant's region number, the AFP section number and are to adhere to the page count limitation.

C. MDCH DECISIONS

Applications will be reviewed by MDHHS staff in the two weeks following submission. MDHHS reserves the right to conduct a short site review to interview staff or stakeholders, and/or to follow up on any responses received via this application that are unclear or incomplete.

The review of applications, scoring, and site visits will result in one of three decisions below that will be announced by the Department following the conclusion of these activities:

1. Award without conditions means that MDHHS will contract with the applicant without changes required in the application and without any conditions for meeting target dates for milestone activities. This action will be announced in early June 2014. Announcement may be as late as July 2, 2013, where items from the application noted as allowable for two-part submission are delayed. Contracts will be signed in December 2013, effective January 1, 2014.

2. Award with conditions means that MDHHS requires that either or both: a) certain improvements must be completed or plans of correction approved before it will contract with the applicant; b) certain milestones must be met by target dates for initiating contract and/or continued contracting as the PIHP for the region. This action will be announced in July 2013, where application is incomplete due to awaiting legal documents or other specifically noted items. Conditions must be met by a date specified in the award announcement. In Wayne County condition may also include transition to authority status by October 1, 2013, as per Public Acts (P.A.) 375 and 376 of 2012. Following the MDHHS acceptance of improvements or plans of correction needing resolution prior to January 1, 2014, contracts will be signed in December 2013, effective January 1, 2014.

3. Unsuccessful application means one or more of the following:
   a. The application was received after the deadline and will be returned to the sender immediately.
   b. The application did not pass the Governance Section. The application contained section(s) that failed to meet standards, and for which acceptable target milestones and timeframes were not provided. Notification of such a situation will be made within one week following the review of the application (approximately three weeks after the due date). If the application is incomplete due to items with allowable extended due date of July 1, 2013, notice of unsuccessful application will be made the first week of July 2013.
   c. The application lacked signatures from all CMHSPs in the state-defined region as authorized by appropriate action of all individual boards.
   d. Required legal documents (Urban Cooperation Act, Regional Entity) were not filed with the county clerks before July 1, 2013, for multi CMH regions.

e. Wayne County authority not created by October 1, 2013, as required by PA 375 and 376 of 2012.

4. Open Competitive Process means the following:
   a. In the event an unsuccessful application is received from a region, MDHHS will proceed with an open competitive bid process specifically for that region.
   b. The vendor selected for a particular region via MDHHS's open competitive process will be the PIHP for that region, and will be required to report contractually to MDCH.
   c. An award of a bid via the open competitive bid process to an entity other than an Urban Cooperative Act or Regional Entity formed by the CMHSPs in that region will not require that PIHP to have CMHSP representation on its board.

Applicants may appeal the decisions in number three above by delivering or faxing a letter requesting reconsideration, within two days of receipt of the notification, to:

Lynda Zeller, Deputy Director
Michigan Department of Health & Human Services
Lewis Cass Building, Fifth Floor
320 S. Walnut Street
Lansing, Michigan 48913
FAX (517) 335-4798

D. THE APPLICATION

1. GOVERNANCE

This section will receive a "pass" or "fail" determination. If any one item receives a fail determination, it will stop the application from further consideration. A fail determination will result from the applicant's answer of either **"no" without sufficient justifiable narrative included** or **an answer of N/A (not applicable) for an application consisting of an affiliation of CMHSPs**. Failed applicants will be notified within one week following review of the application (approximately three weeks after the due date).

The AFP affords initial consideration for specialty prepaid inpatient health plan designation to qualified single county or regional entities (organized under Section 1204b of the Mental Health Code or Urban Cooperation Act). Therefore, the first and most basic requirement is that the organization submitting an application, be comprised of and jointly, representatively governed by all CMHSPs in the region pursuant to Section 204 or 205 of Act 258 of the Public Acts of 1974, as amended in the Mental Health Code.

Check all boxes that are appropriate to the applicant as it will be January 1, 2014

1.1 ☐ Applicant is the sole CMHSP in a state-defined region and is currently one of the following:

- 1.1.2 ☐ County CMH Agency.
- 1.1.3 ☐ Community Mental Health Organization.
- 1.1.4 ☐ Community Mental Health Authority (Required for Wayne County).

OR

1.2 ☐ Applicant is an entity jointly governed by all CMHSPs in a state-defined region and has one of the following legal arrangements:

- 1.2.1 ☐ Section 1204b Regional Entity as defined in Mental Health Code
- 1.2.2 ☐ Urban Cooperation Act (UCA)

1.3 ☐ In Attachment 1.3 is a plan for the legal entity to be finalized with action steps, responsible parties, and timeframes. By no later than 5 p.m. on July 1, 2013, the legal entity shall have by-laws filed with the county clerk, and all member CMHSP board approvals have been completed.

An application for a region comprised of more than one CMHSP shall submit, no later than 5 p.m. on July 1, 2013, one hard copy of the original signed legal documents that establish or validate that the entity making application has status as a Regional Entity under Section 1204b of the Mental Health Code or through Urban Cooperation Act and, where applicable, has the legal basis to enter into a contractual commitment with the Department for a consolidated application for multiple CMHSP service areas. *(These items need not be scanned and submitted electronically. They must, however, be appropriately labeled with the Region number and suitable cover sheets.)* Note: where an application is being made by a single CMHSP, appropriate documentation is currently on file with the MDHHS, with the exception of Wayne County which will require proof of Authority Status no later than

October 1, 2013. **Submit the hard copy legal documents to Thomas Renwick, Director, Bureau of Community Mental Health Services, 5th Floor Lewis Cass Building, 320 South Walnut Street, Lansing, Michigan 48913.**

1.4 ☐ An original signed paper copy of the legal document(s) including by laws and enabling resolutions that establish or validate that the entity making application has a status as a Regional Entity or entity formed by Urban Cooperation Act has been submitted concurrent with this application.

OR

1.5 ☐ The legal document(s) will be submitted no later than 5 p.m. on July 1, 2013. **The application will not be considered complete until the legal document(s) have been submitted to MDHHS, no later than 5 p.m. on July 1, 2013.**

The legal document(s) addresses the following:

1.4.1 ☐ The relationship between the parties.
1.4.2 ☐ The roles of each party to the agreement.
1.4.3 ☐ The rights of each party to the agreement.
1.4.4 ☐ Governance arrangements and conditions.
1.4.5 ☐ Functional consolidation of administrative activities.
1.4.6 ☐ Assurances that all members will comply with federal and state standards and regulation and what processes exist to address non-compliance.
1.4.7 ☐ The financial arrangements and interests of each party to the agreement including, but not limited to: cost-sharing, cost-allocations, local match obligations related to Medicaid funds, fund transfers, re-purchase (contracting back) arrangements, resource/asset claims, liability obligations, risk obligations, risk management, contingencies, areas of limitations, and areas of exclusions.
1.4.8 ☐ Established dispute resolution mechanism(s) between the affiliates.
1.4.9 ☐ Identification of the designated regional entity to act as the prepaid inpatient health plan by all CMHSPs within the region.

1.6 ☐ In the text box below is a list of the PIHP board member categories (e.g., person who receives services, family member of a person who receives services, person with a disability, advocate, provider, county commissioner, CMH representative, community member), the number of people to serve in each category, their affiliation (e.g., county), and if known at the time of application, but no later than July 1, 2013, the name of each PIHP board member.
1.6

MDHHS shall review the applicant's, and CMHSP member status regarding compliance with certification criteria, Section 232 of the Mental Health Code. In order to assure adequate specialty services network and capacity, applications will be reviewed to assure all CMHSPs within the consolidated application meet the criteria. To be referred for scoring of the

proposal, applicants must have substantial or provisional certification for each participant CMHSP within the region at the time of application.

MDHHS shall review the applicant's status regarding MCLA 330.1232a (6); Recipient Rights System. In order to assure adequate specialty services network and capacity, applications will be reviewed to assure all CMHSPs within the region have overall assessment scores of substantial compliance. To be referred for scoring of the proposal, applicants must be determined to have scores of substantial compliance with Recipient Rights System standards.

1.7 ☐ Assessment scores meet substantial compliance.

Because MDHHS continues to value and promote community involvement, there must be documentation that individuals who receive services, family members, and/or advocates representing each service area of the region, if applicable, and all populations served, including, adults with serious mental illness, children with serious emotional disturbance, children and adults with developmental disabilities, and children and adults with substance use disorders were involved in the development of this application.

1.8 ☐ In Attachment 1.8 is a signed statement attesting to consumer/stakeholder involvement.

1.9 ☐ In Attachment 1.9 is a narrative of no more than three pages that defines the vision and values of the stand-alone applicant, or of the UCA/regional entity. Include within the narrative a description of how the affiliation arrangement will actualize this vision and build upon the existing strengths of member CMHSPs. Explain how the PIHP will bring any members with deficits up to standard or acceptable performance.

1.10 ☐ In Attachment 1.10 is a curriculum vitae for the executive director of the applicant organization that verifies that the executive director of the applicant organization meets or exceeds the qualifications of an executive director as specified in Section 226(1) (k) of the Mental Health Code.

OR

1.11 ☐ The executive director of the applicant organization is unknown at the time of the submission of this application. The name and curriculum vitae will be submitted to MDHHS no later than 5 p.m. on July 1, 2013.

1.12 ☐ All text boxes are completed and all attachments required to be submitted are included with this Application for Participation response.

OR

1.13 ☐ Not all text boxes are completed and/or not all required attachments are being submitted with this AFP but will be submitted no later than 5 p.m. on July 1, 2013. It is understood that this is considered an *incomplete application.*

1.14 ☐ Name of contact person who can answer questions about this application: , telephone number: , E-mail address:

Additional Governance Responses Required of Wayne County:

MDHHS seeks a stable transition and the least disruption possible from County oversight to the newly authorized Authority beginning October 2013. No sooner than six months, but no later than nine months, after the Authority begins oversight and operations of the existing MCPN system, the Authority shall submit a written Plan (the Plan) for approval by MDHHS, for the re-procurement and implementation of specialty provider networks that will be administered by two or three Managers of Comprehensive Provider Networks (MCPNs). To achieve better integration and efficiency of administration, the Plan shall include requirements for at least two but no more than three MCPNs to oversee specialty networks that will provide a comprehensive array of services for each of the two primary target populations: (1) people with mental illnesses, substance use disorders, and serious emotional disturbance and 2) people with intellectual/developmental disabilities. Each of the MCPNs shall deliver person-centered, behavioral health or I/DD services, and coordinate those services with the physical health services to be delivered by Integrated Care Organizations in the State's demonstration for people with Medicare and Medicaid eligibility. The Plan shall be reviewed by the MDHHS. MDHHS shall approve the Plan once the MDHHS is confident in the stability of Authority's operations and has ensured that the Plan meets the requirements of this document.

1.14.1 ☐ The Wayne County applicant attests that it will submit, within the time frame noted above, the written Plan for re-procurement of MCPNs that includes all of the following:

a. A description of the process to ensure that there is always a choice of MCPNs (not less than two) for eligible recipients from the two population groups. The Plan shall also include policies and procedures that allow individuals the opportunity to move between MCPNs if they choose.
b. The proposed scope of services for the MCPN contract and procurement. It shall describe the structure and functions of the MCPNs, any legal requirements for corporate status, governance requirements, individual and family representation, financing and reimbursement, and other elements described below. The Plan shall describe the process for re-procurement of the MCPNs to achieve efficiency and care integration goals. The Plan shall include standards for MCPNs and their specialty provider networks on enrollment, person centered planning, care management, clinical service and utilization review standards, provider standards and physical and behavioral health service coordination and integration. The Plan shall also describe required administrative functions including provider network management, accounting, claims, data systems, reporting, after-hours coverage, quality improvement, member services and any other delegated responsibilities. Evidence (copies of public comment) that The Plan was made available for public review prior to submission to the MDHHS shall be provided. This shall include review by consumers, families and other advocacy groups. The Plan shall be approved by the CMHSP Board of Directors and any other applicable Boards and Authorities.
c. Evidence that the MCPNs shall be governed by provider members, members of the community or individuals with specialized experience. The Plan shall also

include plans for involving people with lived experience (either as consumers and or family members) in the governance of the PIHP, the MCPNs and perhaps in an advisory role for the specialty provider networks. The Plan shall also outline how the applicant and the MCPNs will employ people who have lived experience in key positions.

d. Identification of the functions that will be provided by the applicant, other public agencies and those delegated to the MCPNs. Specifically this shall include general management/administrative, financial management, information systems management, provider network management, utilization management, customer services, and quality management. The applicant shall demonstrate that it has examined the effects of this decision on care coordination, quality, cost, and availability. Particular attention will be paid to ways to minimize overall administrative costs. The applicant has also examined the implications of these plans for apparent or real conflicts of interest and has adjusted its policies and procedures as needed to minimize conflict.
e. Assurance that each MCPN or its provider network provides coverage to its target population a comprehensive and similar set of services for the entire geographic service area. The Plan may exempt MCPNs from providing certain highly-specialized or culturally-specific services (that may be provided centrally by the applicant or through other contracts) in order to ensure access to unique providers. The Plan shall outline steps to ensure that similar services and management activities are provided across the MCPNs while allowing for innovative approaches by each MCPN. This will include a common set of benefits and consistent policies for credentialing, care coordination, and access to care.
f. A description of the applicant's procedures for reimbursing the MCPNs, including how rates will be established for services for each population group and what incentives will be used to reimburse MCPNs and providers. This will also include a process for assessing the financial soundness of rates that are set on a capitated or case rate basis. MCPNs shall manage a population that is of sufficient size so that the rates are actuarially sound. The Plan shall also address how financial solvency of the MCPNs will be assessed upon selection and during their contract.
g. The process for MCPN oversight and monitoring. This shall include the implementation of sanctions, including corrective action plans, termination of MCPN enrollment, financial sanctions and contract termination, when the MCPN or its provider network no longer meets the applicant's requirement or standards.
h. Standards for MCPN reporting of data and a uniform set of performance measures and quality improvement protocols. These shall support all of the reporting that are consistent with the requirements for the PIHPs reporting to the MDHHS.
i. A description of how substance abuse (SA) services will be delivered to people in the service area. Specifically the Plan shall include language about the SA services that will be delivered by the MCPNs that focus on the behavioral health

population, and those that may be delivered by other organizations within the CMHSP and the PIHP.

j. Non-Compete terms that do not restrict the rights of MCPNs to contract with any qualified provider for their specialty networks if they meet the standards and criteria established by the applicant. Similarly, the Plan and MCPN contract terms shall ensure that no provisions of an MCPN's contracts shall restrict otherwise qualified providers from participating in more than one MCPN. However, providers may not have an ownership interest or governance relationship in more than one MCPN in which they also provide services.

k. Assurance that all provisions of the MDHHS's Application for Participation for procurement of Medicaid Specialty Prepaid Inpatient Health Plans (PIHP) are either retained as the responsibility of the PIHP or explicitly delegated by contractual terms to the MCPNs. Assurance that each of the re procured MCPNs will be fully operational not later than January 1, 2015.

l. The competitive procurement methodology which assures best value. The Plan shall outline a proposed process for a re-procurement of the existing MCPNs. The actual re-procurement shall be subject to MDHHS approval and will be implemented in the first year of this AFP. The re-procurement shall include policies and procurement criteria that ensure an adequate provider network, stakeholder and community input, and adherence to public policies and service standards that are unique to the needs of each target population.

1.14.2 ☐ Until the Plan is implemented, the Wayne County Authority applicant will have executed contracts with the existing MCPNs so that they are fully operational on January 1, 2014.

2. ADMINISTRATIVE FUNCTIONS

Descriptions and activities of the managed care administrative functions may be found in the document "Establishing Administrative Costs within and across the CMHSP System, December 2011" located at this site: www.michigan.gov/documents/mdch/Establishing_Admin_Costs_12-11_374192_7.pdf

Instructions: check the box provided to attest to the fact. Enter narrative in text boxes where instructed. Attach documents with labels as instructed at the end of the application.

2.1 General Management Functions

The four chief officers below shall be 100% dedicated to the general management functions of the applicant PIHP only. In other words, they may not have a concurrent role at a CMHSP. It is understood that a chief officer might have dual roles within the PIHP, such as managing the finance function AND the information systems function; or may be responsible for the operations function AND provider network management. Likewise the applicant may choose not to have a Chief Operating Officer.

MDHHS prefers that the chief officers are direct employees of the applicant PIHP. However, MDHHS will not prohibit arrangements that lease the officer from another entity, or that contract with a staffing agency. In such cases, MDHHS requires assurances that the officer is accountable solely to the applicant PIHP for purposes of fulfilling PIHP executive functions, and that there are protections against conflict of interest when decisions are made by the officer that impact the entity from which he/she is leased or contracted. The Regional Entity/UCA accepts full responsibility for managing conflicts and compliance with all laws and regulations including but not limited to those of the Internal Revenue Service. The Regional Entity/UCA accepts full responsibility for any and all liabilities resulting from a PIHP executive whose employer of record is a member CMH in the region.
In the boxes below the applicant shall attest that each chief officer is 100% dedicated to the applicant PIHP; that the CEO will be hired, supervised, and terminated, as necessary, by the PIHP governing board; and other chief officers will be hired, supervised, and terminated, as necessary, by the CEO.

2.1.1. **Chief Executive Officer (CEO)**

2.1.1.1 ☐ The chief executive officer is 100% dedicated to the applicant PIHP functions

2.1.1.2 ☐ The chief executive officer is known and his/her name is: and is:

1. ☐ Employed (or will be employed) by the applicant PIHP

OR

2. ☐ Leased or contracted from: and in Attachment 2.1.1.2.2 are the policies and procedures to be used by the PIHP governing body to assure that there are no conflicts of interest between the PIHP CEO and the entity from

whom he/she is leased or contracted. The PIHP governing board will annually certify to MDHHS that it monitors the CEO and assures there are no conflicts of interest in decision-making and that it understands it maintains full responsibility for compliance with all laws and regulations including IRS and any consequences or liabilities resulting from the leased or contracted arrangement.

2.1.1.3 ☐ The chief executive officer is unknown at the time of this application, but his/her name, employer of record, and conflict of interest policies and procedures, if applicable, will be submitted to MDHHS no later than 5 p.m. on July 1, 2013.

2.1.2. **Chief Operating Officer (COO)**

2.1.2.1. ☐ There will be no chief operating officer (if box is checked, applicant may skip to #2.1.3).

2.1.2.2 ☐ The chief operating officer is 100% dedicated to the applicant PIHP functions.

2.1.2.3 ☐ The chief operating officer is: % FTE; if less than 100%, identify the other functions that the chief operating officer will perform:

2.1.2.4 ☐ The chief operating officer is known and his/her name is: and is:

1. ☐ Employed (or will be employed) by the applicant PIHP

OR

2. ☐ Leased or contracted from: and in Attachment 2.1.2.4.2 are the policies and procedures to be used by the PIHP governing body to assure that there are no conflicts of interest between the PIHP COO and the entity from whom he/she is leased or contracted.

2.1.2.5 ☐ The chief operating officer is unknown at the time of this application, but his/her name, employer of record, and conflict of interest policies and procedures, if applicable, will be submitted to MDHHS no later than 5 p.m. on July 1, 2013.

2.1.3. **Chief Financial Officer (CFO)**

2.1.3.1 ☐ The chief financial officer is 100% dedicated to the applicant PIHP functions.

2.1.3.2 ☐ The chief financial officer is: % FTE; if less than 100% identify the other functions that the chief financial officer will perform:

2.1.3.3 ☐ The chief financial officer is known and his/her name is: and is:

1. ☐ Employed (or will be employed) by the applicant PIHP,

OR

2. ☐ Leased or contracted from: and in Attachment 2.1.3.3.2 are the policies and procedures to be used by the PIHP governing body to assure that there are no conflicts of interest between the PIHP CFO and the entity from whom he/she is leased or contracted.

2.1.3.4 ☐ The chief financial officer is unknown at the time of this application, but his/her name, employer of record, and conflict of interest policies and

procedures, if applicable, will be submitted to MDHHS no later than 5 p.m. on July 1, 2013.

2.1.4. **Chief Information Officer (CIO)**

2.1.4.1 ☐ The chief information officer is 100% dedicated to the applicant PIHP functions.

2.1.4.2 ☐ The chief information officer is: % FTE; if less than 100% identify the other functions that the chief information officer will perform:

2.1.4.3 ☐ The chief information officer is known and his/her name is: and is:

1. ☐ Employed (or will be employed) by the applicant PIHP

OR

2. ☐ Leased or contracted from: and in Attachment 2.1.4.3.2 are the policies and procedures to be used by the PIHP governing body to assure that there are no conflicts of interest between the PIHP CIO and the entity from whom he/she is leased or contracted

2.1.4.4 ☐ The chief information officer is unknown at the time of this application, but his/her name, employer of record, and conflict of interest policies and procedures, if applicable, will be submitted to MDHHS no later than 5 p.m. on July 1, 2013.

2.1.5. **Other Executive Staff**

General Management of PIHP	% FTE Dedicated to the PIHP Function	Names (if known)* or "Unknown"	Employer of Record (If not PIHP, indicate whether leased or contracted by PIHP)
Medical Director			
Substance Use Disorder Prevention & Treatment Director			
Human Resources Director			
Compliance Officer/Program Integrity			

*☐ The name(s) is "unknown," it will be submitted to MDHHS along with the Employer of Record no later than 5 p.m. on July 1, 2013.

2.1.5.1 ☐ In Attachment 2.1.5.1 is an organizational chart that depicts the lines of supervision of each position from the PIHP Board and/or CEO.

2.1.5.2 ☐ The applicant attests that it will adopt one set of common General Management function policies and procedures that will be used throughout the region (among member CMHSPs, MCPNs, or Core Providers).

2.1.5.3 ☐ The applicant attests that the General management policies and procedures used throughout the region will include Program Integrity and Compliance components outlined in 42 CFR 438.602 and 42 CFR 438.608.

2.1.5.4 ☐ If a common policy or procedure is based on one or more from any existing (FY'13) PIHP, the Attachment 2.1.5.4. lists the General Management policies and procedures and the PIHP(s) from which they were adopted.

OR

2.1.5.5 ☐ The common policies and procedures are in development at the time of application, and the Attachment 2.1.5.4. will be submitted to MDCH no later than 5 p.m. on July 1, 2013.

2.2 Financial Management Functions

Financial management functions typically include: 1) budgeting – general accounting and financial reporting, 2) revenue analyses, 3) expense monitoring and management, 4) service unit and recipient-centered, 5) cost analyses and rate-setting, 6) risk analyses, risk modeling and underwriting, 7) insurance, re-insurance and management of risk pools, 8) supervision of audit and financial consulting relationships, 9) claims adjudication and payment, and 10) audits. The responses below should take into account those functions, and any other the applicant has identified.

2.2.1 ☐ In Attachment2.2.1 is an organizational chart that depicts the lines of supervision from executive staff and oversight of each of the ten Financial Management Functions above and any others the PIHP will be adding.

2.2.2 ☐ The applicant attests that it will adopt one set of common Financial Management function policies and procedures that will be used throughout the region (among member CMHSPs, MCPNs, or Core Providers).

2.2.3 ☐ If a common policy or procedure is based on one or more from any existing (FY'13) PIHP, the Attachment 2.2.3, lists the Financial Management policies and procedures and the PIHP(s) from which they were adopted.

OR

2.2.4 ☐ The common policies and procedures are in development at the time of application, and the Attachment 2.2.4 will be submitted to MDHHS no later than 5 p.m. on July 1, 2013.

2.3 Information Systems Management

Overview

The PIHP must have an information management system that supports the core administrative activities of the region including:

a. The ability to accept on behalf of entire region of CMHSPs/CAs, enrollment and revenue files, in HIPAA compliant formats, from the State of Michigan.
b. The ability to accept clinical, financial, utilization, demographic, quality and authorization information from CMHSP/CA sources (including providers) in standard electronic formats (i.e., HIPAA Administrative Simplification X12N). Note if the CMHSP/CA/provider source is capable of sending in standard electronic formats, the PIHP must receive via standard electronic means versus requiring direct entry or non-standard format.
c. The ability to accept clinical, financial, utilization, demographic, quality and authorization information through clearinghouses and other viable, secure and efficient means when requested by CMHSP/CA sources and providers.
d. The ability to analyze, integrate and report clinical, financial, utilization, demographic, quality and authorization information.
e. The ability to submit QI and encounter data in compliant formats as specified by MDCH. Data must pass all required data quality edits prior to being accepted into CHAMPS before it is sent to the warehouse.
f. The ability to identify, analyze and report costs and revenues for service components, including, but not limited to, analysis and reporting by regions and CMHSP/CA sources and providers.
g. The ability to detect and correct errors in data receipt, transmissions and analyses. This includes screening for completeness, logic, and consistency; and identifying and tracking fraud and abuse.
h. The ability (within limits of law) to safely and securely send and receive data to and from other systems. This includes, but is not limited to, the State of Michigan, health plans and providers systems including physical health and non-healthcare support systems of care. (Note: If the PIHP region is selected to participate in Medicaid Health Homes and/or Integrated Care For Dual Eligibles demonstrations, the PIHP must be able to interface with health plans and provider systems).

For new entities representing multiple CMHSPs in a state-defined region:

a. The Information Technology Policies, Procedures and systems from one of the existing hub-PIHP/CMHSPs may be utilized as the foundation of the system for the new entity. (Note: this will allow former hub-PIHP/CMHSP performance as verified by MDHHS and external quality review organization to be considered in review of application submission).
b. The PIHP must have the ability to directly transmit and receive data from and to all individual CMHSP/CA sources without the additional step of going through

former hub-PIHP/CMHSP systems for sub-groups of CMHSPs in that same region. If more time is required for smooth transition to a single PIHP IT system supporting all CMHSPs/CAs in the region, then the applicant will list target date for completion. Award and contract with the PIHP entity will include successful transition by target date as a condition of the award and continuing contract past target date.

Response Criteria

Note: For PIHPs representing regions containing more than one CMHSP for each separate response below list the specific name of the former hub PIHP/CMHSP whose policies, procedures, processes and technologies are being adopted as the foundation for the new entity to be deployed region wide. This will allow past performance (as determined by MDHHS monitoring and/or third party reviewer) of a hub CMHSP as PIHP to be considered in review of application submission. This is expected to significantly decrease the length of response needed in this application submission and decrease additional information that may be requested by MDHHS during review of submission.

2.3.1 ☐ In Attachment 2.3.1. is an organizational chart that depicts the lines of supervision from executive staff and oversight for each Information Systems function.

2.3.2 ☐ The applicant attests that it will adopt one set of common Information Systems Management function policies and procedures that will be used throughout the region (among member CMHSPs, MCPNs, or Core Providers).

2.3.3 ☐ If a common policy or procedure is based on one or more from any existing (FY'13) PIHP, the Attachment 2.3.3., lists the Information Systems Management policies and procedures and the PIHP(s) from which they were adopted.

OR

☐ The common policies and procedures are in development at the time of application, and the Attachment 2.3.3. will be submitted to MDHHS no later than 5 p.m. on July 1, 2013.

2.3.4 ☐ In the text box below is a two-page description, of the applicant's process detailing how behavioral health and I/DD data (clinical, encounter, claims, demographics, quality, outcomes) aggregated from all CMHSP/CA sources and providers will be:

a. Tested for accuracy and completeness prior to submission to MDCH. Also, describe the process of that submission.
b. Submitted in a timely fashion to MDHHS.
c. A consistent region-wide process by January 1, 2014.

2.3.4

2.3.5 ☐ More time is needed for transition, the date by which full transition from former PIHPs to new PIHP will be completed is: . In the one-page text box below are the action steps and milestone dates toward achieving a consistent region-wide process:

2.3.5.

2.3.6 ☐ In the text box below is a one-page description of the protection and security features of the PIHP's information management system to ensure confidentiality, data integrity and protection from intrusion. It includes:

a. The risk mitigation and management procedures for a loss of confidential data or security breach to include notification of affected consumers.
b. Confirmation that this will be a consistent region-wide process by January 1, 2014. If more time is needed for transition, list date by which full transition from former PIHPs to new PIHP will be completed: **(date)**

2.3.6

2.3.7 ☐ In Attachment 2.3.7. is a process/information flow diagram(s) and in the text box below is a one-page narrative explaining the following:

d. How individual information will be aggregated, stored and compiled by the PIHP from CMHSP/CA and provider network sources.
e. How data completeness, validation, timeliness and accuracy will be confirmed and coordinated with CMHSPs/CAs to ensure accurate and timely submission to MDCH (QI, encounter).
f. How eligibility/enrollment information will be received from the State and then parsed by the PIHP for use by the CMHSP(s)/CAs in the region.
g. How the PIHP information management system supports authorization and utilization management processes both those delegated and not delegated by the PIHP.

2.3.7

FUNCTIONS SUPPORTING INTEGRATED CARE (Physical, Behavioral/I/DD Supports and Services):

2.3.8 ☐ In the text box below is a one-page description of the steps that will be taken to exchange behavioral healthcare data with local/community partners, Sub-state HIEs (health information exchange), and/or MiHIN/NwHIN (Michigan Health Information Network/Nationwide Health Information Network) that includes:

a. Whether the PIHP will maintain a role in the exchange of HL7 CCD formats on behalf of CMHSPs in the region. If so, there is a description of the process to be used and how consent management will be engaged.
b. How the PIHP will use state and national standards for the transfer and interface of behavioral healthcare data (MI/DD/SUD clinical, encounter, claims, demographics, outcomes) between disparate systems (e.g., Care Bridge, Sub-state HIEs/MiHIN/NwHIN, health plans, providers, etc.).

2.3.8

2.3.9. ☐ In the text box below is a half-page description of the PIHP's capability and/or plan to conduct population-level data analytics from multiple healthcare sources (both primary and behavioral). This includes dashboard indicators and other data mining capabilities that facilitate population management (historical and predictive capacity for assessing cost/risk), utilization management, and care coordination activities.

2.3.9

2.3.10. ☐ In the text box below is a half-page description of the planned actions for engaging standards (statewide/national) that improve care coordination, reduce error, eliminate duplicative data entry efforts, and behavioral healthcare data access to the consumer (promoting meaningful use).

2.3.10

2.3.11. In the table below, name the CMHSPs and core providers who are utilizing EHRs. The name of the EHR software in use at each and whether purchased or developed in-house, and whether nationally certified should also be entered in the third column.

Note: It is not required to have a certified EHR at the PIHP level, but if one is available to the CMHSPs for use, owned by the PIHP, please make note. It is also understood that EHR certification standards are still evolving for purposes of behavioral health.

Table 2.3.11

CMHSP, MCPN, Core Provider Utilizing EHRs	EHR Software Used	Purchased or Developed In-House, and note if Certified

2.4 Provider Network Management

Provider Network Management typically includes the functions of 1) network development and procurement (and re-procurement), 2) provider contract management (including oversight), 3) network policy development, 4) credentialing, privileging and primary source verification of professional staff, and 5) background checks and qualifications of non-credentialed staff. The "provider network" of the PIHP includes as applicable, the member CMHSPs, MCPNs, Core Providers, or any other provider with which the PIHP has a direct contract to deliver a covered service. It is the responsibility of the PIHP to perform the functions above, and to assure that its provider network performs these functions in the management of any providers it procures.

In the text boxes below, provide a half-page description of how the PIHP will oversee the five functions listed above:

2.4.1. Network development and procurement.

2.4.2. Provider contract management and oversight.

2.4.3. Network policy development.

2.4.4. Credentialing, privileging and primary source verification of professional staff.

2.4.5. Background checks and qualifications of non-credentialed staff.

2.4.6. ☐ In Attachment 2.4.6. is an organizational chart that depicts the lines of supervision from executive staff and oversight for each function.

2.4.7. ☐ The applicant attests that it will adopt one set of common Provider Network Management function policies and procedures that will be used throughout the region (among member CMHSPs, MCPNs, or Core Providers).

2.4.8. ☐ If a common policy or procedure is based on one or more from any existing (FY'13) PIHP, the Attachment 2.4.8., lists the Provider Network Management policies and procedures and the PIHP(s) from which they were adopted.

OR

2.4.9. ☐ The common policies and procedures are in development at the time of application, and the Attachment 2.4.9. will be submitted to MDHHS no later than 5 p.m. on July 1, 2013.

2.4.10. ☐ In the text box below is a one-page description of how the applicant will assure that the capacity of the provider network is sufficient to make available all the specialty services and supports in the entire region. Include how capacity will be measured. Include how the applicant will assure that existing standards for geographic access and timeliness of access to the services will be met within the region in accordance with 42 CFR 438.206.

2.4.10.

2.4.11. ☐ In the text box below is a one-page description of how the applicant will perform oversight of its provider network to assure the health and welfare of the region's service recipients.
2.4.11.

2.5 Utilization Management

Utilization management typically includes the following functions: 1) access and eligibility determination, 2) utilization management protocols, 3) service authorization, and 4) utilization review. The functions may be fully or partially-delegated to the PIHP's provider network.

2.5.1. ☐ In Attachment 2.5.1. is an organizational chart that depicts the lines of supervision from executive staff and oversight for each function.

2.5.2. ☐ The function will not be delegated.

OR

2.5.3. ☐ The function will be fully or partially delegated. In the text box below is a one-page description of each function that will be delegated and to what entity it will be delegated; and how the governing structure and CEO will provide monitoring and oversight of the delegated functions.

2.5.3

2.5.4. ☐ The applicant attests that it will adopt one set of common Utilization Management function policies and procedures that will be used throughout the region (among member CMHSPs, MCPNs, or Core Providers).

2.5.5. ☐ If a common policy or procedure is based on one or more from any existing (FY'13) PIHP, the Attachment 2.5.5., lists the Utilization Management policies and procedures and the PIHP(s) from which they were adopted.

OR

2.5.6. ☐ The common policies and procedures are in development at the time of application, and the Attachment 2.5.5. will be submitted to MDHHS no later than 5 p.m. on July 1, 2013.

2.6 Customer Services

Customer services functions are typically: 1) information services that are compliant with 42 CFR 438.10, 2) maintenance and annual provision of the Customer Services Handbook that has been approved by MDHHS, 3) facilitation of consumer empowerment and participation in PIHP planning and monitoring, 4) customer complaint, grievances and appeals, and 5) community benefit. While functions number one and two are the responsibility of the PIHP, the other three functions may be delegated in part or in full.

2.6.1. ☐ In Attachment 2.6.1. is an organizational chart that depicts the lines of supervision from executive staff and oversight for each function.

2.6.2. ☐ The functions will not be delegated.

OR

2.6.3. ☐ The function will be fully or partially delegated. In the text box below is a one-page description of each function that will be delegated and to what entity it will be delegated; and how the governing structure and CEO will provide monitoring and oversight of the delegated functions.
2.6.3.

2.6.4. ☐ The applicant attests that the Customer Services Handbook that reflects the applicant region will be submitted to MDHHS for approval no later than October 1, 2013, and that it will be ready for delivery to the beneficiaries no later than January 1, 2014.

OR

2.6.5. ☐ The applicant attests that the PIHP region is not changing in 2014 and that the current Customer Services Handbook is up-to-date and has been approved by MDCH.

2.6.6. ☐ The applicant attests that it will adopt one set of common Customer Services policies and procedures that will be used throughout the region (among member CMHSPs, MCPNs, or Core Providers).

2.6.7. ☐ If a common policy or procedure is based on one or more from any existing (FY'13) PIHP, the Attachment 2.6.7., lists the Customer Services policies and procedures and the PIHP(s) from which they were adopted.

OR

2.6.8. ☐ The common policies and procedures are in development at the time of application, and the Attachment XX will be submitted to MDHHS no later than 5 p.m. on July 1, 2013.

2.7 Quality Management

Quality Management typically includes the following functions: 1) developing an annual Quality Assessment and Performance Improvement Program (QAPIP) plan and report, 2) standard-setting, 3) conducting performance assessments, 4) conducting on-site monitoring of providers in the provider network, 5) managing regulatory and corporate compliance, 6) managing outside entity review processes (e.g., external quality review, PIHP accreditation), 7) conducting research, 8) facility quality improvement process , 9) facility provider education and oversight, and 10) analyzing critical incidents and sentinel events. MDHHS expects that the PIHP will not delegate these functions and understands that some of the functions will be performed in addition by the provider network (member CMHSPs, MCPNs, or core providers).

2.7.1. ☐ In Attachment 2.7.1. is an organizational chart that depicts the lines of supervision from executive staff and oversight for each function.

2.7.2. ☐ The functions will not be delegated.

OR

2.7.3. ☐ The function will be fully or partially delegated. In the text box below is a one-page description of any of the ten functions that will be delegated and to what entity it will be delegated; and how the governing structure and CEO will provide monitoring and oversight of the delegated functions.
2.7.3.

2.7.4. ☐ The applicant attests that the QAPIP plan that reflects the applicant region will be submitted to MDHHS no later than October 1, 2013, and that it will be ready for implementation by January 1, 2014.

OR

2.7.5. ☐ The applicant attests that the PIHP region is not changing in 2014 and that the current QAPIP plan is up-to-date and has been submitted to MDHHS.

2.7.6. ☐ The applicant attests that it will adopt one set of common Quality Management policies and procedures that will be used throughout the region (among member CMHSPs, MCPNs, or Core Providers).

2.7.7. ☐ If a common policy or procedure is based on one or more from any existing (FY'13) PIHP, the Attachment 2.7.7., lists the Quality Management policies and procedures and the PIHP(s) from which they were adopted.

OR

2.7.8. ☐ The common policies and procedures are in development at the time of application, and the Attachment 2.7.7. will be submitted to MDHHS no later than 5 p.m. on July 1, 2013.

ACCREDITATION STATUS

As evidenced by developments in federal and Michigan policy, the ability to perform managed care functions to industry standards while also assuring program integrity with federal and state funds is an expectation for the Regional Entity or Urban Cooperation Act PIHPs. MDHHS will determine by October 1, 2013, the specific accreditation requirements including NCQA or URAC category options for PIHPs. It is recognized that accreditation is neither quick nor easy; nor inexpensive. Given these realities MDCH is carefully considering the best course of action and required timeframes for accreditation of PIHPs. It should be noted that the "health plan" categories of accreditation for both NCQA and URAC provide the closest match to federal and state requirements for managed care organizations including PIHPs.

3.1. ☐ In the text box below is a half-page description of the status of any URAC or NCQA accreditation of current (2013) PIHP(s) in the applicant's region.

3.1

3.2. ☐ In the text box below is a half-page description of the status of activity, viewpoints, options or plans in this applicant's new region to obtain URAC or NCQA accreditation. Make note of specific categories or programs within NCQA or URAC being considered or evaluated. (examples of categories: URAC-Health Plan, URAC-Health Network, NCQA-MBHO, NCQA-Health Plan). Include target application date if known.

3.2

3. **EXTERNAL QUALITY REVIEW**

Beginning January 1, 2015, the external quality review organization (EQRO) will a) review the new PIHPs' compliance with the Balance Budget Act (BBA) standards; b) validate the performance measures; and c) validate the new mandatory performance improvement project that will commence January 1, 2014. Until then, MDHHS will rely on the performance, as measured by the EQRO, of existing PIHP(s) in each new region. Where there are weaknesses in an existing PIHP, MDHHS expects that applicant to address how performance will be improved. Below is the applicant's assessment of the performance of existing PIHP(s) in the applicant's region.

4.1.1. ☐ All BBA standards in FY'11-12 were determined by Health Services Advisory Group (HSAG) to meet or exceed 95% compliance in any current (FY'13) PIHP in the new region.

OR

4.2. ☐ In the text box below is any BBA standard(s) for which, in FY'11-12, there was less than 95% compliance by one or more current PIHPs in the new region; AND a description of the plan with action steps, responsible staff, and timeframes for the applicant achieving a minimum of 95% compliance with every BBA standard by January 1, 2015.

4.2

4.3. ☐ All Performance Measures were designated "fully compliant" in FY'11-12 for all current PIHPs in the new region.

OR

4.4. ☐ In the text box below is any Performance Measure that, in FY'11-12, received an EQRO audit designation of less than "fully compliant" by one or more current PIHPs in the new region; AND a description of the plan with action steps, responsible staff, and timeframes for the applicant achieving a minimum of fully compliant on all performance measures by January 1, 2015.

4.4

4.5. ☐ All current PIHPs in the new region scored 100% the Performance Improvement Project Validation for FY'11-12 on *Evaluation Element* Met and *Critical Elements* Met.

OR

4.6 ☐ In the text box below is any EQRO score of less than 100% on the Evaluation Elements *Met,* and any score of less than 100% on Critical Elements *Met* on the Performance Improvement Project validation for FY'11-12 by any current PIHP in the new region; AND a description of the plan with action steps, responsible staff, and timeframes for the applicant achieving a minimum of 100% *Met* on both Evaluation Elements and Critical elements by January 1, 2015.

4.6

5. PUBLIC POLICY INITIATIVES

The public policy initiatives outlined below reflect MDHHS's need to certify to CMS that the PIHP assures the full array of specialty services and supports is available and that it maintains adequate provider network capacity to serve the region's Medicaid beneficiaries (42 CFR 438.207). In addition, these public policies address the need to protect the vulnerable people served and at the same time to offer them opportunities to successfully live in the community, to work, and to develop and maintain meaningful relationships.

5.1 Regional Crisis Response Capacity

Crisis Response Capacity comprises three concepts: 1. Ongoing tracking and trending of critical incidents[1] and sentinel events;[2] 2) employing strategies to prevent critical incidents and sentinel events; and 3) having in place the capacity to regionally respond to behavioral or medical crises. The first concept is not new to Michigan's public mental health system, and it is expected that the applicant is in compliance with the Quality Assessment and Performance Improvement Program (QAPIP) standards where those activities are required and are measured by the External Quality Review and the Medicaid Site Review.

For the past few years MDHHS has provided tools to the public mental health system for prevention of, and early intervention in, crises. [See MDCH/PIHP FY'13 Contract Attachment 1.4.1 Technical Requirement for Behavior Treatment Plan Review Committees; Prevention Guide, June 2011 at www.michigan.gov/Mental Health and Substance Abuse (page); Transition Guide for Placement into AFCs; and Center for Positive Living Supports www.positivelivingsupport.org].

Thus the applicant attests that in the region there are common established processes which demonstrate that the provider network effectively:

5.1.1. ☐ Evaluates the systemic factors involved in any occurrence of critical incidents and at-risk health conditions, and behavioral and medical crises.

5.1.2. ☐ Identifies any individual precursors to potential behavioral or medical crises that can serve as a warning to care givers and staff.

5.1.3. ☐ Identifies and implements actions to eliminate or lessen the risk that critical incidents, sentinel events, and behavioral crises will occur.

For this new AFP, it is expected that the applicant describe the crisis response capacity that will be fully available in each PIHP region by January 1, 2015. Crisis response capacity includes clinical expertise that can be immediately accessed for mental health or behavioral crises. That expertise may be a team or teams of clinicians who are available for telephonic consultation and on-site observation and consultation, and have the training and experience to address the needs of children and adults with serious mental illness (SMI/SED) and children and adults with intellectual/developmental disabilities (I/DD), and children and adults with co-occurring SMI/SED and I/DD. This crisis response capacity

[1] Critical incidents as defined by the FY'18 MDHHS/PIHP contract Attachments 7.7.1.1 and 7.9.1

[2] 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 the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. Such events are called "sentinel" because they signal the need for immediate investigation and response.

must also have a residential or inpatient component to which an individual can be transported, reside for a short period, and receive treatment or intervention until his/her crisis stabilizes. This capacity could be **intensive crisis stabilization or crisis residential services in** a free-standing licensed adult foster care facility and a free-standing licensed children's foster care facility, staffed with clinicians and workers who are specially trained to respond effectively to behavioral crises exhibited by adults or children with SMI/SED or adults with I/DD. This capacity could alternatively be an agreement with a regional inpatient psychiatric unit that is willing and able to receive any individual (SMI, SED or I/DD, adult or child) who is exhibiting a behavioral crisis. This capacity must include emergency admission.

5.1.4. ☐ In table 5.1.4 below is a regional analysis of people who are at risk with answers to the five questions following.

OR

☐ The table below will be completed, with the five questions answered, and submitted to MDHHS no later than 5 p.m. on July 1, 2013.

Identify the number of individuals identified as at-risk of crisis placement as determined by experiencing within the last six months: more than one 911 call for police intervention, more than one temporary placement in a crisis home, an on-site visit from the CPLS mobile team, more than one visit to the ER for behavioral episode, an admission to a psych in-patient unit, one or more requests for inpatient admission to a state psychiatric facility. Sort by age (child, adult 18-64, 65+) and disability designation (SED, SMI and I/DD).

Table 5.1.4

	911 calls	Temporary placements in crisis home	On-site visit by CPLS mobile team	ER visit	Admission to psych inpatient unit	Request for inpatient admission to state facility
Child with SED						
Adult with SMI 18-64						
Adult with SMI 65+						
Child with I/DD*						

	911 calls	Temporary placements in crisis home	On-site visit by CPLS mobile team	ER visit	Admission to psych inpatient unit	Request for inpatient admission to state facility
Adult with I/DD* 18-64						
Adult with I/DD* 65+						

***Count people on the Autism Spectrum Disorder or people with co-occurring SMI/SED and I/DD in this category**

5.1.5. ☐ In text box below are the numbers of individuals who have:
- 5.1.5.1. A current (within the last 12 months) behavioral treatment plan with restrictive or intrusive interventions approved by the Behavior Treatment Plan Review Committee:
- 5.1.5.2. Experienced (within the last 12 months) an injury requiring emergency room visit or hospital admission due to an intervention that occurred during a behavioral episode:

5.1.6. ☐ Beds are available in secure settings (e.g., psych unit in a community or private hospital) in the region and organizations "owning" the beds are willing to make them available to people with SMI, SED or I/DD with behaviors.

5.1.7. ☐ In text box below is percent of staff in the region who have participated in the Culture of Gentleness Working with People training:
- 5.1.7.1. Direct care workers:
- 5.1.7.2. Group home managers:
- 5.1.7.3. Supports coordinators/case managers:
- 5.1.7.4. Or other more advanced training such as Culture of Gentleness Practicum or Mentor Training :

5.1.8. ☐ In the text box below is a two-page description of:
- a. The identification of at least one point person in the region who is available 24/7, 365 days/year to respond to crises that require immediate attention and who has the authority to arrange for temporary placement, regional crisis team or CPLS team consultation or visit.
- b. Agreement(s) between the PIHP and hospitals or licensed AFCs in the region that will be available for short-term crisis placement.
- c. Any plans for developing crisis residential programs.
- d. Target dates for achieving full crisis response capacity by January 1, 2015.

5.1.8.

5.2 Health and Welfare

5.2.1. Health

One of MDCH four main strategic priorities for MDHHS is to "Improve the Health of the Population". This includes promoting 4x4 wellness activities to reduce obesity and targeting chronic care "hot spots" in population and geography. The public mental health system serves people who are among the most vulnerable of Michigan's citizens, It is well documented that longevity for persons with mental illness is 25 years shorter than persons without mental illness. MDHHS is seeking greater integration of systems of care to promote healthy behaviors and management of chronic conditions and all aspects of health: physical health, behavioral health, and habilitation.

Primary behavioral health conditions and disabilities frequently are complicated by co-occurring disabilities (e.g., a developmental disability plus epilepsy, swallowing disorder, respiratory or bowel issues), and by co-occurring chronic diseases (e.g., asthma, hypertension, obesity). These conditions, disabilities and diseases usually require frequent and ongoing intervention, treatment and monitoring by health care professionals.

In the absence of ambulatory and preventive care, treatment and monitoring, people use expensive emergency room services or are hospitalized for acute episodes of their conditions. [Please review the Health Services Advisory Group's "2010-2011 Coordination of Care/Medical Services Utilization Focused Study Report, March 2012" at www.michigan.gov/documents/MDHHS/MI2010-11_FocusedStudy_SMI-DD_Report_F1_382152_7.pdf] While PIHPs are not paid to provide primary health care, it is expected that PIHPs assure that individuals being served receive appropriate, culturally-relevant and timely healthcare; that medical care providers are knowledgeable in how to approach and treat individuals with mental illness and/or intellectual/developmental disabilities; and that the PIHPs' provider networks are partners on the health care team for health care planning and monitoring purposes.

The applicant attests to the following:

5.2.1.1 ☐ Reporting on Health Conditions (MDHHS/PIHP FY'13 Contracts, Attachment 6.5.1.1, Quality Improvement Reporting, Elements #39 through 41) is currently at 95% or more completeness for all populations served in the region.

OR

5.2.1.2 ☐ A plan that has action steps, responsible staff, and timeframes has been developed for achieving 95% or more completeness by January 1, 2014.

5.2.1.3 ☐ By January 1, 2014, person-centered planning (as documented in the individual plan of service) for each beneficiary will address:

a. Current physical health conditions.
b. Existence of health care practitioners that are treating any physical health conditions.

c. Any assistance (e.g., referral, coordination, transportation) that the beneficiary needs in accessing health care practitioners.

5.2.1.4 ☐ In Attachment 5.2.1A., is a description of no more than 4 pages, of how the applicant plans to assure coordination between the provider network and the beneficiaries' primary care practitioners to assure that appropriate preventative and ambulatory care are provided; existing health care conditions are treated and monitored by the health care team; and incidents of emergency room visits (for physical health or mental health crises) and hospital admissions (for physical health or mental health episodes) are immediately communicated among the health care team members; and that medical care providers are knowledgeable in how to approach and treat individuals with mental illness and/or intellectual/developmental disabilities. The description includes:

a. Any electronic methodology(ies) that will be used to share information among the health care team members.
b. How follow-up care (to emergency room visits and hospitalization) will be coordinated among the health care team members.
c. Steps to be taken to reduce or prevent recurrence of the issue(s) that have required avoidable emergency room visits and hospital admissions, including staff training and professional(s) identified for monitoring and oversight.
d. Plans for assuring adequate capacity to serve individuals with high medical needs, including the ability to assure smooth and timely transitions for individuals being discharged from the hospital.

OR

5.2.1.5 ☐ The plan noted in number 5.2.1.4 above is in development, and will be submitted to MDHHS no later than 5 p.m. on July 1, 2013.

5.2.2 Welfare

Many individuals served by the public mental health system are victims of abuse, neglect, and exploitation intermittently or for long periods throughout their lives. These traumatizing events have a profound impact on an individual's ability to recover, to learn new skills to improve functioning, to develop and maintain relationships, and to live and work successfully in the community. For many years, MDHHS has provided leadership on evidence-based trauma-informed care.

There are many legal obligations to report abuse, neglect and exploitation to various law enforcement and public entities that will not be repeated here. Assuring welfare goes beyond reporting incident as they occur and includes a robust process for analyzing risk factors and reported incidents by individual beneficiary, population, and provider entity, if applicable. There must be close monitoring and oversight to prevent incidents of abuse, neglect, exploitation and other critical/sentinel events from occurring in the first place whenever possible. Monitoring should include information from other sources, such as licensing reports for group homes where individuals served by the PIHP reside [see Office of Inspector General Report on Home and Community-Based Services in Assisted Living Facilities on the MDHHS web site at Mental Health and Substance Abuse page]. Assuring welfare also includes seeing to the immediate safety of the individual and others, as well as

acting promptly and decisively when an incident is substantiated to prevent future occurrences for that individual or others.

The applicant attests to the following:

5.2.2.1 ☐ A signed agreement between each CMHSP in the region and their local Department of Human Services office and the Bureau of Child and Adult Licensing (BCAL) will be in effect on 1/1/14 to coordinate investigations as applicable.

5.2.2.2 ☐ Percent of staff in the region who have participated in the Trauma-Informed Care training:

a. Direct care workers:
b. Group home managers:
c. Supports coordinators/case managers:
d. Other:

5.2.2.3 ☐ In Attachment 5.2.2.3., is a description of no more than four pages, of how the applicant plans to assure the welfare of beneficiaries. The description includes how the applicant assures that its provider network will:

a. analyze risk factors and reported incidents by individual beneficiary and provider entity if applicable to identify patterns and trends;
b. provide close monitoring and oversight, including the staff responsible and frequency of monitoring and oversight ;
c. assure the immediate safety of the individual and others who may be affected when incidents occur, e.g., provisions for the immediate transfer of recipients to a different provider if their health or safety is in jeopardy.

OR

5.2.2.4 ☐ The plan described above is in development and will be submitted to MDHHS no later than 5 p.m. on July 1, 2013.

5.3 Olmstead Compliance

5.3.1 Community Living

Title II's integration mandate of the Americans with Disabilities Act requires that the "services, programs, and activities" of a public entity be provided "in the most integrated setting appropriate to the needs of qualified individuals with disabilities." 28 CFR 35.130(d). Such a setting is one that "enables individuals with disabilities to interact with nondisabled persons to the fullest extent possible." 28 CFR 35, App. B at 673. [Please refer to the recent activities of the Civil Rights Division of the U.S. Department of Justice that has been working with state and local governmental officials to insure ADA and Olmstead compliance: www.ada.gov/olmstead/index.htm]

A state or local government must eliminate any eligibility criteria for participation in programs, activities, and services that screen out or tend to screen out persons with disabilities, unless it can establish that the requirements are necessary for the provision of the service, program, or activity. The state or local government may, however, adopt legitimate safety requirements necessary for safe operation if they are based on real risks, not on stereotypes or generalizations about individuals with disabilities. Finally, a public entity must reasonably modify its policies, practices, or procedures to avoid discrimination. If the public entity can demonstrate that a particular modification would fundamentally alter the nature of its service, program, or activity, it is not required to make that modification.

Michigan has been a long-time leader in developing community-based living supports and services, so the provisions of the Olmstead decision related to community living and working are not new to the public mental health system.

Respond with the applicant's assurances to the attestations below:

5.3.1.1 ☐ The applicant has a written policy defining the standards the region's provider network will follow in releasing people from institutions. The provider network's treatment professionals must determine that the placement is appropriate; the individual must not object to being released from the institution; and the provider is able to provide supports and services that enable them to live successfully in the community.

OR

5.3.1.2 ☐ The written policy is in development and will be completed by this date:

5.3.1.3 ☐ The applicant has a written regional policy in place that calls for treatment professionals to respect and support the housing preferences and choices of people with disabilities and truly fulfill the mandates of the ADA with respect to community integration.

OR

5.3.1.4 ☐ The written regional policy is in development and will be completed by this date:

5.3.1.5 ☐ There will be a regional plan commencing no later than January 1, 2014 to establish partnerships with local housing agencies and housing providers. The goal of these collaborations should be to develop interagency strategies that increase affordable, community-based, integrated housing options for people with disabilities that meet their preferences and needs.

5.3.1.6 ☐ In the three tables below are regional analyses of the numbers of people served who at the time of application live in the settings noted.

OR

5.3.1.7 ☐ The tables below will be completed and submitted to MDHHS no later than 5 p.m. on July 1, 2013.

Table 5.3.1.6 A

Number of all individuals by children (up to age 18), adults (18-64) and seniors (65+) and primary disability – serious mental illness, serious emotional disturbance, and intellectual/developmental disability living in any licensed setting.

	# in licensed setting <6 beds	# in licensed setting – 6 beds	# in licensed setting 7-12 beds	# in licensed setting 13+ beds	# in Skilled Nursing Facilities	Total # per population	Percent of Total Served
Children w/ SED							
Adults SMI 18-64							
Adults SMI 65+							
Children w/ I/DD							
Adults I/DD 18-64							
Adults I/DD 65+							
Total							

Note: If a beneficiary lives in a group home licensed for six beds but that home is located on a campus with other group homes, report the total number of licensed beds for that provider at that campus location.

Table 5.3.1.6 B
Number of individuals by children (up to age 18), adults (18-64) and seniors (65+) and primary disability – serious mental illness, serious emotional disturbance, and intellectual/developmental disability living in a licensed setting *outside* the PIHP region.

	# in licensed setting <6 beds	# in licensed setting – 6 beds	# in licensed setting 7-12 beds	# in licensed setting 13+ beds	Total # per population	Percent of Total Served
Children w/ SED						
Adults SMI 18-64						
Adults SMI 65+						
Children w/ I/DD						
Adults I/DD 18-64						
Adults I/DD 65+						
Total						

Table 5.3.1.6 C
The number of adults who live independently, with or without supports, with or without house/roommates. Home/apartment is not a licensed facility and is owned or leased by the individual.

	Independent without supports	Independent with supports	Independent with house/roommates	Independent without house/roommates
Adults SMI 18-64				
Adults SMI 65+				
Adults I/DD 18-64				
Adults I/DD 65+				

5.3.1.8. ☐ In the text box below is a narrative of no more than two pages that describes:

a. How informed choice of type of setting, provider, roommates/housemates are guaranteed in the annual person-centered planning process.
b. The transition planning process undertaken to assure that there is the right match between the individual and the licensed setting.

c. How individual opportunities for community integration and inclusion, and productivity are addressed and guaranteed in licensed settings (See Keys Amendment at 1915.1616(e) of the Social Security Act that pertains to social security income recipients living in facilities (e.g., group homes, congregate living arrangements).
d. The determinants of the frequency of PIHP monitoring of individuals living in licensed settings differentiated by Specialized Residential settings, and General AFCs. Include how issues or deficiencies are addressed when noted.
e. Plans with action steps, responsible staff, timeframes and numbers of people for developing increased regional alternative (to licensed AFC) residential capacity. 5.3.1.8

OR

☐ The narrative description above will be submitted no later than July 1, 2013.

5.3.1.9 ☐ In Attachment 5.3.1.10., is a plan with action steps and timeframes for developing capacity for bringing [the number] of people currently living out of the region, or transitioned to another PIHP if chosen by the person, back to live within the region. This may be a phased-in approach, but must commence October 1, 2014.

OR

5.3.1.10 ☐ The plan described above is in development and will be submitted to MDHHS no later than 5 p.m. on July 1, 2013.

Olmstead Compliance:

5.3.1 **Employment and Community Activities**

CMS underscores that the competitive, integrated employment in the community for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities is the **optimal** outcome of Pre-Vocational/Skill-building services. All pre-vocational and supported employment service options should be reviewed and considered as a component of an individual plan of services (IPOS) developed through a person-centered planning process, no less than annually, more frequently as necessary or as requested by the individual. These services and supports should be designed to support successful employment outcomes consistent with the choice and preferred outcomes of the individual's goals and reflected in the IPOS. [Center for Medicaid and CHIP Service (CMCS) Informational Bulletin, September 16, 2011. Also see MDCH Employment Works! Policy, revised July 2012.]

Work is a key component to recovery through Evidence-based Practice/Individual Placement Supports. MDCH also strongly recognizes that employing Peer Specialists and Peer Mentors can help organizations improve their service delivery systems.

MDHHS is initiating an employment data dashboard to track various employment settings (individual, group, Ability One, Clubhouse, and other employment) by wages per hour, and hours per month as well as expected movement toward competitive, integrated community employment. Accurate, timely, and effective federal and state benefits planning related to working is a key to acquiring and maintaining employment.

MDHHS expects that each PIHP will embrace the above tenets and encourage its provider network to provide services in the most integrated setting appropriate to the needs of qualified individuals with disabilities.

Respond with the applicant's attestations below:

5.3.2.1 ☐ The applicant will have a regional policy in place no later than January 1, 2014 that assures consistency across the applicant's service area in the provision of competitive, integrated employment services for the individuals served. This policy will be available for review prior to that date.

5.3.2.2 ☐ The applicant will have in place no later than January 1, 2013 a regional policy that assures there are affirmative efforts are in place to increase agency and subcontractor employment of individuals with disabilities including recruitment, placement and development of pay scales including fringe benefits and training. Applicant has individuals who have disclosed they have disabilities on staff: #FTEs.

5.3.2.3 ☐ The applicant assures that its provider networks will link beneficiaries to accurate and timely information about the continuation of federal and state benefits in preparation for and while they are competitively employed.

5.3.2.4 ☐ In the two tables below are regional analyses of the numbers of people served who at the time of application are engaged in the ways noted.

OR

5.3.2.5 ☐ The tables below will be completed and submitted to MDHHS no later than 5 p.m. on July 1, 2013.

Table 5.3.2.4 A

In this table is a regional analysis of the number of adults in age ranges and with disability designation below who are in each activity solely. If in multiple activities, count the activity where the most time per year is spent.

	Sheltered Workshop	Supported Employment*	Integrated Employment*	Volunteer job	No volunteer or paid work activity, includes retired	Total served
Adults SMI 18-64						
Adults SMI 65+						
Adults I/DD 18-64						
Adults I/DD 65+						

*Refer to the FY13 MDCH/PIHP Contract for definitions of supported and integrated employment

Table 5.3.2.4. B

In this table is a regional analysis of the number of adults in age ranges and with disability designation below who are involved in the community activities with the general public below *at least once a month.*

	Clubs, Social events, visiting friends/relative	Continuing Education, Classes	Athletic/recreational participant	Attendance at sporting, arts, theater, movies	No extra-curricular activity	Total served
Adults SMI 18-64						
Adults SMI 65+						

	Clubs, Social events, visiting friends/relative	Continuing Education, Classes	Athletic/recreational participant	Attendance at sporting, arts, theater, movies	No extra-curricular activity	Total served
Adults I/DD 18-64						
Adults I/DD 65+						

5.3.2.6 ☐ In the text box below Attachment is a narrative, of no more than two pages, that describes:

a. How informed choice of a) the type of work and b) community activities are guaranteed in the annual person-centered planning process.
b. How individual opportunities for community integration and inclusion, and productivity are addressed and guaranteed as a result of person-centered planning.
c. The determinants of the frequency of PIHP monitoring of individuals who participate in segregated activities that include day programs, workshops. Include how issues or deficiencies are addressed when noted.

5.3.2.6

OR

☐ The narrative description is being developed and will be submitted to MDHHS no later than 5 p.m. on July 1, 2013.

5.3.2. ☐ In Attachment 5.3.2.8. is a regional plan with action steps, responsible staff, timeframes and numbers of people for developing increased regional alternatives to segregated day programs and workshops. This may be a phased-in approach, but must commence October 1, 2014.

OR

5.3.2 ☐ The regional plan is in development and will be submitted to MDHHS no later than 5 p.m. on July 1, 2013.

5.4 Substance Use Disorder Prevention and Treatment

Michigan's publicly funded Substance Use Disorder (SUD) Service System is committed to a transformational change that promotes and sustains wellness and recovery for individuals, families, and communities. This change to a recovery-oriented system of care (ROSC) employs strategies to:

- prevent the development of new substance use disorders.
- reduce the harm caused by addiction.
- help individuals make the transition from brief experiments in recovery initiation to sustained recovery maintenance via diverse holistic services.
- promote good quality of life and improve community health and wellness.

Additional information can be found in Michigan's Recovery Oriented System of Care (ROSC) Implementation Plan at http://www.michigan.gov/documents/mdhhs/ROSC_Implementation_Plan_357360_7.pdf.
To develop a holistic and effective SUD Service System that promotes recovery and resilience, PIHPs shall implement a ROSC. In addition, PIHPs shall implement recent Mental Health Code changes, per Public Acts 500 and 501 of 2012, to incorporate SUD administrative functions. Accordingly, the applicant attests to the following:

5.4.1 ☐ Adoption of ROSC's sixteen guiding principles (pages 14-16 of ROSC Implementation Plan).

5.4.2 ☐ Lead person named for transition of SUD administrative functions into the PIHP by April 1, 2013. The lead person's name is:

5.4.3 ☐ Implementation plan made no later than October 1, 2013, for merger of SUD functions into the PIHP to be completed by October 1, 2014. For reference see the, Coordinating Agency contract (http://egrams-mi.com/dch/user/categoryprograms.aspx?CategoryCode=SA&CatDesc=Substance%20Abuse).

5.4.4 ☐ Adherence of federal Substance Abuse Prevention and Treatment Block Grant (SAPT BG) requirements and maintain staff to support.

5.4.5 ☐ Acceptance of fiduciary and local oversight for federally funded discretionary grants.

5.4.6 ☐ Adherence to PA 258 of 1974, Mental Health Code, section 287 by:
- Establishing an SUD Oversight Policy Board by October 1, 2014.
- Providing a list of members and criteria used to make selection.
- Developing procedures for approving budget and contracts by October 1, 2014.
- Attesting to maintaining provider base (as of December 28, 2012) until December 28, 2014.

5.4.7 ☐ Development of a three-year SUD prevention, treatment and recovery plan to be submitted by August 1, 2014, for fiscal years (FY) 2015 to 2017.

5.4.8 ☐ Implementation of evidence-based prevention, treatment, and recovery services.

5.4.9 ☐ Maintenance of a separate Recipient Rights process for SUD service recipients.

5.4.10 ☐ Submission of timely reports on annual budget boilerplate requirements, including:

a. Legislative Report (Section 408), FY2013 due by January 31, 2014
b. Mental Health and Substance Use Disorder Services Integration Status Report (Sections 407 and 470), FY2013 due by January 31, 2014

Note: boilerplate requirements and due dates are subject to change with appropriations

5.5 Recovery

The vision in the *Description of a Good and Modern Addictions and Mental Health Service System* addresses elements necessary for a recovery environment including determinants of health, health promotion, prevention, screening, early intervention, treatment system and service coordination, resilience and recovery support to promote social integration, health and productivity. A good and modern system provides a full range of services to meet the needs of the population with strong integrated efforts between behavioral health and primary care. Integration must be based in a model of community participation, inclusion, and integration with the foundation of trauma informed and recovery oriented supports. The Michigan plan of Bringing Recovery Support to Scale vision for health and wellness includes every person with substance use disorder and/or mental illness will having equal access to and opportunity for person-centered, recovery based services which respect that there are multiple pathways and sources of engagement and support that are dependent on each individual's preference and learning style.

The new working definition published by the federal Substance Abuse and Mental Health Services Administration (SAMHSA) discusses recovery as a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. SAMHSA has delineated four major dimensions and ten guiding principles that support a life in recovery:

- ***Health***: overcoming or managing one's disease(s) or symptoms—and making informed, healthy choices that support and promote physical and emotional wellbeing.
- ***Home:*** a stable and safe place to live;
- ***Purpose:*** meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income and resources to participate in society; and
- ***Community***: relationships and social networks that provide support, friendship, love, and hope.

Guiding Principles of Recovery

Recovery emerges from hope: The belief that recovery is real provides the essential and motivating message of a better future – that people can and do overcome the internal and external challenges, barriers, and obstacles that confront them.

Recovery is person-driven: Self-determination and self-direction are the foundations for recovery as individuals define their own life goals and design their unique path(s).

Recovery occurs via many pathways: Individuals are unique with distinct needs, strengths, preferences, goals, culture, and backgrounds including trauma experiences that affect and determine their pathway(s) to recovery. Abstinence is the safest approach for those with substance use disorders.

Recovery is holistic: Recovery encompasses an individual's whole life, including mind, body, spirit, and community. The array of services and supports available should be integrated and coordinated.

Recovery is supported by peers and allies: Mutual support and mutual aid groups, including the sharing of experiential knowledge and skills, as well as social learning, play an invaluable role in recovery.
Recovery is supported through relationship and social networks: An important factor in the recovery process is the presence and involvement of people who believe in the person's ability to recover; who offer hope, support, and encouragement; and who also suggest strategies and resources for change.
Recovery is culturally-based and influenced: Culture and cultural background in all of its diverse representations including values, traditions, and beliefs are keys in determining a person's journey and unique pathway to recovery.
Recovery is supported by addressing trauma: Services and supports should be trauma-informed to foster safety (physical and emotional) and trust, as well as promote choice, empowerment, and collaboration.
Recovery involves individual, family, and community strengths and responsibility: Individuals, families, and communities have strengths and resources that serve as a foundation for recovery.
Recovery is based on respect: Community, systems, and societal acceptance and appreciation for people affected by mental health and substance use problems – including protecting their rights and eliminating discrimination – are crucial in achieving recovery.

5.5.1 ☐ In the text box below is a two-page explanation of how the applicant's mission and vision support the dimensions and principles of recovery according to the SAMHSA working definition. Explain how substance use disorder and mental health recovery are both supported by the mission and vision.

5.5.1

5.5.2 ☐ The applicant will select a region-wide behavioral health recovery survey tool as a Continuous Quality Improvement project in partnership with a group of stakeholders that includes providers and users of services with a majority of members being people with lived experience. By January 2014 the tool will be submitted and approved by MDCH.

5.5.3 ☐ The applicant assures that its provider network employs a sufficient workforce of individuals with lived experiences throughout all levels of the agency who are paid fair and competitive wages, have multiple opportunities for a balance of full and part-time positions and are offered a viable career ladder.

5.5.4 ☐ By January 1, 2014, applicant's provider network's position descriptions for all paid employees and volunteers contain language of recovery. Job responsibilities will outline recovery-based, person-centered and culturally competent practices. Job qualifications will specify that lived experiences with behavioral health issues are desired.

5.5.5 ☐ By October 1, 2013, the applicant will present to MDHHS a plan for sustaining positions currently supported by federal Mental Health Block Grant funding after the grant has ended. The plan specifically identifies positions that are supporting SUD prevention and Women's Specialty Services for SUD.

5.5.6 ☐ By January 1, 2014, the applicant will have region-wide policies, procedures and a process in place that support and encourage the opportunity to for individuals with serious mental illness to participate in a self-determined arrangement.

5.5.7 ☐ By January 1, 2014, the applicant's provider network will have region-wide explicit policies and procedures for admission, discharge, referral, collaborative care that supports individual choice, person centered, culturally competent, trauma informed practice and the attainment of self-directed goals. The policies and procedures will incorporate SUD provider/recovery networks into the service delivery system.

5.5.8 ☐ By January 1, 2014, the applicant will develop and implement region-wide policies and procedures to support the provision of collaborative work between substance use, mental health and primary care providers resulting in an integrated care plan for individuals.

PROCUREMENT TECHNICAL REQUIREMENT

PROCUREMENT AND SELECTIVE CONTRACTING UNDER MANAGED CARE

Introduction

The assumption of managed care responsibilities for specialized Medicaid mental health, developmental disabilities and/or substance abuse services has implications for the procurement and selective contracting activities of Prepaid Inpatient Health Plans (PIHPs). Soliciting providers and programs for the service delivery system, acquiring claims processing capabilities, enhancements to management information system capacity, or obtaining general management's services to assist in the administration of the managed care program, must be done with due deliberation and sensitivity to procurement and contracting issues.

Procurement of Automatic Data Processing Services and Comprehensive Administrative or Management Services

The Michigan Department of Health and Human Services 's (MDHHS) plan to make sole source "sub-awards" for the administration and provision of Medicaid mental health, developmental disability and substance abuse services raises questions about the applicability of federal procurement regulations to CMHSP and RSACA procurement and contracting activities. Federal regulations regarding procurement are described in the Code of Federal Regulations, (2 CFR Sections 318-326), Office of Management and Budget Circular2 CFR 200 Subpart E Cost Principles, and State Medicaid Manual Part 2 (Sections 2083 through 2087).

In general, these regulations and requirements give the State fairly wide latitude in determining the procedural aspects and applicable circumstances for procurement processes. However, the MDHHS's preliminary interpretation of these regulations suggests that procurement for significant automatic data processing services related to the operation of the Medicaid carve-out program, and contracts for comprehensive management services (so-called MSO or ASO arrangements) must be conducted in compliance with federal procurement requirements outlined in the documents listed above.

Procurement and Contracting for Service Providers

PIHPs will also be soliciting providers to furnish programs, services and/or supports for Medicaid recipients needing mental health, developmental disability or substance abuse services. When soliciting providers, it should be the objective of each PIHP to acquire needed services and supports at fair and economical prices, with appropriate attention to quality of care and maintenance of exiting-care relationships and service networks currently used by Medicaid recipients. Procurement processes should be used to solicit such services. Depending on the circumstances (e.g., local area market conditions, kind or quantity of services needed, etc.) various methods for selecting providers may be used including:

1. Procurement for Selective Contracting[1]

[1] Competitive procurement is usually pursued through either a COMPETITIVE SEALED BIDDING method (the process of publicizing government needs, inviting bids, conducting public bid openings, and awarding a

The PIHP (as the managing entity) purchases services from a limited number of providers who agree to fulfill contractual obligations for an agreed upon price. The managing entity identifies the specific services to be provided, seeks proposals/price bids, and awards contracts to the best bidders. Contracts are let only with a sufficient number of providers to assure adequate access to services. The prospect of increased volume induces providers to bid lower prices.

2. Procurement to Obtain Best Prices Without Selective Contracting

Under an "any willing and qualified provider" process, bids can be solicited and used to set prices for a service, and then contracts or provider agreements can be offered to any qualified provider that is willing to fulfill the contract and meet the bid price.

(NOTE: A procurement process must be used when the managing entity is planning to restrict or otherwise limit the number of providers who can participate in the program.)

3. Non-Competitive Solicitation and/or Selection of Providers

Under certain circumstances, the managing entity may select providers without a competitive procurement process. These circumstances are:

- The service is available only from a single source;
- There is a public exigency or emergency, and the urgency for obtaining the service does not permit a delay incident to competitive solicitation;
- After solicitation of a number of sources, competition is determined inadequate;
- The services involved are professional services (e.g., psychological testing) of limited quantity or duration;
- The services are unique (e.g., financial intermediaries for consumers using vouchers or personal service budgets) and/or the selection of the service provider has been delegated to the consumer under a self-determination program; and
- Existing residential service systems, where continuity of care arrangements are of paramount concern.

In these situations, the managing entity may employ noncompetitive negotiation to secure the needed services. The single- or limited-source procurement process involves

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contract to the lowest responsive and responsible bidder) or a COMPETITIVE SEALED PROPOSAL process (method of publicizing government needs, requesting proposals, evaluating proposals received, negotiating proposals with acceptable or potentially acceptable offerors, and awarding the contract after consideration of evaluation factors in the RFP and the price offered).

soliciting interest and negotiating with a single or limit set of providers. Again, this may be used where competition for a service is deemed inadequate or when the uniqueness of the services or other considerations limits competitive procurement possibilities.

Whether a competitive procurement or noncompetitive solicitation process is used, the managing entity must ensure that organizations or individuals selected and offered contracts have not been previously sanctioned by the Medicaid program resulting in prohibition of their participation in the program.

Checklists for Procurement
(adapted from Section 2087 of the State Medicaid Manual)

This checklist is provided as a guide for planning procurement activities. Use is not mandatory.

1. Planning Checklist
    - Has an analysis been conducted to determine if a procurement process should be initiated (need for services, available providers, likelihood of cost savings, etc.)? Have consumers and family members been involved in this analysis?
    - If a procurement process is warranted, what form should it take?
    - Automatic data processing (ADP) services, significant management information system enhancements, comprehensive management support functions
    - Full Compliance with CFR regulations, OMB Circulars and HCFA State Medicaid Manual
    - Acquisition of Service Provider Capacity - Network Participation
    - Competitive Sealed Bids
    - Competitive Negotiation
    - Non-Competitive Negotiations (if solicitation falls under the exception criteria listed above

2. Request for Proposals Checklist (Competitive Procurement for Providers)
    - Have consumers and families been involved in developing the request for proposals?
    - Are the major time frames of the RFP for response by competitors, evaluation period, award, contract negotiation, implementation and contract start-up time adequate to assure interested contractors a sufficient period to prepare a proposal and assume operations in an orderly manner?
    - Does the RFP contain a detailed and clear description of the scope of work to be contracted?
    - Does the RFP provide for:
        i. Answering written questions from a prospective bidder about the RFP?
        ii. Acceptance of a late or alternate proposal or withdrawal of a proposal?
        iii. Evidence of adequate financial stability of the bidder and of any parent organization?
        iv. Performance standards?
        v. A time-frame requirement for guarantee of all prices quoted in the proposal?

vi. Acceptance by a bidder of any reduction in payments for nonperformance?
vii. A bidders' conference?
viii. The general overall evaluation criteria, including maximum points available by category?
ix. A reference to applicable code requirements, administrative rules, board policies, and managed care program stipulations?

- Does the RFP provide for open solicitation of all technically competent contractors?
- Does the RFP list procedures for handling changes to the RFP that occur after some proposals are submitted, identify who will be notified of the changes, and describe how they will be made?
- Are there any requirements in the RFP that would unduly or unfairly restrict or limit competition among prospective bidders?
- Does the RFP include a copy of the Managing Entity's proposed contract?

3. Proposal Evaluation Plan (PEP) Checklist
   - Does the PEP consider the following in the evaluation of proposals?
     i. Contractor Capability
        Staff qualifications and general experience; Experience with Title XIX or similar programs; Experience in service to the target populations; Contractor stability (including financial stability and reputation in the field); Evaluation by previous clients.
     ii. Technical Approach
        Understanding of the scope, objectives, and requirements; Proper emphasis on various job elements; Responsiveness to specifications; Clarity of statement of implementation plan.
     iii. Financial Aspects
        Realism of total cost estimate and cost breakdown; Realism of estimated hours of staff time; Hourly rate structure; Reasonableness of implementation costs; Reasonableness of turnover costs.

4. Report of the Selection Committee Checklist
   - Are consumers and family members included on the proposal evaluation team?
   - If a contractor that did not submit the lowest offer was selected, was its selection justified as being most advantageous to the CMHSP or RSACA?
   - Is the selection committee's tabulation of proposal scores complete and accurate?
   - Is the evaluation process free of bias?
   - Is a meeting for debriefing of unsuccessful bidders offered after the announcement of the contract award?
   - Did the evaluation committee substantiate reasons a prospective bidder was determined to be non-responsive?
   - Did the evaluation committee document valid reasons for not awarding the maximum points in each category and/or the reasons for awarding bonus points?

Community Mental Health

COMPLIANCE EXAMINATION GUIDELINES

Michigan Department of Health and Human Services

Fiscal Year End September 30, 2019

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INTRODUCTION

These Community Mental Health (CMH) Compliance Examination Guidelines are issued by the Michigan Department of Health and Human Services (MDHHS) to assist independent audit personnel, Prepaid Inpatient Health Plan (PIHP) personnel, and Community Mental Health Services Program (CMHSP) personnel in preparing and performing compliance examinations as required by contracts between MDHHS and PIHPs or CMHSPs, and to assure examinations are completed in a consistent and equitable manner.

These CMH Compliance Examination Guidelines require that an independent auditor examine compliance issues related to contracts between PIHPs and MDHHS to manage the Concurrent 1915(b)/(c) Medicaid, Healthy Michigan, Flint 1115 and Substance Use Disorder Community Grant Programs (hereinafter referred to as "Medicaid Contract"); the contracts between CMHSPs and MDHHS to manage and provide mental health services and supports to individuals with serious mental illness, serious emotional disturbances or developmental disabilities as described in MCL 330.1208 (hereinafter referred to as "GF Contract"); and, in certain circumstances, contracts between CMHSPs or PIHPs and MDHHS to manage the Community Mental Health Services Block Grant Program (hereinafter referred to as "CMHS Block Grant Program"). These CMH Compliance Examination Guidelines, however, DO NOT replace or remove any other audit requirements that may exist, such as a Financial Statement Audit and/or a Single Audit. An annual Financial Statement audit is required. Additionally, if a PIHP or CMHSP expends $750,000 or more in federal awards[1], the PIHP or CMHSP must obtain a Single Audit.

PIHPs are ultimately responsible for the Medicaid funds received from MDHHS, and are responsible for monitoring the activities of network provider CMHSPs as necessary to ensure expenditures of Medicaid Contract funds are for authorized purposes in compliance with laws, regulations, and the provisions of contracts. Therefore, PIHPs must either require their independent auditor to examine compliance issues related to the Medicaid funds awarded to the network provider CMHSPs, or require the network provider CMHSP to contract with an independent auditor to examine compliance issues related to contracts between PIHPs and CMHSPs to manage the Medicaid Contract. Further detail is provided in the Responsibilities – PIHP Responsibilities Section (Item #'s 8, 9, & 10).

These CMH Compliance Examination Guidelines will be effective for contract years ending on or after September 30, 2019 and replace any prior CMH Compliance Examination Guidelines or instructions, oral or written.

Failure to meet the requirements contained in these CMH Compliance Examination Guidelines may result in the withholding of current funds or the denial of future awards.

[1] Medicaid payments to PIHPs and CMHSPs for providing patient care services to Medicaid eligible individuals are not considered Federal awards expended for the purposes of determining Single Audit requirements.

RESPONSIBILITIES

MDHHS Responsibilities

MDHHS must:

1. Periodically review and revise the CMH Compliance Examination Guidelines to ensure compliance with current Mental Health Code, and federal and state audit requirements; and to ensure the **COMPLIANCE REQUIREMENTS** contained in the CMH Compliance Examination Guidelines are complete and accurately represent requirements of PIHPs and CMHSPs; and distribute revised CMH Compliance Examination Guidelines to PIHPs and CMHSPs.
2. Review the examination reporting packages submitted by PIHPs and CMHSPs to ensure completeness and adequacy within eight months of receipt.
3. Issue a management decision (as described in the Examination Requirements – Management Decision Section) on findings, comments, and examination adjustments contained in the PIHP or CMHSP examination reporting package within eight months after the receipt of a complete and final reporting package.
4. Monitor the activities of PIHPs and CMHSPs as necessary to ensure the Medicaid Contract, GF Contract, and CMHS Block Grant Program funds are used for authorized purposes in compliance with laws, regulations, and the provisions of contracts. MDHHS will rely primarily on the compliance examination engagements conducted on PIHPs and CMHSPs by independent auditors to ensure Medicaid Contract, and GF Contract funds are used for authorized purposes in compliance with laws, regulations, and the provisions of contracts. MDHHS will rely on PIHP or CMHSP Single Audits or the compliance examination engagements conducted on PIHPs and CMHSPs by independent auditors to ensure CMHSP Block Grant Program funds are used for authorized purposes in compliance with laws, regulations, and the provisions of contracts. MDHHS may, however, determine it is necessary to also perform a limited scope compliance examination or review of selected areas. Any additional reviews or examinations shall be planned and performed in such a way as to build upon work performed by other auditors. The following are some examples of situations that may trigger an MDHHS examination or review:
    a. Significant changes from one year to the next in reported line items on the FSR.
    b. A PIHP entering the MDHHS risk corridor.
    c. A large addition to an ISF per the cost settlement schedules.
    d. A material non-compliance issue identified by the independent auditor.
    e. The CPA that performed the compliance examination is unable to quantify the impact of a finding to determine the questioned cost amount.
    f. The CPA issued an adverse opinion on compliance due to their inability to draw conclusions because of the condition of the agency's records.

PIHP Responsibilities

PIHPs must:

1. Maintain internal control over the Medicaid Contract that provides reasonable assurance that the PIHP is managing the contract in compliance with laws, regulations, and the contract provisions that could have a material effect on the contract.
2. Comply with laws, regulations, and the contract provisions related to the Medicaid Contract. Examples of these would include, but not be limited to: the Medicaid Contract, the Mental Health Code (Michigan Compiled Laws 330.1001 – 330.2106), applicable sections of the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards located at 2 CFR 200 , the Medicaid Provider Manual, and Generally Accepted Accounting Principles (GAAP).
3. Prepare appropriate financial statements.
4. Ensure that the examination required by these CMH Compliance Examination Guidelines is properly performed and submitted when due.
5. Follow up and take corrective action on examination findings.
6. Prepare a corrective action plan to address each examination finding, and comment and recommendation included in the current year auditor's reports including the name(s) of the contact person(s) responsible for corrective action, the corrective action planned, and the anticipated completion date. If the PIHP does not agree with an examination finding or comment, or believes corrective action is not required, then the corrective action plan shall include an explanation and specific reasons.
7. The PIHP shall <u>not</u> file a revised FSR and Cost Settlement based on the CMH Compliance Examination. Rather, adjustments noted in the CMH Compliance Examination will be evaluated by MDHHS and the PIHP will be notified of any required action in the management decision.
8. Monitor the activities of network provider CMHSPs as necessary to ensure the Medicaid Contract funds are used for authorized purposes in compliance with laws, regulations, and the provisions of contracts. PIHPs must either (a.) require the PIHP's independent auditor (as part of the PIHP's examination engagement) to examine the records of the network provider CMHSP for compliance with the Medicaid Contract provisions, or (b.) require the network provider CMHSP to contract with an independent auditor to examine compliance issues related to contracts between PIHPs and CMHSPs to manage the Medicaid Contract. If the latter is chosen, the PIHP must incorporate the examination requirement in the PIHP/CMHSP contract and develop Compliance Examination Guidelines specific to their PIHP/CMHSP contract. Additionally, if the latter is chosen, the CMHSP examination must be completed in sufficient time so that the PIHP auditor may rely on the CMHSP examination when completing their examination of the PIHP if they choose to.
9. If requiring an examination of the network provider CMHSP, review the examination reporting packages submitted by network provider CMHSPs to ensure completeness and adequacy.

10. If requiring an examination of the network provider CMHSP, issue a management decision (as described in the Examination Requirements – Management Decision Section) on findings and questioned costs contained in network provider CMHSP's examination reporting packages.

CMHSP Responsibilities

(as a recipient of Medicaid Contract funds from PIHP and a recipient of GF funds from MDHHS and a recipient of CMHS Block Grant funds from MDHHS)

CMHSPs must:

1. Maintain internal control over the Medicaid Contract, GF Contract, and CMHS Block Grant Program that provides reasonable assurance that the CMHSP is managing the Medicaid Contract, GF Contract, and CMHS Block Grant Program in compliance with laws, regulations, and the provisions of contracts that could have a material effect on the Medicaid Contract, GF Contract, and CMHS Block Grant Program.
2. Comply with laws, regulations, and the contract provisions related to the Medicaid Contract, GF Contract, and CMHSP Block Grant Program. Examples of these would include, but not be limited to: the Medicaid Contract, the Managed Mental Health Supports and Services Contract (General Fund Contract), the CMHS Block Grant Contract, the Mental Health Code (Michigan Compiled Laws 330.1001 – 330.2106), applicable sections of the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards located at 2 CFR 200, the Medicaid Provider Manual, and Generally Accepted Accounting Principles (GAAP).
3. Prepare appropriate financial statements.
4. Ensure that the examination required by these CMH Compliance Examination Guidelines, and any examination required by the PIHP from which the CMHSP receives Medicaid Program funds are properly performed and submitted when due.
5. Follow up and take corrective action on examination findings.
6. Prepare a corrective action plan to address each examination finding, and comment and recommendation included in the current year auditor's reports including the name(s) of the contact person(s) responsible for corrective action, the corrective action planned, and the anticipated completion date. If the CMHSP does not agree with an examination finding or comment, or believes corrective action is not required, then the corrective action plan shall include an explanation and specific reasons.
7. The CMHSP shall not file a revised FSR and Cost Settlement based on the CMH Compliance Examination. Rather, adjustments noted in the CMH Compliance Examination will be evaluated by MDHHS, and the CMHSP will be notified of any required action in the management decision.

EXAMINATION REQUIREMENTS

PIHPs under contract with MDHHS to manage the Medicaid Contract and CMHSPs under contract with MDHHS to manage the GF Contract are required to contract annually with a certified public accountant in the practice of public accounting (hereinafter referred to as a

practitioner) to examine the PIHP's or CMHSP's compliance with specified requirements in accordance with the AICPA's Statements on Standards for Attestation Engagements (SSAE) 18–Attestation Standards – Clarification and Redcodification–.AT – C Section 205 The specified requirements and specified criteria are contained in these CMH Compliance Examination Guidelines under the Section titled "Compliance Requirements."

Additionally, CMHSPs under contract with MDHHS to provide CMHS Block Grant Program services with a total contract amount of greater than $187,500 are required to ensure the above referenced examination engagement includes an examination of compliance with specified requirements related to the CMHS Block Grant Program **IF** the CMHSP does not have a Single Audit or the CMHSP's Single Audit does not include the CMHS Block Grant (CFDA 93.958) as a major Federal program. The specified requirements and specified criteria related to the CMHS Block Grant Program are contained in these CMH Compliance Examination Guidelines under the Section titled "Compliance Requirements."

Practitioner Selection

In procuring examination services, PIHPs and CMHSPs must engage an independent practitioner, and must follow the Procurement Standards contained in 2 CFR 200.318 through 200.320. In requesting proposals for examination services, the objectives and scope of the examination should be made clear. Factors to be considered in evaluating each proposal for examination services include the responsiveness to the request for proposal, relevant experience, availability of staff with professional qualifications and technical abilities, the results of external quality control reviews, the results of MDHHS reviews, and price. When possible, PIHPs and CMHSPs are encouraged to rotate practitioners periodically to ensure independence.

Examination Objective

The objective of the practitioner's examination procedures applied to the PIHP's or CMHSP's compliance with specified requirements is to express an opinion on the PIHP's or CMHSP's compliance based on the specified criteria. The practitioner seeks to obtain reasonable assurance that the PIHP or CMHSP complied, in all material respects, based on the specified criteria.

Practitioner Requirements

The practitioner should exercise due care in planning, performing, and evaluating the results of his or her examination procedures; and the proper degree of professional skepticism to achieve reasonable assurance that material noncompliance will be detected. The specified requirements and specified criteria are contained in these CMH Compliance Examination Guidelines under the Section titled "Compliance Requirements." In the examination of the PIHP's or CMHSP's compliance with specified requirements, the practitioner should follow the requirements of AT-C 105 and 205:

1. Obtain an understanding of the specified compliance requirements (See AT 601.40).
2. Plan the engagement (See AT 601.41 through 601.44).

3. Consider the relevant portions of the PIHP's or CMHSP's internal control over compliance (See AT 601.45 through 601.47).
4. Obtain sufficient evidence including testing compliance with specified requirements (See AT 601.48 through 601.49).
5. Consider subsequent events (See AT 601.50 through 601.52).
6. Form an opinion about whether the entity complied, in all material respects with specified requirements based on the specified criteria (See AT 601.53).

Practitioner's Report

The practitioner's examination report on compliance should include the information detailed in AT-C 205.63 through 205.86, which includes the practitioner's opinion on whether the entity complied, in all material respects, with specified requirements based on the specified criteria. When an examination of the PIHP's or CMHSP's compliance with specified requirements discloses noncompliance with the applicable requirements that the practitioner believes have a material effect on the entity's compliance, the practitioner should modify the report as detailed in AT-C 205.68 through AT-C 205.75.

In addition to the above examination report standards, the practitioner must prepare:

1. A Schedule of Findings that includes the following:
    a. Control deficiencies that are individually or cumulatively material weaknesses in internal control over the Medicaid Contract, GF Contract, CMHS Block Grant Program, and/or SAPT Block Grant Program.
    b. Material noncompliance with the provisions of laws, regulations, or contract provisions related to the Medicaid Contract, GF Contract, CMHS Block Grant Program, and/or SAPT Block Grant Program.
    c. Known fraud affecting the Medicaid Contract, GF Contract, CMHS Block Grant Program, and/or SAPT Block Grant Program.

    Finding detail must be presented in sufficient detail for the PIHP or CMHSP to prepare a corrective action plan and for MDHHS to arrive at a management decision. The following specific information must be included, as applicable, in findings:

    a. The criteria or specific requirement upon which the finding is based including statutory, regulatory, contractual, or other citation. **The Compliance Examination Guidelines should NOT be used as criterion.**
    b. The condition found, including facts that support the deficiency identified in the finding.
    c. Identification of applicable examination adjustments and how they were computed.
    d. Information to provide proper perspective regarding prevalence and consequences.
    e. The possible asserted effect.
    f. Recommendations to prevent future occurrences of the deficiency(ies) noted in the finding.
    g. Views of responsible officials of the PIHP/CMHSP.
    h. Planned corrective actions.
    i. Responsible party(ies) for the corrective action.

j. Anticipated completion date.

2. A schedule showing final **reported** Financial Status Report (FSR) amounts, examination adjustments [including applicable adjustments from the Schedule of Findings and the Comments and Recommendations Section (addressed below)], and examined FSR amounts. **All examination adjustments must be explained.** This schedule is called the "Examined FSR Schedule." Note that Medicaid FSRs must be provided for PIHPs. All applicable FSRs must be included in the practitioner's report regardless of the lack of any examination adjustments.

3. A schedule showing a revised cost settlement for the PIHP or CMHSP based on the Examined FSR Schedule. This schedule is called the "Examined Cost Settlement Schedule." This must be included in the practitioner's report regardless of the lack of any examination adjustments.

4. A Comments and Recommendations Section that includes all noncompliance issues discovered that are not individually or cumulatively material weaknesses in internal control over the Medicaid Contract, GF Contract, and/or CMHS Block Grant program only in the event the individual comment or recommendation is expected to have an impact greater than or equal to $10,000; and recommendations for strengthening internal controls, improving compliance, and increasing operating efficiency.

Examination Report Submission

The examination must be completed and the reporting package described below must be submitted to MDHHS within the earlier of 30 days after receipt of the practitioner's report, or June 30th following the contract year end. The PIHP or CMHSP must submit the reporting package by e-mail to MDHHS at MDHHS-AuditReports@michigan.gov. The required materials must be assembled as one document in PDF file compatible with Adobe Acrobat (read only). The subject line must state the agency name and fiscal year end. MDHHS reserves the right to request a hard copy of the compliance examination report materials if for any reason the electronic submission process is not successful.

Examination Reporting Package

The reporting package includes the following:

1. Practitioner's report as described above;
2. Corrective action plan prepared by the PIHP or CMHSP.

Penalty

If the PIHP or CMHSP fails to submit the required examination reporting package by June 30th following the contract year end and an extension has not been granted by MDHHS, MDHHS may withhold from current funding five percent of the examination year's grant funding (not to exceed $200,000) until the required reporting package is received. MDHHS may retain the withheld amount if the reporting package is delinquent more than 120 days from the due date and MDHHS has not granted an extension.

Incomplete or Inadequate Examinations

If MDHHS determines the examination reporting package is incomplete or inadequate, the PIHP or CMHSP, and possibly its independent auditor will be informed of the reason of inadequacy and its impact in writing. The recommendations and expected time frame for resubmitting the corrected reporting package will be provided to the PIHP or CMHSP.

Management Decision

MDHHS will issue a management decision on findings, comments, and examination adjustments contained in the PIHP or CMHSP examination report within eight months after the receipt of a complete and final reporting package. The management decision will include whether or not the examination finding and/or comment is sustained; the reasons for the decision and the expected PIHP or CMHSP action to repay disallowed costs, make financial adjustments, or take other action. Prior to issuing the management decision, MDHHS may request additional information or documentation from the PIHP or CMHSP, including a request for practitioner verification or documentation, as a way of mitigating disallowed costs. The appeal process available to the PIHP or CMHSP is included in the applicable contract.

If there are no findings, comments, and/or questioned costs, MDHHS will notify the PIHP or CMHSP when the review of the examination reporting package is complete and the results of the review.

COMPLIANCE REQUIREMENTS

The practitioner must examine the PIHP's or CMHSP's compliance with the A-J specified requirements based on the specified criteria stated below related to the Medicaid Contract and GF Contract. If the PIHP or CMHSP does not have a Single Audit or the Single Audit does not include the CMHS Block Grant (CFDA 93.958) as a major Federal program, the practitioner must also examine the CMHSP's compliance with the K-M specified requirements based on the specified criteria stated below that specifically relate to the CMHS Block Grant, but only if the total contract amount for the CMHS Block Grant is greater than $187,500. If the PIHP does not have a Single Audit, or the Single Audit does not include the Substance Abuse Prevention and Treatment (SAPT) Block Grant (CFDA 93.959) as a major Federal program, the practitioner must also examine the PIHP's compliance with the N-P specified requirements based on the specified criteria stated below that specifically relate to the SAPT Block Grant.

COMPLIANCE REQUIREMENTS A-F

(APPLICABLE TO ALL PIHP AND CMHSP COMPLIANCE EXAMINATIONS)

A. FSR Reporting

The final FSRs (entire reporting package applicable to the entity) comply with contractual provisions as follows:

a. FSRs agree with agency financial records (general ledger) as required by the reporting instructions. (Reporting instructions at http://www.michigan.gov/MDHHS/0,1607,7-132-2941_38765---,00.html).
b. FSRs include only allowed activities as specified in the contracts; allowable costs as specified in the Federal cost principles (located at 2 CFR 200, Subpart E)(GF Contract, Section 6.6.1; and Medicaid Contract, Section 7.8); and allowed activities and allowable costs as specified in the Mental Health Code, Sections 240, 241, and 242.
c. FSRs include revenues and expenditures in proper categories and according to reporting instructions.

Differences between the general ledger and FSRs should be adequately explained and justified. Any differences not explained and justified must be shown as an adjustment on the practitioner's "Examined FSR Schedule." Any reported expenditures that do not comply with the Federal cost principles, the Code, or contract provisions must be shown as adjustments on the auditor's "Examined FSR Schedule."

The following items should be considered in determining allowable costs:
Federal cost principles (2 CFR 200.402) require that for costs to be allowable they must meet the following general criteria:

a. Be necessary and reasonable for the performance of the Federal award and be allocable thereto under the principles.
b. Conform to any limitations or exclusions set forth in the principles or in the Federal award as to types or amount of cost items.
c. Be consistent with policies and procedures that apply uniformly to both federally-financed and other activities of the non-Federal entity.
d. Be accorded consistent treatment.
e. Be determined in accordance with generally accepted accounting principles.
f. Not be included as a cost or used to meet cost sharing or matching requirements of any other federally-financed program in either the current or a prior period.
g. Be adequately documented.

Reimbursements to **subcontractors** (including PIHP payments to CMHSPs for Medicaid services) must be supported by a valid subcontract and adequate, appropriate supporting documentation on costs and services (2 CFR Part 200, Subpart E – Cost Principles, 200.403 (g)). Contracts should be reviewed to determine if any are to related parties. If related party subcontracts exist, they should receive careful scrutiny to ensure the reasonableness criteria of 2 CFR Part 200, Subpart E – Cost Principles, 200.404 was met. If subcontractors are paid on a net cost basis, rather than a fee-for-service basis, the subcontractors' costs must be verified for existence and appropriate supporting documentation (2 CFR Part 200, Subpart E – Cost Principles, 200.403 (g)). When the PIHP pays Federally Qualified Heath Centers (FQHC) and Rural Health Centers (RHC) for specialty services included in the specialty services waiver the payments need to be reviewed to ensure that they are no less than amounts paid to non-FQHC and RHCs for similar services. NOTE: Rather than the practitioner performing examination procedures at the subcontractor level, agencies may

require that subcontractors receive examinations by their own independent practitioner, and that examination report may be relied upon if deemed acceptable by the practitioner.

Reported rental costs for **less-than-arms-length transactions** must be limited to underlying cost (2 CFR Part 200, Subpart E – Cost Principles, 200.465 (c)). For example, the agency may rent their office building from the agency's board member/members, but rent charges cannot exceed the actual cost of ownership if the lease is determined to be a less-than-arms-length transaction. Guidance on determining less-than-arms-length transactions is provided in 2 CFR Part 200.

Reported costs for **sale and leaseback arrangements** must be limited to underlying cost (2 CFR Part 200, Subpart E – Cost Principles, 200.465 (b)).

Capital asset purchases that cost greater than $5,000 must be capitalized and depreciated over the useful life of the asset rather than expensing it in the year of purchase (2 CFR Part 200, Subpart E – Cost Principles, 200.436 and 200.439). All invoices for a remodeling or renovation project must be accumulated for a total project cost when determining capitalization requirements; individual invoices should not simply be expensed because they are less than $5,000.

Costs must be allocated to programs in accordance with relative benefits received. Accordingly, **Medicaid costs must be charged to the Medicaid Program and GF costs must be charged to the GF Program**. Additionally, **administrative/indirect costs** must be distributed to programs on bases that will produce an equitable result in consideration of relative benefits derived in accordance with 2 CFR Part 200, Appendix VII.
Distributions of salaries and wages for employees that work on multiple activities or cost objectives, must be supported in accordance with the standards listed in 2 CFR Part 200, Subpart E – Cost Principles, 200.430 (i).

B. Administration Cost Report

The most recently completed PIHP's or CMHSP's Administration Cost Report complies with the applicable CMHSP/PIHP Administration Cost Reporting Instructions and the applicable standards in ESTABLISHING ADMINISTRATIVE COSTS WITHIN AND ACROSS THE CMHSP SYSTEM and contract provisions (instructions located at http://www.michigan.gov/MDHHS/0,1607,7-132-2941_38765---,00.html and reference guidelines located at http://www.michigan.gov/documents/mdch/Establishing_Admin_costs_480633_7.pdf).

C. Procurement

The PIHP or CMHSP followed the Procurement Standards contained in 2 CFR 200.318 through 200.326. The PIHP or CMHSP ensured that organizations or individuals selected and offered contracts have not been debarred or suspended or otherwise excluded from or ineligible for participation in Federal assistance programs as required by 45 CFR 92.35.

D. Internal Service Fund (ISF)

The PIHP's Internal Service Fund complies with the Internal Service Fund Technical Requirement contained in Contract Attachment P 8.6.4.1 with respect to funding and maintenance.

E. Medicaid Savings and General Fund Carryforward

The PIHP's Medicaid Savings was expended in accordance with the PIHP's reinvestment strategy as required by Sections 8.6.2.2 and 8.6.2.3 of the Contract. The CMHSP's General Fund Carryforward earned in the previous year was used in the current year on allowable General Fund expenditures as required by sections 7.7.1 and 7.7.1.1. of the MDHHS-CMHSP contract.

F. Match Requirement

The PIHP or CMHSP met the local match requirement, and all items considered as local match actually qualify as local match according to Section 7.2 of the General Fund Contract and Section 8.2 of the Medicaid Contract. Some examples of funds that do NOT qualify as local match are: (a.) revenues (such as workers' compensation refunds) that should be offset against related expenditures, (b.) interest earned from ISF accounts, (c.) revenues derived from programs (such as the Clubhouse program) that are financially supported by Medicaid or GF, (d.) donations of funds from subcontractors of the PIHP or CMHSP, (e.) Medicaid Health Plan (MHP) reimbursements for MHP purchased services that have been paid at less than the CMHSP's actual costs, and (f) donations of items that would not be an item generally provided by the PIHP or CMHSP in providing plan services.

If the PIHP or CMHSP does not comply with the match requirement in the Mental Health Code, Section 302, or cannot provide reasonable evidence of compliance, the auditor shall determine and report the amount of the shortfall in local match requirement.

COMPLIANCE REQUIREMENTS G-I

(APPLICABLE TO PIHPs/CMHSPs WITH A CMHS BLOCK GRANT OF GREATER THAN $187,500 THAT DID NOT HAVE A SINGLE AUDIT OR THE CMHS BLOCK GRANT WAS NOT A MAJOR FEDERAL PROGRAM IN THE SINGLE AUDIT)

G. CMHS Block Grant - Activities Allowed or Unallowed

The CMHSP expended CMHS Block Grant (CFDA 93.958) funds only on allowable activities in accordance with Federal Block Grant provisions and the Grant Agreement between MDHHS and the CMHSP.

H. CMHS Block Grant - Cash Management

The CMHSP complied with the applicable cash management compliance requirements contained in the Federal Block Grant Provisions. This includes the requirement that when entities are funded on a reimbursement basis, program costs must be paid for by CMHSP funds before reimbursement is requested from MDHHS.

I. CMHS Block Grant – Sub-recipient Management and Monitoring

If the CMHSP contracts with other sub-recipients ("sub-recipient" per the 2 CFR Part 200.330 definition) to carry out the Federal CMHS Block Grant Program, the CMHSP complied with the Sub-recipient Monitoring and Management requirements at 2 CFR Part 200.331 (a) through (h)

COMPLIANCE REQUIREMENTS J-K

(APPLICABLE TO PIHPs WITH A SAPT BLOCK GRANT THAT DID NOT HAVE A SINGLE AUDIT OR THE SAPT BLOCK GRANT WAS NOT A MAJOR FEDERAL PROGRAM IN THE SINGLE AUDIT)

J. SAPT Block Grant – Activities Allowed or Unallowed

The PIHP or CMHSP expended SAPT Block Grant (CFDA 93.959) funds only on allowable activities in accordance with the Federal Block Grant Provisions and the Grant Agreement.

K. SAPT Block Grant – Sub-recipient Management and Monitoring

If the PIHP contracts with other sub-recipients ("sub-recipient" per the 2 CFR Part 200.330 definition) to carry out the Federal SAPT Block Grant Program, the PIHP or complied with the Sub-recipient Monitoring and Management requirements at 2 CFR Part 200.331 (a) through (h).

RETENTION OF WORKING PAPERS AND RECORDS

Examination working papers and records must be retained for a minimum of three years after the final examination review closure by MDHHS. Also, PIHPs are required to keep affiliate CMHSP's reports on file for three years from date of receipt. All examination working papers must be accessible and are subject to review by representatives of the Michigan Department of Health and Human Services, the Federal Government and their representatives. There should be close coordination of examination work between the PIHP and provider network CMHSP auditors. To the extent possible, they should share examination information and materials in order to avoid redundancy.

EFFECTIVE DATE AND MDHHS CONTACT

These CMH Compliance Examination Guidelines are effective beginning with the fiscal year 2018/2019 examinations. Any questions relating to these guidelines should be directed to:

John Duvendeck, Director
Division of Program Development, Consultation & Contracts
Bureau of Hospitals and Behavioral Health Administration
Michigan Department of Health and Human Services
Lewis Cass Building
320 S. Walnut Street
Lansing, Michigan 48913
duvendeckj@michigan.gov
Phone: (517) 241-5218 Fax: (517) 335-5376

GLOSSARY OF ACRONYMS AND TERMS

AICPA.....American Institute of Certified Public Accountants.

Children's Waiver.....The Children's Waiver Program that provides services that are enhancements or additions to regular Medicaid coverage to children up to age 18 who are enrolled in the program who, if not for the availability and provisions of the Waiver, would otherwise require the level of care and services provided in an Intermediate Care Facility for the Mentally Retarded. Payment from MDHHS is on a fee for service basis.

CMHS Block Grant Program.The program managed by CMHSPs under contract with MDHHS to provide Community Mental Health Services Block Grant program services under CFDA 93.958.

CMHSP.....Community Mental Health Services Program (CMHSP). A program operated under Chapter 2 of the Michigan Mental Health Code – Act 258 of 1974 as amended.

Examination Engagement.....A PIHP or CMHSP's engagement with a practitioner to examine the entity's compliance with specified requirements in accordance with the AICPA's Statements on Standards for Attestation Engagements (SSAE) –Attestation Standards – Clarification and Recodification - AT-C 205 (Codified Section of AICPA Professional Standards).

Flint 1115 Waiver .....The demonstration waiver expands coverage to children up to age 21 years and to pregnant women with incomes up to and including 400 percent of the federal poverty level (FPL) who were served by the Flint water system from April 2014

through a state-specified date. This demonstration is approved in accordance with section 1115(a) of the Social Security Act, and is effective as of March 3, 2016 the date of the signed approval through February 28, 2021. Medicaid-eligible children and pregnant women who were served by the Flint water system during the specified period will be eligible for all services covered under the state plan. All such persons will have access to Targeted Case Management services under a fee for service contract between MDHHS and Genesee Health Systems (GHS). The fee for service contract shall provide the targeted case management services in accordance with the requirements outlined in the Special Terms and Conditions for the Flint Section 1115 Demonstration, the Michigan Medicaid State Plan and Medicaid Policy.

GF Program.....The program managed by CMHSPs under contract with MDHHS to provide mental health services and supports to individuals with serious mental illness, serious emotional disturbances or developmental disabilities as described in MCL 330.1208.

MDHHS.....Michigan Department of Health and Human Services

Medicaid Program.....The Concurrent 1915(b)/(c) Medicaid Program and Healthy Michigan Program managed by PIHPs under contract with MDHHS.

PIHP.....Prepaid Inpatient Health Plan. In Michigan a PIHP is an organization that manages Medicaid specialty services under the state's approved Concurrent 1915(b)/1915(c) Waiver Program, on a prepaid, shared-risk basis, consistent with the requirements of 42 CFR Part 438. The PIHP, also known as a Regional Entity under MHC 330.1204b or a Community Mental Health Services Program, also manages the Autism Program, Healthy Michigan, Substance Abuse Treatment and Prevention Community Grant and PA2 funds.

Practitioner.....A certified public accountant in the practice of public accounting under contract with the PIHP or CMHSP to perform an examination engagement.

Serious Emotional Disturbances Waiver.....The Waiver for Children with Serious Emotional Disturbances Program that provides services to children who would otherwise require hospitalization in the State

psychiatric hospital to remain in their home and community. Payment from MDHHS is on a fee for service basis.

SSAE.....AICPA's Statements on Standards for Attestation Engagements.

SAPT Block Grant Program ..The program managed by PIHPs under contract with MDHHS to provide Substance Use Services Block Grant program services under CFDA 93.959.

SUD Services.....Substance Use Disorder Services funded by Medicaid, Healthy Michigan, and the "Community Grant" which consists of Federal SAPT Block Grant funds and State funds.

APPEAL PROCESS FOR COMPLIANCE EXAMINATION MANAGEMENT DECISIONS

The following process shall be used to appeal MDHHS management decisions relating to the Compliance Examinations that are required in Section 39.0 of the Master Contract.

STEP 1: MANAGEMENT DECISION

MDHHS Bureau of Audit Reimbursement and Quality Assurance	Within eight months after the receipt of a complete and final Compliance Examination, MDHHS shall issue to the PIHP/CMHSP a management decision on findings, comments, and examination adjustments contained in the PIHP/CMHSP examination report. The management decision will include whether or not the examination finding/comment is sustained; the reasons for the decision; the expected PIHP/CMHSP action to repay disallowed costs, make financial adjustments, or take other action; and a description of the appeal process available to the PIHP/CMHSP.

STEP 2: SETTLEMENT AND DISPUTE OF FINDINGS AND QUESTIONED COSTS

PIHP/CMHSP	1. Within 30 days of the PIHP's/CMHSP's receipt of the management decision: A. Submits payment to MDHHS for amounts due other than amounts resulting from disputed items; and B. If disputing items. i. Requests a conference with the Director of the Operations Administration, or his or her designee, to attempt to reach resolution on the audit findings, or files an appeal pursuant to MCL 400.1, et seq. and MAC R400.3402, et seq. as specified in ii below. Any resolution as a result of a conference with the Director of the MDHHS Operations Administration would not be binding upon either party unless both parties agree to the resolution reached through these discussions. If the parties agree to a resolution the terms will be reduced to a written settlement agreement and signed by both parties. If no resolution is reached then there will be no obligation on the part of MDHHS to produce a report of the conference process.

	Matters that remain unresolved after these discussions, would move to the appeal process, at the discretion of the CMHSP/PIHP. Administrative Hearing process ii. Submits an appeal pursuant to MCL 400.1, et seq. and MAC R 400.3401, et seq. This process will be used for all PIHP/CMHSP disputes involving Compliance Examinations whether they involve Medicaid funds or not. Requests must identify the specific item(s) under dispute, explain the reason(s) for the disagreement, and state the dollar amount(s) involved, if any. The request must also include any substantive documentary evidence to support the position. Requests must specifically identify whether the agency is seeking a conference with the Director of the financial Operations Administration, conference, an internal conference or an administrative hearing. To request an internal conference submit a written request within 30 days of the receipt of the management decision to: MDHHS Appeals Section P.O. Box 30807 Lansing, Michigan 48909 To request an administrative hearing, submit a written request within 30 days of receipt of the management decision to: Michigan Administrative Hearing Systems Michigan Licensing and Regulatory Affairs P.O. Box 30763 Lansing, Michigan 48909 If MDHHS does not receive an appeal within 30 days of the date of the management decision, the management decision will constitute MDHHS's Final Determination.

	C. Provides copies of the request for the Medicaid Provider Reviews and Hearings Process to the MDHHS Bureau of Audit, Reimbursement, and Quality Assurance, MDHHS Contract Management, and MDHHS Accounting.
MDHHS Accounting	2. If the PIHP/CMHSP has not requested a conference with the Director of Operations Administration or the Medicaid Provider Reviews and Hearings Process within the timeframe specified, implements the adjustments as outlined in the management decision. If repayment is not made, recovers funds by withholding future payments.
MDHHS Contract Management Unit	3. Ensures audited PIHP/CMHSP resolves all findings in a satisfactory manner. Works with the audited PIHP/CMSHP on developing performance objectives, as necessary.

STEP 3. MEDICAID PROVIDER REVIEWS AND HEARINGS PROCESS

MDHHS Appeals Section	Follows the rules contained in MAC R 400.3401, et seq., and various internal procedures regarding meetings, notifications, and decisions.

MDHHS AUDIT REPORT & APPEAL PROCESS

The following process shall be used to issue audit reports, and appeal audit findings and recommendations. Established time frames may be extended by mutual agreement of the parties involved.

STEP 1: AUDIT / PRELIMINARY ANALYSIS / RESPONSE

MDHHS Bureau of Audit, Reimbursement, and Quality Assurance	1. Completes audit of PIHP and holds an exit conference with PIHP management. 2. Issues a preliminary analysis within 60 days of the exit conference. The preliminary analysis is a working document and is not subject to Freedom of Information Act requests.
Audited PIHP	3. Within 10 days of receipt of the preliminary analysis, requests a meeting with the MDHHS Bureau of Audit, Reimbursement, and Quality Assurance to discuss disputed audit findings and conclusions in the preliminary analysis. Since the preliminary analysis serves as the basis for the final report, the PIHP shall take advantage of this opportunity to ensure that any factual disagreements or wording changes are considered before the final report is issued.
MDHHS Bureau of Audit, Reimbursement, and Quality Assurance	4. If a meeting is requested, convenes a meeting to discuss concerns regarding the preliminary analysis.
Audited PIHP	5. Within 14 days of the meeting with the MDHHS Bureau of Audit, Reimbursement, and Quality Assurance to discuss the preliminary analysis, submits to the MDHHS Bureau of Audit, Reimbursement, and Quality Assurance any additional evidence to support its arguments.
MDHHS Bureau of Audit, Reimbursement, and Quality Assurance	6. Within 30 days of either the meeting to discuss the preliminary analysis, or receipt of additional information from the PIHP, whichever is later, revises and issues the preliminary analysis as appropriate based on factual information submitted at the meeting or other supporting documentation provided subsequent to the meeting.
Audited PIHP	7. Within 30 days of receipt of the revised preliminary analysis, submits a brief written response indicating agreement or disagreement with each finding and recommendation. If there is disagreement, the response shall explain the basis or rationale for the disagreement and shall include additional documentation if appropriate. If there is agreement, the response shall briefly describe the actions to be taken to

	correct the deficiency and an expected completion date. Include responses on the Corrective Action Plan Forms included in the preliminary analysis. 8. If a meeting is not requested, within 30 days of receipt of the preliminary analysis, submits a brief written response to each finding and recommendation as described in STEP 1, #7 above.

STEP 2: FINAL AUDIT REPORT

MDHHS Bureau of Audit, Reimbursement, and Quality Assurance	1. Within 30 days of receipt of the PIHPs response to the preliminary analysis, prepares and issues final audit report incorporating paraphrased PIHP's responses, and Bureau of Audit, Reimbursement, and Quality Assurance responses where deemed necessary. 2. Forwards final audit report to audited PIHP and other relevant parties. The letter bound with the final audit report describes the audited PIHP's appeal rights.

STEP 3: SETTLEMENT AND DISPUTE OF FINDINGS

Audited PIHP	1. Within 30 days of receipt of the final audit report: A. Submits payment to MDHHS for amounts due other than amounts resulting from disputed findings; and B. If disputing findings, appeals under MCL 400.1 et seq. and MAC R 400.340 1, et seq. This process will be used for all CMHSP audits regarding the Specialty Service Contract whether they involve Medicaid funds or not. Requests must identify the specific audit adjustment(s) under dispute, explain the reason(s) for the disagreement, and state the dollar amount(s) involved, if any. The request must also include any substantive documentary evidence to support the position. Requests must specifically identify whether the agency is seeking a preliminary conference, a bureau conference or an administrative hearing. To request an internal conference submit a written request within 30 days of the receipt of the management decision to: MDHHS Appeals Section P.O. Box 30807 Lansing, Michigan 48909

	To request an administrative hearing, submit a written request within 30 days of receipt of the management decision to: Michigan Administrative Hearing Systems Michigan Licensing and Regulatory Affairs P.O. Box 30763 Lansing, Michigan 48909 If MDHHS does not receive an appeal within 30 days of the date of the letter transmitting the final audit report, the letter will constitute MDHHS's Final Determination Notice according to MAC R 400.3405. C. Provides copies of the request for the Medicaid Provider Reviews and Hearings Process to the MDHHS Bureau of Audit, Reimbursement, and Quality Assurance, MDHHS Contract Management, and MDHHS Accounting.
MDHHS Accounting	2. If the PIHP has not requested the Medicaid Provider Reviews and Hearings Process within the time frame specified, implements the adjustments as outlined in the final report. If repayment is not made, recovers funds by withholding future payments.
MDHHS Contract Management Unit	3. Ensures audited PIHP resolves all findings in a satisfactory manner. Works with the audited PIHP on developing performance objectives, as necessary.

STEP 4: MEDICAID PROVIDER REVIEWS AND HEARINGS PROCESS

MDHHS Appeals Section	Follows the rules contained in MAC R 400.3401, et seq., and various internal procedures regarding meetings, notifications, documentation, and decisions.

MICHIGAN DEPARTMENT OF HEALTH & HUMAN SERVICES

Substance Use Disorder (SUD) Services Policy Manual

Effective October 1, 2018

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SUD DATA COLLECTION/RECORDING AND REPORTING REQUIREMENTS

Overview of Reporting Requirements
The reporting of substance abuse services data by the PIHP as described in this material meets several purposes at MDHHS including:

-Federal data reporting for the SAPT Block Grant application and progress report, as well as for the treatment episode data set (TEDS) reported to the federal Office of Applied Studies, SAMHSA.

-Managed Care Contract Management

-System Performance Improvement

-Statewide Planning

-CMS Reporting

-Actuarial activities

Special reports or development of additional reporting requirements beyond the initial data and reports required by the Department may be requested within the established parameters of the contract. The PIHP will likely maintain, for management and local decision-making, additional information to that specified in the reporting requirements.

Standards for collecting and reporting data continue to evolve. Where standards and data definitions exist, it is expected that each PIHP will meet those standards and use the definitions in order to assure uniform reporting across the state. Likewise, it is imperative that the PIHP employs quality control measures to check the integrity of the data before it is submitted to MDHHS. Error reports generated by MDHHS will be available to the submitting PIHP the day following a DEG submission. MDHHS's expectation is that the records that receive error Ids will be corrected and resubmitted as soon as possible. The records in the error file are cumulative and will remain errors until they have been corrected.

Individual services recipient data received at MDHHS are kept confidential and are always reported out in aggregate. Only a limited number of MDHHS staff can access the data that contains any possible individual client identifiers. (Social Security number, date of birth,

diagnosis, etc.) All persons with such data access have signed assurances with MDHHS indicating that they are knowledgeable about substance abuse services confidentiality regulations and agree to adhere to these and other departmental safeguards and protections for data.

A. Basis of Data Reporting

The basis for data reporting policies for Michigan substance abuse services includes:

1. Federal funding awarded to Michigan through the Substance Abuse Prevention and Treatment (SAPT) federal block grant to share in support of substance abuse treatment and prevention requires submission of proposed budgets and plans. Resources and plans must be reviewed and considered by the State in light of statewide needs for substance abuse services.

2. Public Act 368 of 1978, as amended, requires that the department develop:

   A comprehensive State plan through the use of federal, State, local, and private resources of adequate services and facilities for the prevention and control of substance abuse and diagnosis, treatment, and rehabilitation of individuals who are substance abusers.

   In addition, the department shall:

   Establish a statewide information system for the collection of statistics, management data, and other information required.

   Collect, analyze and disseminate data concerning substance abuse treatment and rehabilitation services and prevention services.

   Conduct and provide grant-in-aid funds to conduct research on the incidence, prevalence, causes, and treatment of substance abuse and disseminate this information to the public and to substance abuse services professionals.

3. Comprehensive planning requires statewide needs assessments to include identification of the extent and characteristics of both risks for development and current substance abuse problems for the citizens of Michigan.

B. Policies and Requirements Regarding Data

Treatment Data reporting will encompass Substance Abuse (SA) services provided to

clients supported in whole or in part with state administered funds through funds for SA services to Medicaid recipients included in PIHP contracts.

Definitions:
State administered funds: Any state or federal funding provided by the MDHHS/DSAGS/SA contract. Funds provided include federal SAPT Block Grant, state general funds, MIChild, and other categorical or special funds. Medicaid funds that are covered under the MDHHS/PIHP contract are considered state administered funds.

Data: Client admission and discharge records (for treatment services), and client institutional and professional encounter records, and backup required to produce this information (e.g. billings from providers, services logs, etc.). Prevention services data are not addressed herein.

Services: Substance abuse treatment (residential, residential detox, intensive outpatient, outpatient, including pharmacological supports as part of above), substance abuse assessment (screening, assessment, referral and follow-up) provided by appropriately state licensed programs. Prevention services data are not addressed herein.

Supported in whole or in part: Describes those services for which the PIHP pays, inclusive of co-pays with other sources of funds (e.g. first party, third party insurance, and/or other funding sources).

Policy:
Reporting is required for all clients whose services are paid in whole or in part with state administered funds regardless of the type of co-pay or shared funding arrangement made for the services. This includes both co-pay arrangements where public funds are applied from the starting date of admission to a service, as well as those where public funds are applied subsequent to the application of other funding or payments.

For purposes of MDHHS reporting, an admission is defined as the formal acceptance of a client into substance abuse treatment. An admission has occurred if and only if the client begins treatment.

A client is defined as a person who has been admitted for treatment of his/her own drug problem. A co-dependent (a person with no alcohol or drug abuse problem who is seeking services because of problems arising from his or her relationship with an alcohol or drug user) who has been formally admitted to a treatment unit and who has his/her own client record also should be reported with the record indicating his/her co-dependency.

A client's episode of treatment is tracked by service category and by license number. The first

event at a new provider or in a new service category 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 discharge. For reporting purposes, "completion of treatment" is defined as the completion of ALL planned treatment for the current episode.
Completion of treatment at one level of care or with one provider is not "completion of treatment" if there is additional treatment planned or expected as part of the current episode. The reason for discharge given in all instances where the treatment has not been terminated should be

06 (Transfer-Continuing in Treatment). The code of 06 will identify the fact that the client's treatment episode did not terminate on the date reported.

1. Data definitions, coding and instructions issued by MDHHS apply as written. Where a conflict or difference exists between MDHHS definitions and information developed by the PIHP or locally contracted data system consultants, the MDHHS definitions are to be used.

2. All data collected and recorded on admission and discharge forms shall be reported using the proper Michigan Department of Licensing and Regulatory Affairs (LARA) substance abuse services site license number. LARA license numbers are the primary basis for recording and reporting data to MDHHS at the program level **(along with the National Provider Identifier (NPI).**

3. Combined reporting of client data in data uploads from more than one license site number is not acceptable or allowable, regardless of how a PIHP funds a provider organization.

4. Failure to assure initial set up and maintenance of the proper site license number and PIHP code will result in data that will be treated as errors by MDHHS. Any data submitted to MDHHS with improper license numbers will be rejected in full. The necessary corrections and data resubmissions will be the sole responsibility of the PIHP in cooperation with the involved service providers.

5. There must be a unique Substance Abuse client identifier assigned and reported. It can be up to 11 characters in length, all numeric. This same number is to be used to report data for all admissions and encounters for the individual within the PIHP. It is recommended that a method be established by the PIHP and funded programs to ensure that each individual is assigned the same identification number regardless of

how many times he/she enters services in any program in the region, and that the client number be assigned to only one individual.

6. Any changes or corrections made at the PIHP on forms or records submitted by the program must be made on the corresponding forms and appropriate records maintained by the program. Failure to maintain corresponding data at the PIHP and program levels will result in data audit exceptions on discovery of discrepancies during an MDHHS on-site data audit/review. Each PIHP and its programs shall establish a process for making necessary edits and corrections to ensure identical records. The PIHP is responsible for making sure records at the state level are also corrected via submission of change records in data uploads.

7. Providers of residential and/or detoxification services must maintain a daily client census log that contains a listing of each individual client in treatment. This listing can be made in client name or using the client identification number. Census must be taken at approximately the same time each day, such as when residents are expected to be in bed. MDHHS or the PIHP will review the daily client census logs in data auditing site visits.

8. Providers of pharmacological support services (either methadone or buprenorphine) must maintain a log that contains a listing of each client in treatment, and their daily dosages of these medications provided by the program. MDHHS or the PIHP will review these logs in data auditing site visits

9. Diagnosis coding on client data forms shall be consistent with the client's substance abuse treatment plan. If there is more than one substance abuse diagnosis determined, then the secondary diagnosis code should be reported accordingly. Diagnosis codes on the data records must be consistent with those listed on other client documentation (such as billing forms, etc.). Codes should be entered using only the proper DSM definitions for substance abuse and other related problems that are being treated.

10. The primary diagnosis should correspond to the primary substance of abuse reported at admission. The secondary diagnosis may or may not be consistent with the secondary substance of abuse if another diagnosis better reflects a more serious secondary problem than the secondary substance.

11. PIHPs must make corrections to all records that are submitted but fail to pass the error checking routine. All records that receive an error code are placed in an error master file and are not included in the analytical database. Unless acted upon, they remain in the error file and are not removed by MDHHS.

12. The PIHP is responsible for generating each month's data upload to MDHHS consistent with established protocols and procedures. Monthly and quarterly data uploads must be received by MDHHS via the DEG no later than the last day of the following month.

13. Treatment clients may be admitted to more than one program or one service category at the same time.

14. The PIHP must communicate data collection, recording and reporting requirements to local providers as part of the contractual documentation. PIHPs may not add to or modify any of the above to conflict with or substantively affect State policy and expectations as contained herein.

15. Statements of MDHHS policy, clarifications, modifications, or additional requirements may be necessary and warranted. Documentation shall be forwarded accordingly.

16. Treatment clients who have not had any treatment activity in a 45-day period shall be considered inactive and their case discharged. A treatment discharge record should be completed and submitted; the effective date of discharge will be the last date of actual contact with the program. The record should be completed and submitted based on the client's status as of the last date of service; records with all data items marked as unknown or left blank are not acceptable.

Encounter Reporting
Via
Health Insurance Portability and Accountability Act (HIPPA)
837 Standard Transactions

For the first quarter of FY 2012, the X12 version 40101A of the 837 Encounter will be accepted (as it has been for the last three years). However:

Effective January 1, 2012, must submit electronic healthcare transactions using the X12 version 5010. Those who do not convert to the version 5010 by the compliance date will have their encounters and other transactions rejected. Reimbursement delays and resubmission costs could occur.

Please reference this single web page for up-to-date instructions and guidance:

http://ww.michigan.gov/mdhhs/0,1607,7-132-2945_42542_42543_42546_42552_42696-256754--,00.html

Relevant documents at this site are the following:

1. HIPPA 5010A1 EDI Companion Guide for ANSI ASC X12N 837P Professional Encounter
   Regional PIHPs
2. HIPPA 5010A1 EDI CDI Companion Guide for ANSI ASC X12N 837I Institutional Encounter
   Regional PIHPs
3. Michigan Department of Health & Human Services Electronic Submission Manual March 18, 2011
4. HIPPA 5010A1EDI Companion Guide for ANSI ASC X12N 270/271 Health Care Eligibility Benefit Inquiry and Response

STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

RICK SNYDER
GOVERNOR

NICK LYON
DIRECTOR

PIHP Region: _____

Quarter (check one): 1st ☐ 2nd ☐ 3rd ☐ 4th ☐

	Prevention services	Treatment Services	MH services	Other
# of children referred to:				
# of children who accessed:				
# who refused services				

* For children who "enter" services with their mother. Child might not be physically present, but clinician and case manager should be asking about any concerns regarding the child/children, and noting and tracking all referrals made for services

II. METHADONE REQUIREMENTS

Treatment Policy #03, Buprenorphine—
Effective October 1, 2006

Treatment Policy #04, Off-site Dosing Requirements for Medication-Assisted Treatment—

Effective December 1, 2006

Treatment Policy #05, Criteria for Using Methadone for Medication assisted Treatment and Recovery--

Effective October 1, 2012

JENNIFER M. GRANHOLM
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

JANET OLSZEWSKI
DIRECTOR

MEMORANDUM

Date: June 28, 2006

To: Regional Coordinating Agencies
Opioid Treatment Programs

From: Doris Gellert, Director
Bureau of Substance Abuse and Addiction Services
Office of Drug Control Policy

Subject: Revised Treatment Policy # 03: *Buprenorphine*

Enclosed is Revised Treatment Policy # 03: *Buprenorphine*. This revised policy incorporates the Medicaid primary health care pharmacy benefit.

Policy compliance will be reviewed as part of program site visits. Please direct any questions to Marilyn Miller, Treatment Specialist, at 517-241-2608, via fax at 517-335-2121, or via email at MillerMar@michigan.gov.

DG/MM/mlf

Enclosure

TREATMENT POLICY # 03

SUBJECT: Buprenorphine

ISSUED: **August 2004, revised June 6, 2006**

EFFECTIVE: September 1, 2004, revision effective October 1, 2006

PURPOSE:

This policy establishes standards for the use of buprenorphine when used as adjunct therapy in the treatment of opioid addiction for clients receiving substance abuse services administered through the Michigan Department of Health & Human Services, Office of Recovery Oriented Systems of Care (MDHHS/OROSC). PIHPs are required to provide additional reports so the overall cost and experience gleaned from the use of buprenorphine as adjunct to treatment can be used to determine future planning and policy.

SCOPE:

PIHPs may choose to fund the cost of the buprenorphine/naloxone medication as adjunct therapy for opioid addiction in treatment services including residential, intensive outpatient, outpatient, and methadone programs. Allowable funding consists of federal block grant, state general funding, and local funding. Medicaid reinvestment savings may also be used if part of a Medicaid reinvestment plan submitted by the Pre-paid Inpatient Health Plan (PIHP) and approved by Centers for Medicare and Medicaid Services (CMS) and MDHHS/OROSC. PIHPs may use clients on a discretionary basis after covered services have been paid.

Clients with Medicaid coverage may have access to the pharmacy benefit for buprenorphine/naloxone. It must be preauthorized through the Medicaid pharmacy plan.

Opioid Treatment Programs (OTPs) providing services must conform to the Federal opioid treatment standards set forth under 42 C.F.R. Part 8, including off-site dosing when dispensing buprenorphine/naloxone. There is no limit to the number of clients to whom buprenorphine can be dispensed from an OTP.

Private physicians who have the Substance Abuse and Mental Health Services Administration (SAMHSA) waiver for prescribing buprenorphine/naloxone are limited to managing 30 clients on buprenorphine at any one time. An OTP physician who has the SAMHSA waiver may prescribe the medication for off-site use as if the physician were in private practice. The maximum number of active clients would be 30 clients.

BACKGROUND:

The Food and Drug Administration (FDA) approved Buprenorphine hydrochloride (Subutex®) and buprenorphine hydrochloride/naloxone hydrochloride (Suboxone®) on October 8, 2002 for the treatment of opioid addiction. Both buprenorphine and buprenorphine/naloxone are administered in sublingual tablets (placed under the tongue) and gradually absorbed. Prior to their approval and subsequent scheduling as Schedule III medications, the only prescription medications approved for opioid substitution agents were methadone and LAAM, both Schedule II medications. Schedule II medications must be prescribed to patients enrolled in OTPs. Because of the numerous federal and state regulations with respect to OTPs, the addition of Schedule III medications as adjunctive treatment greatly increases access to services for potential opioid treatment clients because they can now receive medication for opioid addiction treatment through a qualified physician's office.

Buprenorphine has a ceiling effect for toxicity because of its antagonist properties. Once a certain dose or receptor occupancy level is reached, additional dosing does not produce further toxicity. Studies have shown that buprenorphine plateaus at the equivalent of 40 to 60 milligrams of methadone. Because of the maximum for toxicity, respiratory depression and/or death from overdose are less common than with opiate agonists, such as heroin, oxycodone, or methadone. Concurrent use of buprenorphine with alcohol, benzodiazepines, or other respiratory depressants can still result in overdose. Naloxone (Narcan) is added to buprenorphine by the manufacturer to prevent diversion because, although the naloxone will have no effect when absorbed under the tongue, crushing and injecting the medication will result in sudden and intense withdrawal symptoms. The ceiling effect also restricts the medication's effectiveness in treating patients who have a need for high levels of opioid replacement medication. Studies are currently being done to determine the safety of buprenorphine/naloxone in pregnancy as well as breastfeeding.

REQUIREMENTS:

Program Requirements

1. The client must have a Diagnostic Statistical Manual (DSM) impression of opioid dependency as determined by the Access Management System (AMS). All six dimensions of the current American Society of Addiction Medicine (ASAM) Patient Placement Criteria must be used. The client must meet medical necessity criteria as determined by a physician who has a SAMHSA waiver to prescribe or dispense buprenorphine.

2. Buprenorphine/naloxone must be used as adjunct to opioid treatment throughout the continuum of care (OP, IOP, Residential, sub-acute detoxification, and methadone adjunctive treatment as part of a detoxification regimen). It cannot be used without counseling.

3. Toxicology screens must be done at intake and then on a random, at least weekly, frequency until three (3) consecutive screens are negative. Thereafter, they must be done on a monthly, random frequency. Screens must assay for opioids, cocaine, amphetamines, cannabinoids, benzodiazepines, and

methadone metabolites. Screens must be random for days of the week and days since last screen was administered.

4. As an adjunctive medication for the treatment of opioid addiction, the PIHP cannot pay for the buprenorphine/naloxone alone. The medication must be used in conjunction with counseling at a substance abuse treatment program under contract with the PIHP. The PIHP must develop a plan in which the substance abuse treatment program, a qualified physician, and a pharmacy are involved.

Reporting Requirements

The data system has been modified to accommodate reporting for clients receiving buprenorphine/naloxone.

Data system:

- **Admission and discharge Treatment Episode Data Set (TEDS) records must be submitted as is routine with other clients. In the client admission record, the field OPIOD TREATMENT PROGRAM (1= Methadone, 2= No, and 3= Buprenorphine) must be coded with "3" for all clients receiving buprenorphine/naloxone, regardless of service category.**
- **Buprenorphine/naloxone daily dosages and associated cost must be reported with HCPCS Code of H0033 as required in the 837 Professional Encounter record.**

PROCEDURE:

Prescribing Policy

1. All physicians, including those at an OTP, must have a waiver from SAMHSA permitting them to prescribe or dispense buprenorphine/naloxone (e.g., Suboxone®).

2. Buprenorphine/naloxone (Suboxone®) must be used as an adjunctive treatment within an individualized treatment plan for opioid addiction. It is not appropriate as a stand-alone treatment procedure.

3. The target populations for buprenorphine/naloxone are the following:

   - Clients who are being transferred from methadone as part of a detoxification regimen;
   - Clients that have been opioid dependent less than one year, but for whom adjunctive therapy is deemed medically necessary; and
   - Clients that are eligible for methadone adjunctive therapy within the 40-60 milligrams therapeutic range.

4. In accordance with FDA regulations, buprenorphine is not currently approved for pregnant women.

5. The combination medication buprenorphine/naloxone (Suboxone®) is the only medication approved for use under these guidelines. No "off-label" or experimental use of buprenorphine/naloxone is permitted under these policies.

REFERENCES:

American Psychiatric Association. (2000). *The Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Text Revision, Washington, DC.

American Society of Addiction Medicine. (2001). *ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders*, Second Edition-Revised, ASAM UPC-2R, Chevy Chase, Maryland.

Certification of Opioid Treatment Programs: United States Code of Federal Regulations, Title 42, Part 8, Washington, D.C. (2003).

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Schuster, C and Seine, S. (October 8, 2002). *Interview*. University Psychiatric Clinic, Wayne State University, Detroit Michigan.

APPROVED BY: ___*SIGNED*_____

Donald L. Allen, Jr., Director
Office of Drug Control Policy

JENNIFER M. GRANHOLM
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

JANET OLSZEWSKI
DIRECTOR

DATE: November 30, 2006

TO: Regional Coordinating Agencies
Opioid Treatment Programs

FROM: Doris Gellert, Director
Bureau of Substance Abuse and Addiction Services
Office of Drug Control Policy

SUBJECT: Revised Treatment Policy-04: Off-Site Dosing Requirements for Medication Assisted Treatment

Enclosed is the final version of the Michigan Department of Community Health/Office of Drug Control Policy (MDCH/ODCP) Treatment Policy #4 – Off-Site Dosing Requirements for Medication Assisted Treatment

There were no comments from the field. The following changes were made by MDCH/ODCP staff:

1. Labeling- page 5 – because Suboxone® is in tablet form rather than liquid like methadone, it can be dispensed for multiple days in the same bottle.

2. Out of Country Travel, page 9 – Center for Substance Abuse Treatment/Division of Pharmacologic Therapies (CSAT/DPT) approval is no longer necessary solely because the client wishes to travel outside the country. MDCH/ODCP approval is still required.

Reminder: Extranet submissions are required. The use of the Extranet, which is maintained by CSAT, will be the only manner in which exception requests will be accepted by MDCH/ODCP effective January 1, 2007. Call 1-866-687-2728 to sign up for the Extranet. For those OTPs that do not have Internet capability, a waiver of this requirement can be obtained by submitting a request, in writing, to ODCP. Fax the request to the attention of Marilyn Miller at 517-335-2121. This request should state the reasons why use of the Extranet cannot start on the effective date and the planned date for starting.

Should you have any questions or require further clarification of any issues in this policy, please contact Marilyn Miller at 517-241-2608, or by email at millermar@michigan.gov.

Enclosure

TREATMENT POLICY 04

SUBJECT: **Off-Site Dosing Requirements for Medication Assisted Treatment**

ISSUED: September 1, 2004, revised March 1, 2006, revised November 13, 2006

EFFECTIVE: **December 1, 2006**

PURPOSE:

The purpose of this policy is to clarify the rules and procedures pertaining to off-site dosing of opioid treatment medication by clients in Opioid Treatment Programs (OTP).

SCOPE:

This policy pertains to off-site dosing for all clients who are receiving medication-assisted treatment as an adjunct in an OTP in Michigan, regardless of the funding source. Due to the complexities of off-site usage and the variety of rules and regulations involved, in situations where there is a conflict between state and federal rules not otherwise addressed in this policy, the most stringent rule applies. Off-site dosing is a privilege, not an entitlement, nor a right.

BACKGROUND:

The use of methadone and buprenorphine, through an OTP, as adjunct therapies in substance abuse treatment, is highly regulated. Clients must attend the OTP daily for on-site supervised dispensing of their medication until they have met certain specified criteria for the privilege of reduced attendance and dosing off site. Safety is the driving force behind the strict regulations for off site dosing with the goal of preventing diversion of the medication to the general public and the accidental ingestion of the medication by children.

Off-site dosing can be used on a temporary basis in cases when the clinic is closed for business, such as Sundays and holidays. On an individual basis, off-site dosing may be temporary or

permanent. As specified in this policy, some off-site dosing may need approval from the Michigan Department of Health & Human Services/Office of Recovery Oriented Systems of Care (MDHHS/OROSC) and/or the Center for Substance Abuse Treatment/Division of Pharmacologic Therapies (CSAT/DPT).

REQUIREMENTS:

OTP program physicians and other designated OTP staff must ensure that clients are responsible for managing off-site dosing prior to granting the privilege. The amount of time in treatment, progress towards meeting the treatment goals, as well as exceptional circumstances or physical/medical issues are used to determine the number of doses of methadone allowed off site. Exceptions to these rules are allowed with approval from the State Methadone Authority (SMA) at MDHHS/OROSC and, where federal law requires, CSAT/DPT approval.

On-Site OTP Clinic Attendance Requirements

A client in maintenance treatment must ingest the medication under observation, at the OTP clinic, for not less than six days a week for a minimum of the first 90 days in treatment (R 325.14417 Part 417[1]). If a client discontinues treatment and later returns, the time in treatment is restarted as if the client was newly admitted to treatment, unless there are extenuating circumstances.

When a client transfers from another OTP, the cumulative time in treatment must be used in calculating the client's time if the gap in treatment time is less than 90 days (R 325.14417 Part 417[4]).

After 90 days of treatment, a client may be allowed to reduce on-site dosing to three times weekly while receiving no more than two doses at one time for off-site dosing (R 325.14417 Part 417[2]).

After two years in treatment, a client may be allowed to reduce the on-site dosing to two times weekly while receiving no more than three doses at one time for off-site dosing (R 325.14417 Part 417[3]).

The inability of the client to qualify for off-site dosing or to maintain an off-site dosing schedule must be addressed as part of the client's individualized treatment plan. Dosage adjustments, establishment of compliance contracts, additional counseling sessions, specialized treatment groups, or assessment for another level of care must be considered. OTPs must coordinate sanctions with the prior authorization source such as an Access Management System (AMS) agency for funded clients or other involved third party as appropriate.

Off-Site Dosing Requirements

Rules that Apply to All Off-Site Dosing:

All clients who are dispensed medication for off-site dosing must be deemed responsible for handling the medication. This includes when the program is closed for business, such as Sundays and holiday observances as well as other qualified times. If the client is deemed not to be responsible for any of these times, other arrangements must be made for the client to be dosed on site at their current OTP or at another OTP. If a client needs to go to another program to be dosed, coordination between both programs is required to ensure the client is only dosing at one OTP for days when the client's OTP of record is closed.

Client Criteria:

Medication for off-site dosing may only be given to a client who, in the reasonable clinical judgment of the program physician, is responsible in the handling of opioid substitution medication. Before reducing the frequency of on-site dosing, the rationale for this decision must be documented in the client's treatment record by a program physician or a designated staff. If a designated staff member records the rationale for the decision, a program physician must review, countersign, and date the client's record (R 325.14416 Part 416[1] and 42 CFR Part 8.12[I][3]). The client's off-site dosing schedule is to be reviewed every sixty days while the client receives doses for off-site use.

The program physician must utilize all of the following information in determining whether or not a client is responsible to handle opioid medication off site:

- Background and history of the client: the client is employed, actively seeking employment as evidenced by a sign-off sheet from potential employers, or disabled and unable to work as evidenced by a Social Security Income or Social Security Income Disability or Workmen's Compensation checks; and the client has appropriately handled off-site dosing in the past such as on Sundays and holidays or other off-site situations.

- General and specific characteristics of the client and the community in which the client resides (the client is working toward or maintaining treatment goals; the client has taken measures to ensure that third parties do not have access to the medication).

- An absence of current and/or recent abuse (within 90 days) of drugs, including alcohol on the basis of toxicology screens that must include opioids, methadone metabolites, barbiturates, amphetamines, cocaine, cannabinoids, benzodiazepines and any other drugs as appropriate for individual clients. Alcohol testing must be conducted by the use of a Breathalyzer or other standard testing means if alcohol is suspected at the time of dosing. (Clients who appear to be under the influence of

any drug or alcohol will not be dosed until safe to do so. Clients should not be allowed to drive under this condition.) Any evidence of alcohol abuse in the client's chart within the past 90 days will be considered as positive for alcohol, as will any legal charges related to alcohol consumption. The need to verify toxicology tests or the need for more frequent toxicology tests must be components of the clinic rules. Legally prescribed drugs, including controlled substances, will not be considered as illicit substances, provided the OTP has verification the drug(s) were prescribed for the client. Such documentation must be included in the client's chart. Prescription documentation for all prescribed medication must be updated at least every 60 days until discontinued. Prescription medication documentation must be updated in the client's chart at the first opportunity – preferably at the next clinic visit – when the client is prescribed a medication or a medication is renewed. A copy of the prescription label, a printout from the pharmacy, or the information recorded in the chart from viewing the patient's prescription bottle shall constitute documentation. All medications are to be considered within the context of coordinating care with other prescribing healthcare providers, and the safety considerations of granting off-site dosing privileges.

- Regularity of clinic attendance.
- Absence of serious behavioral problems in the clinic.
- Stability of the client's home environment and social relationships.
- Absence of recent known criminal activity.
- Length of time in opioid substance abuse treatment with medication as an adjunct.
- Assurance that medication can be safely stored off site, particularly with respect to prevention of accidental ingestion by children.
- The rehabilitative benefit to the client derived from decreasing the frequency of clinic attendance outweighs the potential risks of diversion.

R 325.14416 Part 416[3] and 42CFR Part 8.12 [I][2][i-viii]

Clients must receive a copy of the clinic's rules pertaining to responsible handling of off-site doses and the reasons for revoking them. Clinic rules must include a list of graduated sanctions such as decreasing and rescinding of all off-site dosing. A form signed by the client acknowledging receipt of this information must be included in the

client file.

Product Preparation:

Methadone for off-site dosing must be dispensed in a liquid, oral form and formulated in such a way to minimize use by injection. The methadone must contain a preservative so refrigeration is not required.

Methadone must be dispensed in disposable, single use bottles, and must be packaged in childproof containers pursuant to section 3 of the Poison Prevention Packaging Act, 15 USC Part 1472. (R 325.14415 Part 415) In cases when clients take medication twice daily (split dosing), two separate childproof containers must be utilized. These efforts will help minimize the likelihood of accidental ingestion by children.

Buprenorphine/naloxone must be packaged in childproof containers and labeled similar to methadone. However, because buprenorphine/naloxone is in tablet form, a maximum of 30-day supply can be contained in the same bottle. The dose(s) dispensed for unsupervised off-site use must adhere to 42 CFR Part 8 unless an exception request has been approved. (MCL 333.17745)

Labeling:

Medication for off-site administration must be labeled as follows:

- The name of the medication
- The strength of the medication
- The quantity dispensed
- The OTP's name, address, and phone number
- Client's name or code number
- Medical director's/prescriber's name
- Directions for use
- The date dispensed and the date to be used
- A cautionary statement that the medication should be kept out of the reach of children
- Statement that this medication is only intended for the person to whom it was prescribed

R 325.14415 Part 415(2)
MCL 333.17745(7)(a-h)

Security:

The client is expected to secure all take home medication in a locked box prior to leaving the OTP. It is expected that the client store this box in a manner that will prevent the key or combination from being readily available to children and/or others who could be harmed from accidental use and to prevent diversion to or by third parties. Clients should be able to explain the process that will be used to secure the medications that are taken home when asked by an OTP staff member. This process should be recorded in the client's record and updated when the client's take home status is reviewed every 60 days. Empty and unused bottles are to be returned to the OTP in the locked box for proper disposal. Failure to do so could result in revocation of take home privileges.

Temporary Off-Site Dosing:

Special circumstances such as a client's physical/medical needs or other exceptional circumstances, situations in which a program is closed such as Sundays and Holidays, or emergency situations may result in cases when the client is allowed to dose off site for a temporary time period.

Physical/Medical Necessity:

If a client's physician provides written documentation that reduced attendance at the clinic is necessary due to physical/medical necessity of the client and the OTP physician concurs, off-site dosing of up to 13 doses within a 14-day time frame is allowed without prior MDHHS/OROSC approval unless the request exceeds the CSAT/DPT amounts allowed. (See Section entitled "CSAT/DPT Approval Required.")

The written documentation from the client's physician must include a medical diagnosis and whether the condition is permanent or temporary. If the condition is temporary, the date the client can return to his/her usual clinic attendance must be indicated. Whenever possible, the client's personal physician and the OTP physician should coordinate care including the prescribing of medication that interacts with methadone.

Temporary exceptions need to be reviewed and reissued if the exception is needed beyond the initial time frame. All exceptions must be reviewed during the usual 60-day OTP physician's review. All documentation must be maintained in the client's chart (R 325.14417 Part 417(5)). Requirements for counseling sessions and toxicology screens must be coordinated with CAs if the client is funded.

Exceptional Circumstances:

Medication for off-site dosing may only be given to a client who has an exceptional circumstance as indicated in this section and who, in the reasonable clinical judgment of the program physician, is responsible in the handling of opioid substitution medication. The exceptional circumstance must be clearly documented and any supportive documentation should be included in the client's chart.

Clients who have been in OTP treatment for at least 6 months and who are eligible for a 3-times a week schedule may be permitted up to three consecutive off-site doses within a specific 7-day period, depending on the situation, without prior approval from MDHHS/OROSC, for the following exceptional circumstances:

- Employment schedule conflicts
- Educational training schedule conflicts
- Medical or mental health appointment conflicts
- Appointments with other agencies relative to the client's treatment goals

Clients who have been in OTP treatment for at least nine months may be permitted up to six off-site doses within a 7-day time period without prior approval from MDHHS/OROSC for the following exceptional circumstance:

- Travel hardship (at least 60 miles or 60 minutes one way from an OTP). The actual mileage must be documented in the client's chart with the city of origin listed.

Vacations are a special type of exceptional circumstance and shall be limited to six days within a 7-day period for clients who have been in treatment for at least nine months and 13 days within a 14-day period for clients who have been in treatment for one year or more without prior MDHHS/OROSC approval. Sunday and holiday doses must be included in the specified off-site amounts (R 325.14416 Part 417[6]). Documentation must be included in the chart verifying the client did travel to the planned destination(s) as indicated on the exception request.

Allowable Program Closures:

Medication for off-site dosing due to program closure may only be given to a client who, in the reasonable clinical judgment of the program physician, is responsible in the handling of opioid substitution medication.

Sunday Dosing

OTPs may be closed on Sundays without prior approval from MDHHS/OROSC.

Holiday Observances

- OTPs may be closed for the following holidays without prior MDHHS/OROSC approval:

New Year's Day	Labor Day
Martin Luther King, Jr. Birthday	Veterans' Day
Presidents' Day	Thanksgiving Day
Memorial Day	Christmas Day
Independence Day – July 4	

- Should the holiday fall on a Sunday, OTPs may be closed the following Monday without prior MDHHS/OROSC approval.
- A day in which the OTP has abbreviated hours in which methadone will be dispensed will not be considered as a program closure.
- If the OTP wishes to close for more than two consecutive days (including Sundays and holidays), the SMA at MDHHS/OROSC and CSAT/DPT must approve a plan. The plan must meet the following criteria:
  - The request must be for each circumstance. OTPs may request all holidays for the entire year at once. No approvals will be automatically approved from year to year.
  - The request must be submitted for each individual OTP.

- The plan must be submitted to the SMA at MDHHS/OROSC at least 10 working days prior to the first day the program wishes to close. MDHHS/OROSC is not obligated to approve any plans submitted that do not meet the 10 day criteria. Fax the request to the current number for MDHHS/OROSC– (517) 335-2121.

- Be written on OTP letterhead.

- Be signed by the OTP sponsor or administrator.

- Name holidays to be closed.

- List dates to be closed including the holiday as well as a Sunday, if applicable.

- Describe how clients who lack 90 days in treatment and those clients who do not meet the criteria for unsupervised dosing will be dosed face-to-face.

MDHHS/OROSC will approve and forward the request to CSAT/DPT for their approval. Should MDHHS/OROSC not approve the plan, the OTP will be notified. This notification will include the reason(s) for the denial.

Emergency Situations

OTPs must have written plans and procedures which include how dosing clients on-site, as well as dispensing doses for off-site use, will be accomplished in emergency situations. Emergency situations include power failures, natural disasters, and other situations in which the OTP cannot operate as usual. This plan must also include how the security of the medication and client records will be maintained.

PROCEDURE:

MDHHS/OROSC Approval Required:

MDHHS/OROSC approval for off-site dosing is needed for clients who do not meet the criteria for approval at the OTP level and for all those cases where federal approval is needed. In addition, any client taking medication out of the country must have MDHHS/OROSC approval. Note: medication transported out of the country is subject to that country's jurisdiction.

CSAT/DPT Approval Required:

CSAT/DPT approval is needed for clients not meeting the following federal off-site criteria for length of time in treatment:

- Less than 90 days in treatment - 1 dose plus the Sunday dose
- 90 to 180 days in treatment - 2 doses plus the Sunday dose
- 180 to 270 days in treatment - 3 doses plus the Sunday dose
- 270 to 360 days in treatment - 6 doses (includes the Sunday dose)
- One year in continuous treatment - 14 doses (includes the Sunday dose)

Submission Of Exception Requests:

As the CSAT/DPT Extranet system is in place and functioning well, the hard copy and fax method may only be used when the Extranet system is temporarily unavailable. The Extranet system is more efficient and allows for faster responses by MDHHS/OROSC and CSAT/DPT and provides better confidentiality and eliminates the chance of not being able to read a hand written request due to fax quality and/or legibility. Programs must not submit both hard copy and Extranet-based forms for the same exception request. Programs may request a short-term waiver from the use of the Extranet from the SMA at MDHHS/OROSC. Each request will be considered on a case-by-case basis.

Extranet System:

The CSAT/DPT Extranet System was designed to facilitate the processing of Exception and Record of Justification Forms nationwide. Instructions for using this system are the responsibility of CSAT/DPT. The Extranet form will be available as directed by CSAT/DPT on a Website designated by SAMHSA. OTPs must submit all exception requests using this method, even those that only require MDHHS/OROSC approval. In those cases, CSAT/DPT will indicate, "Decision not required."

MDHHS/OROSC requires that all exception requests be submitted by using the Extranet system. Faxed forms will only be accepted if the system is down or in special, pre-approved situations.

Extranet Downtime Procedure for Hard Copy Forms and Faxing:

All downtime exceptions to the rules for off-site dosing must be submitted to

MDHHS/OROSC on the "MDHHS/OROSC Methadone Exception Request and Record of Justification" form (Attachment A). **This is the only form that will be accepted by MDHHS/OROSC.** In urgent situations, such as funerals, illness, immediate work and travel hardships, this form can be used but the OTP should call the SMA so this exception can be obtained quickly. The SMA reserves the right to determine if the situation is urgent enough to warrant not using the Extranet and may request it is made in that manner.

MDHHS/OROSC will identify those exception requests that also need CSAT/DPT approval by marking the appropriate box on the form when it is sent back. It is the responsibility of the OTPs to complete the SMA-168 "Exception Request and Record of Justification" (Attachment D) – **this is not the same form that is sent to** MDHHS/OROSC– and fax it to CSAT/DPT at their current fax number for exceptions. As indicated on this form, the current fax number is (240) 276-1630. A copy of the approved MDHHS/OROSC Exception Request and Record of Justification Form must be submitted along with this form. Attachment D was included in this policy as a convenience to the OTPs. However, OTPs are responsible for using the most current CSAT/DPT form and fax number. This information can be located on the SAMHSA Website, www.dpt.samhsa.gov.

Delivery of Methadone to a Client by a Third Party or to Another Facility

***Delivery of Methadone to a Client by a Third Party*:**

Documentation must be kept in the client's file that the client meets the criteria for off-site dosing as indicated in R 325.14416 (3) (a)-(k) and 42CFR Part 8.12 (i)(2)(i-viii). In addition, a "MDHHS/OROSC Delivery to a Client by a Third Party" form (Attachment B) must be completed and maintained at the program. A copy of the form signed by the person receiving the methadone must be returned to the program so that the chain of custody can be documented before another supply is issued. A maximum of 7 doses may be delivered to a client for self-administration. The methadone must be secured in a locked box before leaving the OTP. Empty and unused bottles must be returned to the OTP.

***Delivery of Methadone to Another Facility Form*:**

A "MDHHS/OROSC Delivery of Methadone to Another Facility Form" (Attachment C) must be completed and maintained at the program. A copy of the form signed by the person receiving the methadone must be returned to the program so that the chain of custody can be documented before another supply is issued. A staff member of the facility in which the client is housed may obtain a maximum of 14 doses. The facility will transport, secure, and administer the methadone, as well as dispose of empty and unused bottles, according to that facility's protocols for the use of medications that are controlled substances.

Exception Verification for PIHPs:

Funded OTPs must submit a copy of approved MDHHS OROSC Methadone Exception and Record of Justification Form to their respective PIHPs when requested to do so.

Monitoring For Compliance:

Site visits to OTPs by MDHHS/OROSC will include a review of documentation verifying that clients meet the criteria for off-site dosing. Probation or rescinding of off-site dosing privileges, when the client has not followed the rules for off-site usage, will also be reviewed. This document must include the coordination of sanctions and any changes to the treatment plan or services authorized by the PIHP or AMS for funded clients. OTPs must have a system to readily identify those clients issued doses for off-site use.

REFERENCES:

American Society of Addiction Medicine (for Buprenorphine information). http://www.asam.org/

Certification of Opioid Treatment Programs: United States Code of Federal Regulations, Title 42, Part 8, Washington, D.C. (s003) http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&tpl=%2Findex.tpl

Division of Pharmacologic Therapies. (2002). *Patient Exceptions SMA-168-Exception Request and Record of Justification under 42 CFR § 8.12.* Retrieved from the Substance Abuse and Mental Health Services Administration website at http://dpt.samhsa.gov/webintro.htm

Drug Addiction Treatment Act of 2000: Public Law 106-310, Section 3502, United States House, 106th Congress, Washington, DC. (October 17, 2000).

Labeling and Dispensing of Prescription Medication. *Public Health Code:* 1978 Public Act 369, as amended, Article 6. MCL 333.17745, Michigan Legislature, 1977-78 Legislative Session, Lansing, Michigan. (September 30, 1978). http://www.legislature.mi.gov/mileg.aspx?page=getObject&objectName=mcl-333-17745

Methadone Treatment and Other Chemotherapy: Michigan Administrative Code, Rules 325.14401-325.14423, State Office of Administrative Hearings and Rules. Lansing, Michigan. (September 10, 1971). http://www.michigan.gov/documents/cis_bhs_fhs_sa_part4_37163_7.pdf

Poison Prevention Packaging Act of 1970: Public Law 91-601, 84 Stat. 1670, as amended, 90th Congress, Washington, DC. (December 30, 1970). http://www.cpsc.gov/businfo/pppatext.html

Public Health Code: 1978 Public Act 368, as amended, MCL 333.1100-333.25211, Michigan Legislature, 1977-1978 Legislative Session, Lansing, Michigan. (September 30, 1978). http://www.legislature.mi.gov/mileg.aspx?page=getobject&objectname=mcl-act-368-of-1978

APPROVED BY: ___*Signed*_____
Donald L. Allen, Jr., Director
Office of Drug Control Policy

EXHIBIT A

MDHHS/OROSC METHADONE EXCEPTION REQUEST AND RECORD OF JUSTIFICATION FORM

DIRECTIONS FOR COMPLETING THE FORM:

NOTE: This form is only to be used during Extranet downtime and may be used in rare urgent situations at the SMAs discretion.

Program ID: Type the I-SATS Number.

City: Fill in the location of the program.

Client ID: Fill in the client's ID number.

Program Telephone: Type the program's phone number.

E-mail Address: Type the program's e-mail address if available.

Name and Title of Requestor: Type name and title of requestor.

Client's admission date: Fill in the patient's admission date to the program.

If transfer from another program-original date: If the client transferred from another OTP, use that program's admission date in addition to the admission date to your program if the gap between services is less than 90 days. If there has been a 90-day or more gap in treatment, leave this blank.

Client's dosage level: Fill in the patient's dosage level.

Client's program attendance schedule per week: Circle appropriate days.

Client is: employed, unemployed, student, other (specify): Circle appropriate category. If other, explain.

Client is disabled (specify): Specify and provide an explanation of the disability.

Permanent Decrease in Attendance to: Circle days.

Temporary Change in Attendance: Temporary Change in Attendance (please explain). Fill in the explanation.

Justification for request: Describe the justification for request. Be as specific as possible without providing any patient identifying information. Travel hardships must include the city and the roundtrip mileage. If visiting another city, indicate city and state and why guest dosing is not being done. Any criterion that is not in compliance must be explained. A positive toxicology screen for drugs other than methadone metabolites must be documented as having a prescription for that time period. Toxicology screens must be positive for methadone or methadone metabolites.

DO NOT SUBMIT DOCUMENTATION TO MDHHS/OROSCOR CSAT/DPT UNLESS IT IS SPECIFICALLY REQUESTED. ENSURE THAT ALL CLIENT IDENTIFYING INFORMATION IS REMOVED FROM THE DOCUMENTS.

Dates of Exception: Fill in the date of the first and last off-site doses.

Number of doses to be dispensed: Fill in number of doses to be dispensed.

Has the client been informed of the dangers of children ingesting methadone: Circle the correct response.

Does the client meet the criteria used to determine if the patient is responsible in handling methadone as outlined in MDHHS/OROSC Policy-04, Administrative Rules of Substance Abuse Treatment Programs in Michigan – R 325.14416 Part 416(3)(a-k) and 42 CFR Part 8.12(i)(2) (i-viii):
Circle the correct response. If no, the explanation must be included under the justification.

Name of Concurring Physician: Type the name of the concurring physician and MD or DO.

Signature of Physician: Signature by physician along with MD or DO.

DO NOT WRITE BELOW THIS LINE: Leave Blank.

MDHHS/OROSC will approve or deny the Exception Request. Denials will be explained.

This Exception Request Also Requires Federal Approval. MDHHS/OROSC will identify those Exception Requests that also need CSAT/DPT approval. IT IS THE RESPONSIBILITY OF THE OTP TO COMPLETE FEDERAL FORM SMA-168 EXCEPTION REQUEST AND RECORD OF JUSTIFICATION AND FAX IT TO CSAT/DPT AT 240-276-1630 ALONG WITH A COPY OF THE SIGNED MDHHS/OROSC FORM. SUBMIT ONLY THOSE REQUESTS THAT NEED CSAT/DPT APPROVAL.

TO: State Methadone Authority, MDHHS/OROSC Fax: 517-335-2121 **DATE**_____

FROM: Program Name_____ **FAX** _____

MDHHS/OROSCEXCEPTION REQUEST AND RECORD OF JUSTIFICATION

NOTE: This form is only to be used during Extranet downtime and may be used in rare urgent situations at the SMAs discretion.

Program ID: _____City: _____ Client ID: _____

Program Telephone: _____ E-Mail Address_____

Name & Title of requestor _____

Client's admission date _____ If transfer, original admission date _____ Client's dosage level_____

Client's program attendance schedule per week S M T W T F S (circle days)

Client is: Employed Unemployed Student Other (Circle) (specify)_____

Client has a disability (please explain)_____

Permanent Decrease in Attendance to S M T W T F S (circle days)

Temporary Change in Attendance (please explain)_____

Justification for request:_____

Dates of Exception ___/___/___ to ___/___/___ Number of doses to be dispensed

_____

Has the client been informed of the dangers of children ingesting methadone? Yes No (circle)

Does the client meet the criteria used to determine if the client is responsible in handling methadone as outlined in MDHHS/OROSC

Policy-04, Administrative Rules of Substance Abuse Treatment Programs in Michigan – R 325.14416 part 416(3)(a-k) and 42 CFR § 8.12(i) (2) (i-viii)? Yes No (circle)

_____ _____

Print Name of Concurring Physician

Signature of Physician

STATE USE ONLY

Approved Denied Date ___/___/___ _____

State Methadone Authority or Designee

ODCP (517) 373-4700

Explain:_____

☐ **This Exception Request Also Needs Federal Approval.** Complete Form SMA-168 for federal approval and fax Form SMA-168 and this state approved request to CSAT per Form SMA-168 instructions.

State Comments:_____

EXHIBIT B

DIRECTIONS FOR COMPLETING MDHHS/OROSC DELIVERY TO A CLIENT BY A THIRD PARTY FORM

Date: Fill in date methadone dispensed.

Client#: Fill in client's number.

Program Treatment Name: Fill in Treatment Programs Name

Program ID: Fill in Program's I-SATS Number

Program Telephone: Fill in Program's Phone Number

Fax: Fill in Program's Fax Number

E-Mail: Fill in Program's E-Mail Address

Name of Dispensing Nurse: Fill in Name of Dispensing Nurse

Licensing Number of Dispensing Nurse: Fill in Licensing Number

Signature of Dispensing Nurse: Dispensing Nurse's Signature

Justification for why client is unable to pick up the methadone at the clinic: Explain the reason, such as a disability; specify. A note from the client's physician or similar documentation from the OTP physician must be placed in the client's chart.

Methadone is being transported to: Fill in client at residence, relative's residence, not the specific address.

Medication provided from _____to _____: List dates

Number of Doses Dispensed at One Time_____: List number of doses dispensed. Not to exceed 7 doses without MDHHS/OROSC written permission.

Person Delivering the Methadone: List person's name that is delivering the methadone.

Relationship to Client: Indicate relationship to client, such as spouse, roommate, etc.

Liability Statement: Person delivering methadone should read and sign on the signature line.

Signature of Person Delivering Methadone: Deliverer signs.

Witness: Witness to the Deliverer's signature.

Signature of Person Receiving Medication: Signature of client who receives the methadone.

THE FORM, SIGNED BY THE CLIENT, IS TO BE RETURNED TO THE CLINIC WITH THE EMPTY AND UNUSED BOTTLES.

Both the delivery person and the client agree to all terms stated on this form as well as to additional requirements the OTP may have pertaining to off-site dosing. By signing this form, both parties will not hold the OTP or MDHHS/OROSC liable for any unauthorized use of the methadone.

Distribution

Original Copy to OTP: The original of the form is retained at the OTP.
Copy to Client: A copy of the form is to be made and given to the client.

MDHHS/OROSC DELIVERY TO A CLIENT BY A THIRD PARTY FORM

DATE:_____ Client #:_____

Program Treatment Name:_____ Program ID:_____

Program Telephone:_____Fax:_____E-Mail:_____

Name Of Dispensing Nurse:_____License#:_____

Signature of Dispensing Nurse:_____

Justification for why client is unable to pick up the methadone at the clinic:

_____

_____

(Documentation from the client's physician or OTP physician must be included in the client's chart)

Methadone is being Delivered to: _____

Methadone provided from: _____to _____ Number of Doses Dispensed at One Time:_____
(Date) (Date) (Not to exceed 7 doses)

Person Delivering Methadone :_____Relationship to Client:_____

Due to the above named client's temporary inability to pick-up his/her methadone, the above named Opioid Treatment Program has permission from MDHHS/OROSC to allow delivery of the methadone to the client. I understand that this arrangement is for a specific period of time only, and that when this time ends, I will either no longer be picking up the medication, or will have to complete another MDHHS/OROSC DELIVERY TO CLIENT BY A THIRD PARTY FORM. I further understand that methadone is a narcotic, to be ingested by the client only, and that harm, including death could come to anyone else ingesting it. When I pick-up this medication, I must present current government issued pictured identification (Driver's License, State Identification Card, Military Identification Card). I must also present any necessary documentation from the treating physician, so that the clinic is kept up-to-date on the current status of the client's medical condition. I am aware that the methadone must be transported in a locked box and kept in this manner. Empty and unused bottles must be returned in the locked box. I have been made aware that loitering within a one-block

radius of the clinic is prohibited. Both the delivery person and the client agree to all terms stated on this form as well as to additional requirements the OTP may have pertaining to off-site dosing. By signing this form, both parties will not hold the OTP or MDHHS/OROSC liable for any unauthorized use of the methadone.

_____ _____

Signature of Person Delivering the Methadone Signature of Person Receiving Methadone

_____

Witness

THE FORM, SIGNED BY THE BOTH THE PERSON DELIVERING AND THE PERSON RECEIVING THE METHADONE, IS TO BE RETURNED TO THE CLINIC WITH THE USED BOTTLES.

DISTRIBUTION: Original to OTP
Copy to Client

EXHIBIT C

DIRECTIONS FOR COMPLETING MDHHS/OROSC DELIVERY OF METHADONE TO ANOTHER FACILITY FORM

Date: Fill in date methadone dispensed.

Client#: Fill in client's number.

Program Treatment Name: Fill in Treatment Programs Name

Program ID: Fill in Program's I-SATS Number

Program Telephone: Fill in Program's Phone Number

Fax: Fill in Program's Fax Number

E-Mail: Fill in Program's E-Mail Address

Methadone Delivered to: Facility Name, Phone Number: Fill in name of facility and phone number.

Name of Dispensing Nurse: Fill in Name of Dispensing Nurse

Licensing Number of Dispensing Nurse: Fill in Licensing Number

Signature of Dispensing Nurse: Dispensing Nurse's Signature

Justification for why client is unable to pick up the methadone at the clinic: Explain the reason such as incarceration, etc.

Methadone is being transported to: Facility's Name and Phone Number.

Medication provided from _____to _____: List dates

Number of Doses Dispensed at One Time_____: List number of doses dispensed. Not to exceed 14 doses without MDHHS/OROSC written permission.

Liability Statement: Person delivering the methadone should read and then sign.

Person Delivering the Methadone: Print the facility staff person's name.

Witness: Witness to the transporters signature. Print name and Sign.

Name of Person Receiving the Methadone at the Facility: Printed Name and Signature of facility staff who accepts delivery of the methadone.

Both the delivery person and the facility agree to all terms stated on this form as well as to additional requirements the OTP may have pertaining to off-site dosing. By signing this form, both parties will not hold the OTP or MDHHS/OROSC liable for any unauthorized use of the methadone.

Distribution: Original Copy to OTP: The original of the form is retained at the OTP.
Copy to Facility: A copy of the form is made and given to the facility.

MDHHS/OROSC DELIVERY OF METHADONE TO ANOTHER FACILITY FORM

DATE:_____ Client # _____

Program Treatment Name:_____ Program ID:_____

Program Telephone:_____Fax:_____E-Mail:_____

Methadone Delivered to: Facility Name_____Phone _____

Name Of Dispensing Nurse:_____License#:_____

Signature of Dispensing Nurse:_____

Justification for why client is unable to pick up the methadone at the clinic:

_____

_____

_____

Methadone provided from: _____to _____ Number of Doses Dispensed at One Time:_____
(Date)(Date) (Not to exceed 14 doses)

Due to the above named client's temporary inability to pick-up his/her methadone, the above named Opioid Treatment Program has permission from MDHHS/OROSC to allow transportation of the methadone to the above named facility. I understand that this arrangement is for a specific period of time only, and that when this time ends, I will either no longer be picking up the methadone, or will have to complete another "MDHHS/OROSC Delivery of Methadone to another Facility Form". I further understand that methadone is a narcotic, to be ingested by the client only, and that harm, including death could come to anyone else ingesting it. When I pick-up the methadone I must present current government issued pictured identification (Driver's License, State Identification Card, Military Identification Card). I must also present any necessary documentation from the treating physician, so that the clinic is kept up-to-date on the current status of the client's medical condition. I have been made aware that loitering within a one-block radius of the

clinic is prohibited. I am aware that the methadone is a controlled substance and my institution's protocols will be observed. Both the delivery person and the client agree to all terms stated on this form as well as to additional requirements the OTP may have pertaining to off-site dosing. By signing this form, both parties will not hold the OTP or MDHHS/OROSC liable for any unauthorized use of the methadone.

Person Transporting Methadone _____ Title_____
Print Print

_____
Signature

Facility Staff Receiving the Methadone_____
Print

_____
Signature Date

Witness_____ _____
Print Signature

DISTRIBUTION: Original to OTP
Copy to Client

EXHIBIT D

INSTRUCTIONS FOR

EXCEPTION REQUEST AND RECORD OF JUSTIFICATION UNDER 42 CFR ' 8.11(h)

(FORM SMA-168)

Purpose of Form: The SMA-168 form was created to facilitate the submission and review of patient exceptions under 42 CFR ' 8.11(h). SAMHSA will use the information provided to review patient exception requests@ and determine whether they should be approved or denied. A patient exception request@ is a request signed by the physician for approval to change the patient care regimen from the requirements specified in Federal regulation (42 CFR, Part 8). The physician makes this request when he/she seeks SAMHSA approval to make a patient treatment decision that differs from regulatory requirements.

This is a flexible, multi-purpose form on which various patient exception requests may be documented and approved or denied, along with an explanation for the action taken. It is most frequently used to request exceptions to the regulation on the number of take-home doses permitted for unsupervised use, such as during a family or health emergency. The form is also frequently used to request a change in patient protocol or for an exception to the detoxification standards outlined in the regulation.

GENERAL INSTRUCTIONS

Please complete **ALL** items on the form. As appropriate, there is space to indicate if an item does not apply.

The instructions below show the item from the form in **bold text**. In the column next to the bold text is a description of the information requested.

ITEM	INSTRUCTION
BACKGROUND INFORMATION ON PROGRAM AND PATIENT	
Program OTP No	Opioid Treatment Program (OTP) identification numberCsame as the old FDA number. Begins with 2 letters of your State abbreviation, followed by 5 numbers, then a letter. This number should fit into the format on the form.
Patient ID No	Confidential number you use to identify the patient. Please do not use the patient=s name or other identifying information. Number of digits does **NOT** have to match number of boxes on the form.
Program Name	Name of opioid treatment program, clinic or hospital in which patient enrolled.
Telephone	Voice telephone number. **PLEASE INCLUDE YOUR AREA CODE.**

ITEM	INSTRUCTION
Fax	Facsimile (FAX) number. **PLEASE INCLUDE YOUR AREA CODE.**
Email	Indicate electronic mail (e-mail) address of the CONTACT person.
Name & Title of Requestor	Name and title of physician or staff member authorized to submit this request.
Patient=s Admission Date	Date patient enrolled at this facility.
Patient=s current dosage level	Dosage patient receives **NOW.** Please indicate the dosage in milligrams (mg).
Methadone/LAAM/Other	Place an AX@ on the line next to the medication the patient takes. If you check AOther,@ write in the name of the medication in the space provided.
Patient=s program attendance schedule per week	Place an AX@ on the line to the left of each day per week the patient **NOW** reports to the clinic for medication.
***If current attendance is less than once per week, please enter the schedule**	If patient **NOW** reports to the clinic **LESS** that once a week, please indicate how often he/she reports.
Patient status	Place an AX@ on the line to the left of the item that best describes the patient=s **CURRENT** status. If the patient=s status does not appear on the list on the form, please place an AX@ on the line next to AOther@ and write in the patient=s **CURRENT** status.

REQUEST FOR CHANGE

Nature of request	Please place an AX@ on the line to the left of the description that **BEST** describes this request. If your request is not listed in this item on the form, place an AX@ on the line to the left of AOther@ and describe your request.
Decrease regular attendance to	Place an AX@ on the line to the left of each day per week that the patient is to report for medication.
Beginning date	Enter the date that the exception is scheduled to begin.
***If new attendance is less than once per week, please enter the schedule**	If you are asking to reduce the patient=s attendance schedule to **LESS THAN** once per week, please indicate the schedule on the line provided.
Dates of Exception	Please indicate the dates that the exception will be effective.
# of doses needed	Indicate how many doses will be dispensed during the exception period.
Justification	Please place an AX@ on the line to the left of the best description of the reason for this request. If the reason is not listed in this item, place an AX@ on the line next to AOther@ and write in the justification.

REQUIREMENTS

Regulation Requirements	There are certain guidelines that programs must follow regarding take-home medication and detoxification admissions. Next to each of the 3 statements listed in this item, please indicate whether the OTP followed the stipulated requirements. For each statement that does not apply, place an AX@ on the line to the left of AN/A@ (not applicable).

Submitted by:

Printed Name of Physician	Please **PRINT** the name of the physician making the request.
Signature of Physician	Once ALL the items above have been completed, the physician should SIGN here.

ITEM	INSTRUCTION
Date	Date the form is signed.

APPROVALCThis section will be completed by the appropriate authorities.

State response to request	If this form must be reviewed or approved by your State, be sure that you forward this form to the proper authority, who will indicate approval or denial of your request in the space provided.
Federal response to request	This is the place on the form where CSAT will indicate whether the request is accurate and approved. The form will be faxed or e-mailed back to you.
Please submit to CSAT/OPATC Fax: (301) 443-3994 or Email: otp@samhsa.gov	When you have completed the form, either fax or email it to CSAT at the numbers provided here.

Effect: This form was created to facilitate the submission and review of patient exceptions under 42 CFR ' 8.11(h). This does not preclude other forms of notification.

Paperwork Reduction Act Statement

Public reporting burden for this collection of information is estimated to average 25 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to SAMHSA Reports Clearance Officer; Paperwork Reduction Project (0930-xxxx); Room 16-105, Parklawn Building; 5600 Fishers Lane, Rockville, MD 20857. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0930-xxxx).

SMA-168 INSTRUCTIONS (BACK)

1. BACKGROUND INFORMATION

DEPARTMENT OF HEALTH AND HUMAN SERVICES SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION CENTER FOR SUBSTANCE ABUSE TREATMENT	Form Approved: OMB Number 0930-0206 Expiration Date: 09/30/2003 See OMB Statement on Reverse
Exception Request and Record of Justification **Under 42 CFR ' 8.11 (h)**	DATE OF SUBMISSION Date you submit form to CSAT.

Note: This form was created to assist in the interagency review of patient exceptions in opioid treatment programs (OTPs) under 42 CFR ' 8.11 (h).

Detailed INSTRUCTIONS are on the cover page of this form. PLEASE complete **ALL** applicable items on this form. Your cooperation will result in a speedy reply. Thank you.

BACKGROUND INFORMATION ON PROGRAM AND PATIENT

Program OTP No:
(Same as FDA No.)

B ' B

Patient ID No:

Program identification numberCold FDA number. Begins with 2 letters of your State abbreviation, followed by 5 numbers, then a letter. Should fit into the format above.

Number you use to identify patient. Number of digits does **NOT** have to match number of boxes above. **DO NOT USE PATIENT=S NAME.**

Program Name: Name used to identify opioid treatment program, clinic, or hospital in which patient enrolled.

Telephone: Phone #, **including area code.** **Fax:** Fax #, **including area code.** **E-mail:** . . . of contact person.

Name & Title of Requestor: Name and title of physician or staff member authorized to submit request.

Patient=s Admission Date: Date patient enrolled in this facility.

Patient=s current dosage level: ____ mg ____ Methadone ____ LAAM ____ Other: ____

Dosage patient receives **NOW.**

Place an AX@ on the line next to the medication the patient takes. If you check AOther,@ write in the name of the medication.

Patient=s program attendance schedule per week
(Place an AX@ next to all days that the patient attends*):

S ____ M ____ T ____ W ____ T ____ F ____ S ____

Place an AX@ on the line to the left of each day per week the patient **NOW** reports to the clinic for medication.

*If **current** attendance is less than once per week, please enter the schedule:

If patient **NOW** reports to the clinic **LESS** that once weekly, please indicate how often he/she reports.

Patient status: ____ Employed ____ Unemployed ____ Homemaker ____ Student ____ Disabled ____ Other: ____

Place an AX@ on the line next to the item that best describes the patient=s **CURRENT** status. If that status does not appear on this list, please place an AX@ on the line next to AOther@ and write in the patient=s **CURRENT** status.

REQUEST FOR CHANGE

REQUEST FOR CHANGE REGARDING PATIENT TREATMENT

Nature of request:

___ Temporary take-home medication ___ Temporary change in protocol ___ Detoxification exception ___ Other : _____

Please place an AX@ on the line next to the item above that **BEST** describes what this request is about. If your request is not listed above, place an AX@ on the line next to AOther@ and describe your request.

Decrease regular attendance to

(Place an AX@ next to appropriate days*):

S	M	T	W	T	F	S

Beginning date: _____

Place an AX@ on the line to the left of each day per week you want the patient to report for medication.

Date you want new attendance schedule to begin.

*If **new** attendance is less than once per week, please enter the schedule: _____

If you are asking to reduce the number of days per week the patient reports to the program to **LESS THAN** once per week, please indicate the schedule on the line above.

Dates of Exception: **From** _____ **to** _____ **# of doses needed:** _____

Please indicate the dates that the exception you are requesting will be effective.

Indicate how many doses will be dispensed during the exception period.

Justification:

___ Family Emergency ___ Incarceration ___ Funeral ___ Vacation ___ Transportation Hardship

___ Step/Level Change ___ Employment ___ Medical ___ Long Term Care Facility ___ Other Residential Treatment

___ Homebound ___ Split Dose ___ Other : _____

Please place an AX@ on the line to the left of the item above that best describes the reason for this request. If the reason is not listed above, place an AX@ on the line next to AOther@ and write in the justification.

REQUIREMENTS

REQUIREMENTS (GUIDELINES AND SIGNATURE)

Regulation Requirements:

2. **For take-home medication:** Has the patient been informed of the dangers of children ingesting methadone or LAAM? Yes No N/A
3. **For take-home medication:** Has the program physician determined that the patient meets the 8-point evaluation criteria to determine whether the patient is responsible enough to handle methadone as outlined in 42 CFR '8.12(i)(2)(i)-(viii)? Yes No N/A
4. **For multiple detoxification admissions:** Did the physician justify more than 2 detoxification episodes per year and assess the patient for other forms of treatment (include dates of detoxification episodes) as required by 42 CFR '8.12(e)(4)? Yes No N/A

There are certain guidelines that programs must follow regarding take-home medication and detoxification admissions. Next to each item above, please indicate whether you followed the stipulated requirements. For each statement that does not apply to you, place an AX@ on the line to the left of AN/A@ (not applicable).

Submitted by:

Printed Name of Physician	**Signature of Physician**	**Date**
Please PRINT the name of the physician making the request.	Once ALL the items above have been completed, the physician should SIGN here.	Date form is signed.

APPROVAL OF AUTHORITIES

APPROVAL

State response to request:

___ Approved ___ Denied _____

State Methadone Authority **Date**

Explanation: _____

If this form must be reviewed or approved by your State, be sure that you forward this form to the proper authority, who will indicate approval or denial of your request in the space above.

Federal response to request:

___ Approved ___ Denied _____

Public Health Advisor, Center for Substance Abuse Treatment **Date**

Explanation: _____

CSAT will indicate whether the request is accurateand approved or denied in this space. The form will be faxed or emailed back to you.

Please submit to CSAT/OPATCFax: (301) 443-3994; Email: otp@samhsa.gov

This exception is contingent upon approval by your State Methadone Authority (as applicable) and may not be implemented until you receive such approval.

FORM SMA-168 (FRONT)

Purpose of Form: This form was created to facilitate the submission and review of patient exceptions under 42 CFR ' 8.11(h). This does not preclude other forms of notification.

Paperwork Reduction Act Statement

Public reporting burden for this collection of information is estimated to average 25 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to SAMHSA Reports Clearance Officer; Paperwork Reduction Project (0930-0206); Room 16-105, Parklawn Building; 5600 Fishers Lane, Rockville, MD 20857. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0930-0206.

FORM SMA-168 (BACK)

DEPARTMENT OF HEALTH AND HUMAN SERVICES

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION

CENTER FOR SUBSTANCE ABUSE TREATMENT

FORM SMA-168

Exception Request and Record of Justification

Under 42 CFR ' 8.11 (h)

Form Approved: OMB Number 0930-0206

Expiration Date: 09/30/2006

See OMB Statement on Reverse

DATE OF SUBMISSION

Note: This form was created to assist in the interagency review of patient exceptions in opioid treatment programs (OTPs) under 42-CFR ' 8.11 (h).

Detailed INSTRUCTIONS are on the cover page of this form. PLEASE complete **ALL** applicable items on this form. Your cooperation will result in a speedy reply. Thank you.

Program OTP No: (Same as FDA ID) B ' B **Patient ID No:**

Program Name:

Telephone: **Fax:** **E-mail:**

Name & Title of Requestor:

Patient=s Admission Date: **Patient=s current dosage level:** mg Methadone LAAM Other:

Patient=s program attendance schedule per week (Place an AX@ next to all days that the patient attends*): S M T W T F S

*If **current** attendance is less than once per week, please enter the schedule:

Patient status: Employed Unemployed Homemaker Student Disabled Other:

Request
Change
Nature of request:

Temporary take-home medication Temporary change in protocol Detoxification exception Other:

Decrease regular attendance to (Place an AX@ next to appropriate days*): S M T W T F S **Beginning date:**

*If **new** attendance is less than once per week, please enter the schedule:

Dates of Exception: From to # of doses needed:

Justification Family Emergency Incarceration Funeral Vacation Transportation Hardship

Step/Level Change Employment Medical Long Term Care Facility Other Residential Treatment

___ Homebound ___ Split Dose ___ Other _____

Regulation Requirements:

5. **For take-home medication:** Has the patient been informed of the dangers of children ingesting methadone or LAAM? Yes No N/A
6. **For take-home medication:** Has the program physician determined that the patient meets the 8-point evaluation criteria to determine whether the patient is responsible enough to handle methadone as outlined in 42 CFR '8.12(i)(2)(i)-(viii)? Yes No N/A

3. For multiple detoxification admissions: Did the physician justify more than 2 detoxification episodes per year and assess the patient for other forms of treatment (include dates of detoxification episodes) as required by 42 CFR '8.12(e)(4)? Yes No N/A

Submitted by:

Printed Name of Physician **Signature of Physician** **Date**

State response to request:

___ Approved ___ Denied _____

State Methadone Authority **Date**

Explanation: _____

Federal response to request:

___ Approved ___ Denied _____

C. Todd Rosendale, Public Health Advisor **Date**

Center for Substance Abuse Treatment

Explanation: _____

This exception is contingent upon approval by your State Methadone Authority (as applicable) and may not be implemented until you receive such approval.

STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

RICK SNYDER
GOVERNOR

JAMES K. HAVEMAN
DIRECTOR

MEMORANDUM

DATE: October 15, 2012

TO: Regional Substance Abuse Coordinating Agency Directors

FROM: Deborah J Hollis, Director
Bureau of Substance Abuse and Addiction Services

SUBJECT: Final Treatment Policy #5, Criteria for Using Methadone for Medication-Assisted Treatment and Recovery

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On July 23, 2012, the Bureau of Substance Abuse and Addiction Services (BSAAS) sent a draft of the revised *Treatment Policy #5, Criteria for Using Methadone for Medication-Assisted Treatment and Recovery*, to all coordinating agencies for review and comment. Comments were due to BSAAS by August 23, 2012. No comments were received; therefore, this policy went into effect October 1, 2012 as revised.

As noted in the memo that accompanied the draft, changes were required to the portions of the policy and the consent form that addressed medication-assisted treatment for pregnant and non-pregnant adolescents. These revisions were on page six of the policy and page one of the consent form, and were made to clarify the previous policy as detailed in our April 20 memo (attached).

If you have any questions, please contact Lisa Miller at millerL12@michigan.gov or 517-241-1216.

Thank you.

Attachments

c: Felix Sharpe

TREATMENT POLICY #05

SUBJECT: Criteria for Using Methadone for Medication-Assisted Treatment and Recovery

ISSUED: September 1, 2003, revised August 5, 2005, October 3, 2007, July 31, 2011, October 1, 2011, and August 24, 2012

EFFECTIVE: October 1, 2012

PURPOSE:

The purpose of this policy is to clarify the process for the use of methadone in medication-assisted treatment and recovery for opioid dependence.

SCOPE:

This policy applies to all regional substance abuse PIHPs and their provider network of opioid treatment programs (OTPs). Medicaid-specific services are also identified in this document. The state administrative rules and federal regulations are not replaced or reduced by these criteria.

BACKGROUND:

Methadone Use in Medication-Assisted Treatment and Recovery

Methadone is an opioid medication used in the treatment and recovery of opioid dependence to prevent withdrawal symptoms and opioid cravings, while blocking the euphoric effects of opioid drugs. In doing so, methadone stabilizes the individual so that other components of the treatment and recovery experience, such as counseling and case management, are maximized in order to enable the individual to reacquire life skills and recovery. Methadone is not a medication for the treatment and recovery from non-opioid drugs.

The Medicaid Provider Manual lists the medical necessity requirements that shall be used to determine the need for methadone as an adjunct treatment and recovery service. The Medicaid-covered substance use disorder benefit for methadone services includes the provision and administration of methadone, nursing services, physician encounters, physical examinations, lab tests (including initial blood work, toxicology screening, and pregnancy tests) and physician-ordered tuberculosis (TB) skin tests. The medical necessity requirements and services also apply to all non-Medicaid covered individuals.

Consistent with good public health efforts among high-risk populations, and after consultation with the local health department, an OTP may offer Hepatitis A and B, as well as other adult immunizations recommended

by the health department, or they should refer the individual to an appropriate health care provider. Smoking cessation classes or referrals to local community resources may also be made available.
The American Society of Addiction Medicine (ASAM) level of care (LOC) indicated for individuals receiving methadone is usually outpatient. The severity of the opioid dependency and the medical need for methadone should not be diminished because medication-assisted treatment has been classified as outpatient. Counseling services should be conducted by the OTP that is providing the methadone whenever possible and appropriate. When the ASAM LOC is not outpatient or when a specialized service is needed, separate service locations for methadone dosing and other substance use disorder services are acceptable, as long as coordinated care is present and documented in the individual's record.

If methadone is to be self-administered off-site of the OTP, off-site dosing must be in compliance with the current Michigan Department of Health & Human Services (MDHHS) *Treatment Policy #4: Off-Site Dosing Requirements for Medication-Assisted Treatment.* This includes Sunday and holiday doses for those individuals not deemed to be responsible for managing take-home doses.

All six dimensions of the ASAM patient placement criteria must be addressed:

1. Acute intoxication and/or withdrawal potential.
2. Biomedical conditions and complications.
3. Emotional/behavioral conditions and complications (e.g., psychiatric conditions, psychological or emotional/behavioral complications of known or unknown origin, poor impulse control, changes in mental status, or transient neuropsychiatric complications).
4. Treatment acceptance/resistance.
5. Relapse/continued use potential.
6. Recovery/living environment.

In using these dimensions, the strengths and supports, or recovery capital, of the individual will be a major factor in assisting with the design of the individualized treatment and recovery plan.

In many situations, case management or care coordination services may be needed by individuals to further support the recovery process. These services can link the individual to other recovery supports within the community such as medical care, mental health services, educational or vocational assistance, housing, food, parenting, legal assistance, and self-help groups. Documentation of such referrals and follow up must be in the treatment plan(s) and progress notes within the individual's chart. If it is determined that case management or care coordination is not appropriate for the individual, the rationale must be documented in the individual's chart. The acupuncture detoxification five-point protocol is suggested as a means of assisting the individual with symptom management of anxiety and restorative sleep.

Clarification of Substance-Dependence Treatment and Recovery with Methadone in Individuals with Prior or Existing Pain Issues

All persons assessed for a substance use disorder must be assessed using the ASAM patient placement criteria and the current Diagnostic and Statistical Manual of Mental Disorders (DSM). In the case of opioid addiction, pseudo-addiction must also be ruled out. Tolerance and physical dependence are normal consequences of sustained use of opioid analgesics and are not synonymous with addiction. In some cases, primary care and other doctors may misunderstand the scope of the OTP and refer individuals to the OTP for pain control. The "Michigan Guidelines for the Use of Controlled Substances for the Treatment of Pain," should be consulted to assist in determining when substance use disorder treatment is appropriate, as well as the publication, *Responsible Opioid Prescribing: A Michigan Physician's Guide* by Scott M. Fishman, MD. This publication was distributed to all controlled substance prescribers in Michigan by the Michigan Department of Health &

Human Services, Bureau of Health Professions, in September of 2009. OTPs are not pain clinics, and cannot address the underlying medical condition causing the pain. The OTP and CA are encouraged to work with the local medical community to minimize inappropriate referrals to OTPs for pain.

Individuals receiving methadone as treatment for an opioid addiction may need pain medication in conjunction with this adjunct therapy. The use of non-opioid analgesics and other non-medication therapy is recommended whenever possible. Opioid analgesics as prescribed for pain by the individual's primary care physician (or dentist, podiatrist) can be used; they are not a reason to initiate detoxification to a drug-free state, nor does their use make the individual ineligible for using methadone for the treatment of opioid addiction. The methadone used in treating opioid addiction does not replace the need for pain medication. It is recommended that individuals inform their prescribing practitioners that they are on methadone, as well as any other medications. On-going coordination (or documentation of efforts if prescribing practitioners do not respond) between the OTP physician and the prescribing practitioner is required for continued services at the OTP and for any off-site dosing including Sunday and holidays.

REQUIREMENTS:

These codes, regulations, and manuals must be followed:

- *Methadone Treatment and Other Chemotherapy*, Michigan Administrative Code, Rule 325.14401-325.14423
- *Certification of Opioid Treatment Programs*, U.S. Code of Federal Regulations, 42 CFR Part 8
- *Michigan Medicaid Provider Manual*

An OTP using methadone for the treatment and recovery of opioid dependency must be:

1. Licensed by the state as a methadone provider.
2. Accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF), the Council on Accreditation (COA) or The Joint Commission (TJC), formerly JCAHO.
3. Certified by the Substance Abuse and Mental Health Services Administration (SAMHSA) as an OTP.
4. Registered by the Drug Enforcement Administration (DEA).

PROCEDURE:

Admission Criteria

Decisions to admit an individual for methadone maintenance must be based on medical necessity criteria, satisfy the LOC determination using the six dimensions of the ASAM Patient Placement Criteria, and have an initial diagnostic impression of opioid dependency for at least one year based on current DSM criteria. It is important to note that each individual, as a whole, must be considered when determining LOC, as methadone maintenance therapy may not be the best answer for every individual. For exceptions, see "Special Circumstances for Pregnant Women and Adolescents" on page six (6). Consistent with the LOC determination, individuals requesting methadone must be presented with all appropriate options for substance use disorder treatment, such as:

- Medical Detoxification.
- Sub-acute Detoxification.
- Residential Care.
- Buprenorphine/Naloxone.
- Non-Medication-Assisted Outpatient.

In addition to these levels of care, each CA is expected to have providers available that can also offer case management services, treatment for co-occurring disorders, early intervention, and peer recovery and recovery support services. Acupuncture detoxification may be used in all levels of care. These additional service options can be provided to opioid dependent individuals who do not meet the criteria for adjunct methadone treatment. Individuals should be encouraged to participate in treatment early in their addiction before methadone is necessary.

Admission procedures require a physical examination. This examination must include a medical assessment to confirm the current DSM diagnosis of opioid dependency of at least one year, as was identified during the screening process. The physician may refer the individual for further medical assessment as indicated.

Individuals must be informed that all of the following are required:

1. Daily attendance at the clinic is necessary for dosing, including Sundays and holidays if criteria for take home medication are not met.
2. Compliance with the individualized treatment and recovery plan, which includes referrals and follow-up as needed.
3. Monthly random toxicology testing.
4. Coordination of care with all prescribing practitioners (physicians, dentists, and any other health care provider) over the past year.

It is the responsibility of the OTP, as part of the informed consent process, to ensure that individuals are aware of the benefits and hazards of methadone treatment. It is also the OTP's responsibility to obtain consent to contact other OTPs within 200 miles to monitor for enrollments in other programs (42 CFR §2.34).

OTPs must request that individuals provide a complete list of all prescribed medications. Legally prescribed medication, including controlled substances, must not be considered as illicit substances when the OTP has documentation that it was prescribed for the individual. Copies of the prescription label, pharmacy receipt, pharmacy print out, or a Michigan Automated Prescription System (MAPS) report must be included in the individual's chart or kept in a "prescribed medication log" that must be easily accessible for review.

Michigan law allows for individuals with the appropriate physician approval and documentation to use medical marijuana. Although there are no prescribers of medical marijuana in Michigan, individuals are authorized by a physician to use marijuana per Michigan law. For enrolled individuals, there must be a copy of the MDHHS registration card for medical marijuana issued in the individual's name in the chart or the "prescribed medication log." Following these steps will help to ensure that an individual who is using medical marijuana per Michigan law will not be discriminated against in regards to program admission and exceptions for dosing.

If an individual is unwilling to provide prescription or medical marijuana information, the OTP must include a statement to this effect, signed by the individual, in the chart. These individuals will not be eligible for off-site dosing, including Sunday and holiday doses. OTPs must advise individuals to include methadone when providing a list of medications to their healthcare providers. The OTP physician may elect not to admit the individual for methadone treatment if the coordination of care with health care providers and/or prescribing physicians is not agreed to by the client.

Off-site dosing, including Sundays and holidays, is not allowed without coordination of care (or documentation of efforts made by the OTP for coordination) by the OTP physician, the prescriber of the identified controlled substance (opioids, benzodiazepines, muscle relaxants), and the physician who approved the use of medical marijuana. This coordination must be documented in either the nurse's or the doctor's notes. The documentation must be individualized, identifying the individual, the diagnosis, and the length of time the individual is expected to be on the medication. A MAPS report must be completed at admission. A MAPS report should be completed before off-site doses, including Sundays and holidays, are allowed and must be completed when coordination of care with other physicians could not be accomplished.

If respiratory depressants are prescribed for any medical condition, including a dental or podiatry condition, the prescribing practitioners should be encouraged to prescribe a medication which is the least likely to cause danger to the individual when used with methadone. Individuals who have coordinated care with prescribing practitioners, and are receiving medical care or mental health services, will be allowed dosing off site, if all other criteria are met. If the OTP is closed for dosing on Sundays or holidays, arrangements shall be made to dose the individual at another OTP if the individual is not deemed responsible for off-site dosing.

Special Circumstance for Pregnant Women and Adolescents

Pregnant women

Pregnant women requesting treatment are considered a priority for admission and must be screened and referred for services within 24 hours. Pregnant individuals who have a documented history of opioid addiction, regardless of age or length of opioid dependency, may be admitted to an OTP provided the pregnancy is certified by the OTP physician, and treatment is found to be justified. For pregnant individuals, evidence of current physiological dependence is not necessary. Pregnant opioid dependent individuals must be referred for prenatal care and other pregnancy-related services and supports, as necessary.

OTPs must obtain informed consent from pregnant women and all women admitted to methadone treatment that may become pregnant, stating that they will not knowingly put themselves and their fetus in jeopardy by leaving the OTP against medical advice. Because methadone and opiate withdrawal are not recommended during pregnancy, due to the increased risk to the fetus, the OTP shall not discharge pregnant women without making documented attempts to facilitate a referral for continued treatment with another provider.

Pregnant adolescents

For an individual under 18 years-of-age, a parent, legal guardian, or responsible adult designated by the relevant state authority, must provide consent for treatment in writing (Attachment A). In Michigan, the "relevant state authority" to provide consent is children's protective services (CPS) through the Department of Human Services [Public Act 238 722.621]. A copy of this signed, informed consent statement must be placed in the individual's medical record. This signed consent is in addition to the general consent that is signed by all individuals receiving methadone, and must be filed in the medical record.

Non-Pregnant adolescents

An individual under 18 years-of-age is required to have had at least two documented unsuccessful attempts at short-term detoxification and/or drug-free treatment within a 12-month period to be eligible for maintenance treatment. No individual under 18 years-of-age may be admitted to maintenance treatment unless a parent, legal guardian, or responsible adult designated by the relevant state authority/CPS consents, in writing, to such treatment (Attachment A). This is sufficient consent to allow for persons 16 and 17 years-of-age to enter methadone treatment [*Administrative Rules for Substance Abuse Services, Rule 325.14409(5)*]. However, persons 15 years-of-age and under must also have permission for admission by the state opioid treatment authority (SOTA), as well as the Drug Enforcement Administration (DEA). A copy of this signed informed consent statement must be placed in the individual's medical record. This signed consent is in addition to the general consent that is signed by all individuals receiving methadone, and must be filed in their medical record [42CFR Subpart 8.12 (e) (2)].

Treatment and Continued Recovery Using Methadone

Individual needs and rate of progress vary from person-to-person and, as such, treatment and recovery must be individualized and treatment and recovery plans must be based on the needs and goals of the individual (*Treatment Policy #06: Individualized Treatment Planning*). Referrals for medical care, mental health issues, vocational and educational needs, spiritual guidance, and housing are required, as needed, based on the information gathered as part of the assessment and other documentation completed by the individual. The use of case managers, care coordinators, and recovery coaches is recommended for individuals whenever possible (*Treatment Policy #8: Substance Abuse Case Management Requirements*). Increasing the individual's recovery capital through these supports, will assist the recovery process and help the individual to become stable and more productive within the community.

Compliance with dosing requirements or attendance at counseling sessions alone is not sufficient to continue enrollment. Reviews to determine continued eligibility for methadone dosing and counseling services must occur at least every four months by the OTP physician during the first two years of service. An assessment of the ability to pay for services and a determination for Medicaid coverage must be conducted at that time, as well. If it is determined by the OTP physician that the individual requires methadone treatment beyond the first two years, the justification of the medical necessity for methadone only needs to occur annually. However, financial review and eligibility for Medicaid is required to continue at a minimum of every six months.

An individual may continue with services if all of the following criteria are present:

a. Applicable ASAM criteria are met.
b. The individual provides evidence of willingness to participate in treatment.
c. There is evidence of progress.
d. There is documentation of medical necessity.
e. The need for continuation of services is documented in writing by the OTP physician.

Individuals, who continue to have a medical need for methadone, as documented in their medical record by the OTP physician, are not considered discharged from services; nor are individuals who have been tapered from methadone, but still need counseling services.

All substances of abuse, including alcohol, must be addressed in the treatment and recovery plan. Treatment and recovery plans and progress notes are expected to reflect the clinical status of the individual along with progress, or lack of progress in treatment. In addition, items such as the initiation of compliance contracts, extra counseling sessions, or specialized groups provided, and off-site dosing privileges that have been initiated, rescinded, or reduced should also be reflected in progress notes. Referrals and follow-up to those referrals must be documented. The funding authority may, at its discretion, require its approval of initial and/or continuing treatment and recovery plans.

For individuals who are struggling to meet the objectives in his/her individual treatment and recovery plans, OTP medical and clinical staff must review, with the individual, the course of treatment and recovery and make adjustments to the services being provided. Examples of such adjustments may be changing the methadone dosage (including split dosing), increasing the length or number of counseling sessions,

incorporating specialized group sessions, using compliance contracts, initiating case management services, providing adjunctive acupuncture treatment, and referring the individual for screening to another LOC.

Medical Maintenance Phase of Treatment

As individuals progress through recovery, there may be a time when the maximum therapeutic benefit of counseling has been achieved. At this point, it may be appropriate for the individual to enter the medical maintenance (methadone only) phase of treatment and recovery if it has been determined that ongoing use of the medication is medically necessary and appropriate for the individual. To assist the OTP in making this decision, *TIP 43: Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs* offers the following criteria to consider when making the decision to move to medical maintenance:

- Two years of continuous treatment.
- Abstinence from illicit drugs and from abuse of prescription drugs for the period indicated by federal and state regulations (at least two years for a full 30-day maintenance dosage).
- No alcohol use problem.
- Stable living conditions in an environment free of substance use.
- Stable and legal source of income.
- Involvement in productive activities (e.g., employment, school, volunteer work).
- No criminal or legal involvement for at least three years and no current parole or probation status.
- Adequate social support system and absence of significant un-stabilized co-occurring disorders.

Discontinuation of Services

Individuals must discontinue treatment with methadone when treatment is completed with respect to both the medical necessity for the medication and for counseling services. In addition, individuals may be terminated from services if there is clinical and/or behavioral non-compliance. If an individual is terminated, the OTP must attempt to make a referral for another LOC assessment or for placing the individual at another OTP, and must make an effort to ensure that the individual follows through with the referral. These efforts must be documented in the medical record. The OTP must follow the procedures of the funding authority in coordinating these referrals.

Any action to terminate treatment of a Medicaid recipient requires a notice of action be given to the individual. The individual has a right to appeal this decision; services must continue and dosage levels maintained while the appeal is in process.

The following are reasons for discontinuation/termination:

1. Completion of Treatment – The decision to discharge an individual must be made by the OTP's physician with input from clinical staff and the individual. Completion of treatment is determined when the individual has fully or substantially achieved the goals listed in his/her individualized treatment and recovery plan and when the individual no longer needs methadone as a medication. As part of this process, a reduction of the dosage to a medication-free state (tapering) should be implemented within safe and appropriate medical standards.

2. Administrative Discontinuation – The OTP must work with the individual to explore and implement methods to facilitate compliance. Administrative discontinuation relates to non-compliance with treatment and recovery recommendations, and/or engaging in activities or behaviors that impact the safety of the OTP environment or other individuals who are receiving treatment.

The repeated or continued use of illicit opioids and non-opioid drugs, including alcohol, would be considered non-compliance. OTPs must perform toxicology tests for methadone metabolites, opioids, cannabinoids, benzodiazepines, cocaine, amphetamines, and barbiturates (*Administrative Rules of Substance Abuse Services Programs in Michigan*, R 325.14406). Individuals whose toxicology results do not indicate the presence of methadone metabolites must be considered noncompliant, with the same actions taken as if illicit drugs (including non-prescribed medication) were detected.

OTPs must test for alcohol use if: 1) prohibited under their individualized treatment and recovery plan; or 2) the individual appears to be using alcohol to a degree that would make dosing unsafe. The following actions are also considered to be non-compliant:

- Repeated failure[1] to submit to toxicology sampling as requested.
- Repeated failure[1] to attend scheduled individual and/or group counseling sessions, or other clinical activities such as psychiatric or psychological appointments.
- Failure to manage medical concerns/conditions, including adherence to physician treatment and recovery services and prescription medications that may interfere with the effectiveness of methadone and may present a physical risk to the individual.
- Repeated failure[1] to follow through on other treatment and recovery plan related referrals.

[1] *Repeated failure should be considered on an individual basis and only after the OTP has taken steps to assist individuals to comply with activities.*

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

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

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

1. Immediate Termination – This involves the discontinuation of services at the time of one of the above safety-related incidents or at the time an incident is brought to the attention of the OTP.

2. Enhanced Tapering Discontinuation – This involves an accelerated decrease of the methadone dose (usually by 10 mg or 10% a day). The manner in which methadone is discontinued is at the discretion of the OTP physician to ensure the safety and well-being of the individual.

It may be necessary for the OTP to refer individuals who are being administratively discharged to the local access management system for evaluation for another level of care. Justification for noncompliance termination must be documented in the individual's chart.

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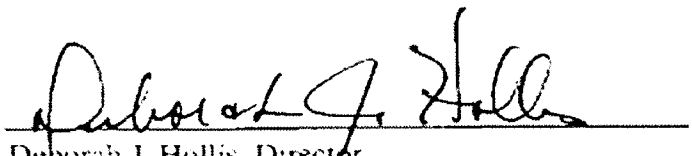


Deborah J. Hollis, Director
APPROVED BY: Bureau of Substance Abuse and Addiction Services

An electronic version of the *Consent for an Adolescent to Participate in Opioid Pharmacotherapy Treatment* form (Attachment A) can be found on our website at www.michigan.gov/mdhhs-orosc, choose 'Treatment' and then 'OROSC Policy and Technical Advisory Manual'.

TREATMENT POLICY #05 October 1, 2012 ATTACHMENT A

Consent for an Adolescent to Participate in Opioid Pharmacotherapy Treatment

Name of Patient_____ Date_____

Date of Birth (MM/DD/YY)_____ Patient's Age_____ Pregnant: Yes___ No___

Name of Parent or Legal Guardian_____

Name of Practitioner Explaining Procedures_____

Name of Program Medical Director_____

An individual under 18 years of age, who is not pregnant, is required to have had at least two documented unsuccessful attempts at short-term detoxification and/or drug-free treatment within a 12-month period to be eligible for maintenance treatment.

No individual 16 or 17 years-of-age may be admitted to maintenance treatment unless a parent or legal guardian consents, in writing, to such treatment. For persons 15 years-of-age and under, a parent or legal guardian consent is required, as well as permission for admission by the state opioid treatment authority (SOTA). A copy of the program's signed informed consent statement must be placed in the individual's clinical chart. This signed consent is in addition to the general consent that is signed by all individuals receiving methadone and shall be filed in their clinical charts.

The parent or legal guardian must sign a release of information for the Opioid Treatment Program (OTP) staff to verify the individual's admission and discharge dates and any other specific information requested by the OTP.

Verification of Detoxification/Drug-Free Treatment Attempts

(DOES NOT APPLY TO PREGNANT ADOLESCENTS)

Facility/Counselor Name_____

Street Address_____

City, State, Zip_____

Phone Number _____

Fax Number _____

Dates of Service: From (MM/DD/YY)_____

To (MM/DD/YY)_____

Verified by:

*OTP Staff Person Name*_____

*Title*_____ *OTP*

*Staff Signature*_____

*Date*_____

Facility/Counselor Name_____

Street Address_____

City, State, Zip_____

Phone Number_____

Fax Number _____

Dates of Service: From (MM/DD/YY)_____

To (MM/DD/YY)_____

Verified by:

*OTP Staff Person Name*_____

*Title*_____ *OTP*

*Staff Signature*_____

*Date*_____

Consent for an Adolescent to Participate in Opioid Pharmacotherapy Treatment

– Page 2 –

INFORMED CONSENT STATEMENT

FOR PARENT/GUARDIAN

I hereby authorize and give voluntary consent to_____Medication-Assisted Treatment Program and its medical personnel to dispense and administer opioid pharmacotherapy (includes methadone or buprenorphine) as part of the treatment of my child's addiction to opioid drugs. Treatment procedures have been explained to me, and I understand that this will involve taking the prescribed opioid drug on the schedule determined by the program physician in accordance with federal and state regulations.

I further authorize provision of the following: diagnostic assessment, individual and group counseling, medication review and monitoring. My child's participation is voluntary. I understand that this program follows person-centered planning guidelines and that my child's treatment plan will be individualized to meet my child's needs and goals, and I will participate in the development of my child's treatment plan.

I understand that it is important for me to inform any medical provider, who may treat my child for any medical problem, that my child is enrolled in an opioid treatment program so that the provider is aware of all the medications my child is taking, can provide the best possible care, and can avoid prescribing medications that might affect the opioid pharmacotherapy or the chances of successful recovery from opioid addiction. If pregnant, my child will receive prenatal care and I will sign releases for coordination of care with that provider.

I understand that I may withdraw my child, from this treatment program and discontinue the use of the medications prescribed at any time. Should I choose this option, I understand my child will be offered a medically supervised tapering process for discontinuation. Withdrawal is not recommended when the individual is pregnant.

Parent/Guardian:

Name_____Signature_____Date_____

Witness:

Name_____Signature_____Date_____

OTP Physician:

Name_____Signature_____Date_____

State Opioid Treatment Authority (Required for minors 15 years-of-age and younger.)**:**

Name___Signature_____Date___

III. PREVENTION REQUIREMENTS

Prevention Policy #01, Synar— Effective July 21, 2015
Amendment #2

Prevention Policy #02 Addressing Communicable Disease Issues in the Substance Abuse Service Network—

Effective January 1, 2012

PREVENTION POLICY # 01

SUBJECT: Synar
RE-ISSUED: July 21, 2015
EFFECTIVE: July 21, 2015

PURPOSE:

The purpose of this policy is to specify Prepaid Inpatient Health Plans (PIHP) requirements with regard to federal Substance Abuse Prevention and Treatment (SAPT) Block Grant Synar compliance.

SCOPE:

This policy applies to Prepaid Inpatient Health Plans (PIHPs) and their Synar-related provider network, including Designated Youth Tobacco Use Representatives (DYTUR), which are part of substance abuse services administered through the Michigan Department of Health and Human Services, Office of Recovery oriented Systems of Care (MDHHS/OROSC).

BACKGROUND:

States must show compliance with federal requirements to be considered eligible for the SAPT Block Grant. States are also required to submit an annual report and an implementation plan with regard to Synar related activities. These requirements are incorporated in the annual SAPT Block Grant application. The state may be penalized up to 40 percent of the State's federal (SAPT) Block Grant award for non-compliance.

The Synar Requirements are summarized as follows:

1) States must enact a youth access to tobacco law restricting the sale and distribution of tobacco products to minors. The Michigan Youth Tobacco Act (YTA) satisfies this requirement by restricting the sale and distribution of tobacco products to minors.

2) States must actively enforce their youth access to tobacco laws.

3) The State must conduct a formal Synar survey annually, to determine retailer compliance with the tobacco youth access law and to measure the effectiveness of the enforcement of the law.

4) The State must achieve and maintain a youth tobacco non-sales rate of 80 percent or better to underage youth during the formal Synar survey.

In addition, the Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Prevention (SAMHSA/CSAP) requires that an accurate listing of tobacco retail outlets be maintained, including periodic tobacco retail outlet coverage studies intended to confirm the accuracy of the list and establishes Synar sampling requirements.

REQUIREMENTS:

It is the responsibility of the PIHP to implement tobacco access prevention measures to achieve and maintain a youth tobacco non-sales rate of 80 percent or better within their region. In doing so, it is required that the PIHP will:

1) Use best practices relative to reducing access to tobacco products by underage youth;

2) Incorporate use of data specific to the PIHP region including youth sales data, analysis of the effectiveness of Synar related activities; and

3) Collaborate with local partners including law enforcement.

Activities associated with Synar best practices and other evidenced based prevention such as conducting inspections, and providing merchant or vendor education are defined as prevention services and must be carried out by a licensed substance abuse prevention program.
Specific responsibilities include the following:

1) Develop and implement a regional plan of Synar/tobacco prevention activity that will restrict youth access to tobacco and surpass the 80 percent non-sales rate.

2) Conduct activities necessary to ensure the Tobacco Retailer Master List is correct and participate in the clarification and improvement initiative, as well as the CSAP Mandated Coverage Study. Submit to OROSC all information as required by the OROSC/PIHP contract agreement.

3) Annually conduct and complete the Formal Synar Survey to all outlets in the sample draw listing during the designated time period and utilize the official OROSC protocol. Additionally, edit the survey compliance check report (CCR) forms and submit all required information to OROSC as required by the OROSC/PIHP contract agreement.

4) Contribute to enforcement of the Michigan YTA at tobacco outlets within the PIHP region by conducting non-Synar enforcement checks with law enforcement participation. If law enforcement involvement is not feasible, conduct non-Synar enforcement activity through civilian checks.

It is recommended that non-Synar checks be carried out in no less than 25 percent of the outlets in the PIHP region with priority to vendor categories that have historically had a higher sell rate to minors, e.g., Gas Stations, Bar/Lounges, and Restaurants.

For PIHPs with a 20 percent "sell rate" or Retailer Violation Rate (RVR) higher than 20 percent for two consecutive Synar surveys, the requirement is that no less than 50 percent of the outlets within the region will have at least one enforcement check activity during the subsequent third year

Note: SAPT Block Grant funds cannot be used for law enforcement; this includes Formal Synar and non-Synar activities.

5) Conduct Vendor Education activities, utilizing the OROSC approved vendor education protocol, with not less than 25 percent of the total outlets within the PIHP region.

6) Seek to change community norms and conditions by forming relationships with stakeholders for the purposes of developing joint initiatives and/or for collaboration to impact sales trends to youth.

7) Identify a DYTUR agency to implement Synar-related activities. The agency or individual identified as the DYTUR, must have knowledge in the area of youth tobacco access reduction and related Synar prevention initiatives.

8) Provide information to satisfy federal reporting requirements including information about law enforcement activities relevant to violations of the YTA. Correspondingly, it is the responsibility of the

PIHP to comply with Synar protocol, and demonstrate a good faith effort to, obtain and report this information. Documentation of good faith effort may be required if the PIHP cannot provide the required information.

REPORTING REQUIREMENTS:

See the MDHHS/PIHP agreement for PIHP reporting requirements.

PROCEDURE:

Identification and implementation of activities, and local data collection and evaluation procedures, are left to the discretion of the PIHP with the exception of the Formal Synar Survey Protocol (to be used for all enforcement checks), the Vendor Education Protocol, the Synar Tobacco Retailer Master List Clarification, and Improvement/Coverage Study Procedures complete with methodology and practices requirements. All associated protocols are placed on the OROSC website, and updated as needed.

Technical assistance to PIHPs in development of local procedures is available through OROSC.

REFERENCES:

Youth Tobacco Act 31 of 1915, MCL1915 PA31, Michigan Legislature, 1915-1916 Legislative Session, Lansing, MI. (Amended September 1, 2006). Can be found on website: http://www.legislature.mi.gov/(c32puon1tgtsa355dn3zqljp)/mileg.aspx?page=MCLPASearch

APPROVED BY: Deborah J. Hollis, Director
Bureau of Substance Abuse and Addiction Services

PREVENTION POLICY # 02

SUBJECT: Addressing Communicable Disease Issues in the Substance Abuse Service Network

ISSUED: October 1, 2006; Revised: April 1, 2011, and September 14, 2011

EFFECTIVE: January 1, 2012

PURPOSE:

This policy revises regional substance abuse coordinating agency (CA) requirements with regard to addressing communicable disease. The primary charge of communicable disease efforts is to prevent the further spread of infection in the substance using population. The original policy, effective October 1, 2006, converted guidelines issued in the 2004 Action Plan Guidelines document, to a policy requirement. The policy was revised in April 2011 to re-affirm many of the original policy requirements, and implemented new requirements for targeting resources.

This revision eliminates most of the prior requirements that were put in place even though, for the past several years, Michigan has not been a designated state required to expend block grant funding on communicable disease (CD) services. When the results of CD services, such as outreach, counseling and testing services, performed over the years were examined, very low prevalence rates of new HIV infection and other CDs were found. Therefore, on the basis of a low prevalence rate of CDs, primarily new HIV infection rates, and reduced availability of funding for core substance use disorder (SUD) services, the requirement for designated communicable disease funding is repealed beginning in fiscal year 2012. However, in recognition of the linkage between CDs and SUD treatment, minimal requirements have been retained to assure needs are met for persons with, or at-risk for, HIV/AIDS or other communicable diseases, and are in treatment for substance abuse.

SCOPE:

This policy applies to CAs and their provider network, which are a part of substance abuse services administered through the Michigan Department of Health & Human Services (MDHHS), Office of Recovery Oriented Systems of Care (OROSC).

BACKGROUND:

Given the causal relationship between HIV/AIDS, hepatitis, other CDs, substance abuse, and the importance of recognizing the role of CD assessment in the development of substance abuse treatment plans for clients, a comprehensive approach is the most effective strategy for preventing infections in the drug using population and their communities.

The CA must assure persons with SUDs who are at-risk for and/or living with HIV/AIDS, sexually transmitted diseases/infections (STD/Is), tuberculosis (TB), hepatitis C, and other CDs, have access to culturally sensitive and appropriate substance abuse prevention and treatment to address their multiple needs in a respectful and dignified manner.

REQUIREMENTS:

Staffing

Each CA must assure staff knowledge and skills in the provider network are adequate and appropriate for addressing communicable disease related issues in the client population, as appropriate for each position within each provider, in accordance with the "Minimum Knowledge Standards" that follow:

Minimum Knowledge Standards for Substance Abuse Professionals - Communicable Disease Related

BSAAS mandates that all staff with client contact at a licensed treatment provider have at least a basic knowledge of HIV/AIDS, TB, Hepatitis, and STD, and the relationship to substance abuse. BSAAS provides a web-based training that will cover minimal knowledge standards necessary to meet this **Level 1** requirement. However, if a CA region desires to provide this training through other mechanisms, the following information must be included:

- HIV/AIDS, TB, Hepatitis (especially A, B, and C) and STD/Is, as they relate to the agency target population.
- Modes of transmission (risk factors, myths and facts, etc.).
- Linkage between substance abuse and these CDs.
- Overview of treatment possibilities.
- Local resources available for further information/screening.

CA regions are required to maintain a tracking mechanism to assure SUD provider staff completes Level 1 training.

Services

1. All persons receiving SUD services who are infected by mycobacterium tuberculosis must be referred for appropriate medical evaluation and treatment. The CA's responsibility extends to ensuring that the agency, to which the client is referred to, has the capacity to provide these medical services, or to make these services available, based on the client's ability to pay. If no such agency can be identified locally (within reasonable distance), the CA must notify MDHHS/OROSC.
2. All clients entering residential treatment and residential detoxification must be tested for TB upon admission. With respect to clients who exhibit symptoms of active TB, policies and procedures must be in place to avoid a potential spread of the disease. These policies and procedures must be consistent with the Centers for Disease Control (CDC) guidelines and/or communicable disease best practice.
3. All pregnant women presenting for treatment must have access to STD/Is and HIV testing.
4. Each CA is required to assure that all SUD clients entering treatment have been appropriately

screened for risk of HIV/AIDS, STD/Is, TB, and hepatitis, and that they are provided basic information about risk.

5. For those clients entering SUD treatment identified with high-risk behaviors, additional information about the resources available, and referral to testing and treatment must be made available.

Financial and Reporting Requirements

For the required services set forth in this policy, there are no separate financial or reporting requirements.

If a CA chooses to utilize state funds to provide communicable disease services beyond the scope of this policy:

1. The CA must ensure that recipients are persons with SUDs.
2. The Communicable Disease Provider Information Plan must be completed at the beginning of each fiscal year in conjunction with the CA Action Plan submission (Attachment A).
3. The Communicable Disease Provider Information Report must be completed within 60 days following the end of a fiscal year and submitted to MDHHS-OROSC@michigan.gov (Attachment A).
4. The CA must submit data to the HIV Event System [HES] for Health Education/Risk Reduction Informational Sessions and Single-Session Skills Building Workgroups, as well as HIV Counseling, Testing and Referral Services (CTRS), consistent with MDHHSHIV/AIDS Prevention and Intervention Section (HAPIS) data collections methods.

PROCEDURE:

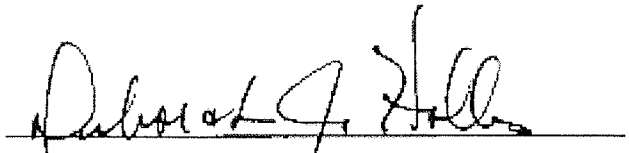
Procedures to meet these requirements are at the discretion of the PIHP.

REFERENCES:

Center for Substance Abuse Treatment. (Reprinted 2000). *Substance Abuse Treatment for Persons with HIV/AIDS*, Treatment Improvement Protocol (TIP) Series 37. U.S. Department of Health and Human Services, Substance Abuse, and Mental Health Services Administration. Rockville, MD.

Center for Substance Abuse Treatment. (Reprinted 1995). *Screening for Infectious Disease Among Substance Abusers*, Treatment Improvement Protocol (TIP) Series 6. U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. Rockville, MD.

Approved by:



Deborah J. Hollis, Director
Bureau of Substance Abuse and Addiction Services

COMMUNICABLE DISEASE PROVIDER INFORMATION PLAN / REPORT				
PIHP:	**Fiscal Year:**	**Date Submitted/ Revised:**		
Name(s) of CD Providers under Contract with the PIHP:				
PIHP Contact Person and E-mail Address:				
For each intervention listed below and provided in the PIHP's region, complete the following information:				
INTERVENTION *NOTE: Those items identified with an * are required to be reported in the* HIV Event System (*HES).*	**PLAN** Original	Revised	**REPORT** (Actual #'s) Due Date: 60 days following the end of the fiscal year.	
	Estimated Number of Individuals to Receive Services	**Estimated Number of Sessions to be Provided**	**Number of Individuals who Received Services**	**Number of Sessions that were Provided**
Column A	*Column B*	*Column C*	*Column D*	*Column E*
* **HE/RR HIV/AIDS Information Session**				
* **HE/RR Skills Building Workshops** (singl e session)				
* **HIV CTRS at SUD Treatment Provider** (include site type/site number on separate attachment)				
* **HIV CTRS at Other Locations** (include site type/site number on separate attachment)				
* **Other/Non-HIV CTRS Outreach Contacts** (include schedule of locations and times on separate attachment)				
TOTALS				

Site Type/Site Numbers for locations where HIV CTRS will be provided:

Locations and Times where non-HIV CTRS Outreach will be provided:

COMMUNICABLE DISEASE PROVIDER INFORMATION PLAN/REPORT INSTRUCTIONS

If a PIHP chooses to continue to fund CD services, the information on this form must be completed. The form lists various communicable disease (C D) interventions/services that are eligible, although not required, to be funded through community grant dollars based on PIHP need and priority.

I. Completing the Plan

Columns B and C (Estimated Number of Individuals to Receive Services and Estimated Number of Sessions to be Provided) must be completed each fiscal year and is due to the Office of Recovery Oriented Systems of Care with the PIHP's Action Plan submission.

Please use the check box provided to identify the CD Provider Information Plan as "Original" at the initial submission of the plan. If the CD Provider Information Plan data does change, please use the check box provided to identify that the plan was "Revised" as appropriate through the course of the fiscal year.

II. Completing the Report

For those services/events that an identified CD provider conducted for the PIHP, post the number of individuals who received the services and the number of sessions provided in Columns D and E.

Report Due Date: An annual report is required to be completed within sixty (60) days following the end of the fiscal year and submitted to mdhhs-orosc@michigan.gov.

III. Questions

For questions or assistance regarding this form, contact the OROSC Communicable Disease Specialist, at mdhhs-orosc@michigan.gov or 517-373-4700.

IV. CREDENTIALING AND STAFF QUALIFICATION REQUIREMENTS

Michigan Department of Health & Human Services

Behavioral Health and Developmental Disabilities Administration

Bureau of Community Mental Health Services

Credentialing and Staff Qualification Requirements for the Prepaid Inpatient Health Plan Provider Network

This contract attachment outlines requirements for credentialing and staff qualifications throughout the substance abuse PIHP provider network. This document is organized as follows:

I. PIHP Credentialing Requirements
II. Provider Staff Certification Requirements
III. Staff Qualifications for Substance Use Disorder Prevention Services
IV. Staff Qualifications for Substance Use Disorder Treatment Services
V. Other Staff-Related Definitions

I. PIHP CREDENTIALING REQUIREMENTS

In implementing staff qualifications requirements, the PIHP must:

1) Adopt and disseminate policy with respect to required professional qualifications for prevention and treatment direct service personnel in the PIHP network, applicable both to salaried and contractual personnel. In general, the requirements contained herein are expected to represent the minimum standards for substance use disorder (SUD) prevention and treatment services. However, it is recognized that specialized services may require enhanced staff qualifications.

   When establishing requirements for qualifications or training, for staff that do not require certification, PIHPs are expected to:

   a) Recognize and utilize training and education that is specific or related to the needed knowledge and skills necessary to perform the required tasks.

   b) Recognize in-service and provider new staff orientation.

   c) Recognize and provide reciprocity for training provided through PIHPs that address relevant topic and content areas.

2) Assure that staff qualifications are met throughout the provider panel through PIHP policy and procedures.

PIHPs must consider the use of deemed status, reciprocity and delegation provisions when permissible, in order to establish a single credentialing and associated monitoring requirements for the provider, and reduce administrative burden on both the provider and the PIHP. Whenever possible, it is preferable that PIHPs permit deemed status or reciprocity, and that a single responsible PIHP be identified when multiple PIHPs contract with a single provider.

3) Assure that criminal background checks are conducted as a condition of employment for its own potential employees and for network provider employees. Although criminal background checks are required, it is not intended to imply that a criminal record should necessarily bar employment. The verification of these checks and a justification for the decisions that are made should be documented in the employee personnel or interview file. The decisions must be consistent with state and federal rules and regulations regarding individuals with a criminal history. PIHPs may also establish criteria for the frequency of criminal background checks for individuals during employment episodes. At a minimum, checks should take place every other year from when the initial check was made.

   Criminal background checks must be completed by an organization, service, or agency that specializes in gathering the appropriate information to review the complete history of an individual. Use of the state of Michigan Offender Tracking Information System (OTIS) or a county level service that provides information on individuals involved with the court system are not appropriate resources to use for criminal background checks.

4) Recognize and comply with state health care licensing professional scope of practice and supervision requirements.

Credentialing Responsibilities

Primary responsibility for assurance that staff qualification requirements are met rests with the individual and the provider agency that directly employs or contracts with the individual to provide prevention or treatment services.

Responsibilities of the individual, provider agency and the PIHP are generally as follows:

1) The individual is responsible for achieving and maintaining his or her certification.
2) The provider agency that directly employs or contracts with the individual to provide prevention or treatment services is responsible for verifying the ongoing certification status of the employee. This includes verification of the credential(s), monitoring staff, development plans, and compliance with continuing education requirements.
3) The PIHP is responsible for establishing certification-related contractual obligations with their provider network consistent with these requirements. With the intended locus of responsibility resting with the individual and the provider agency, the PIHP has responsibility for provider agency performance monitoring to assure these

obligations have been met.

Although it is not intended that PIHPs maintain primary source verification functions or individual certification or credentialing files on behalf of their provider network, it is recognized that this may represent a prudent or necessary business practice of the PIHP. PIHPs maintaining primary source verification files may be asked to provide their justification for doing so.

Compatibility with PIHP Requirements

PIHP policy and procedures with regard to credentialing should be compatible with PIHP credentialing and re-credentialing business processes. MDHHS has issued a PIHP Credentialing policy entitled *Credentialing and Re-Credentialing Processes* (Attachment of the MDHHS PIHP contract). This policy defines organizational providers as entities that directly employ and/or contract with individuals to provide health care services. These services include treatment of substance use disorders. In this regard, PIHPs are considered to be organizational providers.

The PIHP credentialing policy outlines two requirements associated with credentialing of organizational providers:

1) Each PIHP must validate, and re-validate at least every 2 years that the organizational provider is licensed or certified as necessary to operate in the state and has not been excluded from Medicaid or Medicare participation.
2) The PIHP must ensure that the contract between the PIHP and any organizational provider requires that the organizational provider credential and re-credential their directly employed and subcontracted direct service providers in accordance with the PIHP's policies and procedures (which must conform to MDHHS's credentialing process).

Added clarification for CAs that are not PIHPs: The intention of this policy is to assure that credentialing responsibilities are carried out, and associated records are maintained at the provider organization level. If a PIHP employs individual practitioners for the purposes of providing treatment or prevention services, the CA is an organizational provider. The PIHP is not required by the MDHHS with providers that meet the organizational provider definition, then the PIHP must:

1) Ensure that the contract between the PIHP and their organizational provider requires that the provider credential and re-credential their directly employed and subcontracted providers in accordance with the policy.
2) Ensure that the provider has not been excluded from Medicaid or Medicare participation.

II. PROVIDER STAFF CERTIFICATION REQUIREMENTS

The following provides detailed information regarding the certification requirements for the PIHP provider network.

General

These certification requirements represent the standards for individual PIHP provider network requirements. Special consideration can be made for both special population needs (such as those of adolescents) and for specialty services (such as provision of methadone to women that are pregnant).

Also, it is expected that reimbursement rates reasonably acknowledge the cost implications of certification requirements and recognize workforce development obligations already incorporated in provider accreditation requirements. PIHPs may consider rate incentives for enhanced staffing requirements for specialty services.

Application

Certification requirements apply to the entire PIHP provider network for services directed to the prevention and treatment of substance use disorders. This includes staff working for or within local governmental units such as intermediate school districts, local health departments, or community mental health service board programs when these are under contract to the PIHP as a provider and/or funded through the MDHHS/PIHP master agreement, depending on the scope of their work, as described in this document.

Certification requirements do not apply to staff solely engaged in:

1) Synar tobacco compliance checks or vender education.
2) Provision of communicable disease prevention and education services.

Refer to revised Prevention Policy #02-*Addressing Communicable Disease Issues in the Substance Abuse Service Network* for information about communicable disease staff training requirements.

Certification requirements apply on the basis of staff role and responsibility regardless of employment status or type. Examples of employment status include: direct employee, contractual, or volunteer. Examples of type include: full-time, part-time, intermittent, or seasonal.

An individual's certification requirements are determined on the basis of each of their job responsibilities. That is, situations in which an individual's responsibilities cross roles and responsibilities as outlined below, and each role category independently determines the associated certification requirement. For example, an individual functioning as a case manager (certification not required) and as a treatment clinician would be required to be certified even though their responsibilities include functions for which certification is not required. Unless an exception is specified below under the various staff types, individuals who are timely in the process of completing their registered development plan for the specified credential are considered to meet certification requirements. For example, a recent MSW graduate working in a position providing treatment to persons with substance use disorders with an approved development plan would be considered to meet certification requirements.

Development plans are required to include time frames, milestones, be date-specific and appropriate to the experience requirements associated with the certification credential. For example, a development plan must recognize hours of experience requirements in the context of the employee's status (full, part time). However, development plans must contain prompt and reasonable timeframes for completion. In general, a clinical staff person employed full-time will have up to a three-year development plan, and those working part-time will have up to a six-year plan. It is the responsibility of the individual to make the necessary changes to their plan, through MCBAP, if there is a change in work status. A six-year plan for an individual working full-time would not be considered to have reasonable timeframes for completion.

Timely completion of a development plan refers to the completion of the plan in the established timeframe based on work status. Timely in the process of completion refers to the yearly progress being made with the goals of the plan. At minimum, this should reflect an appropriate proportion of the work being completed in each year of the plan.
An individual who does no work on a three-year plan during years one and two and then seeks to complete everything during year three would not be seen as being timely in the process of completion and would not meet the credentialing requirements that have been established.

Since June 2007, the accepted equivalent credentials to the Michigan Certification Board for Addiction Professionals (MCBAP) certification are as follows:

- For prevention: Certified Health Education Specialist (CHES) through the *National Commission for Health Education Credentialing*
- For treatment: Certification through the *Upper Midwest Indian Council on Addiction Disorders (UMICAD)*
- For medical doctors: *American Society of Addiction Medicine (ASAM)* (Some physicians, depending on the scope of their work performed at the agency, will function in the category of "Specifically Focused Staff, " as described in this

document)

- For psychologists: *American Psychological Association (APA) specialty in addiction*

This listing will be updated, and PIHPs notified in writing, should additional equivalent credentials be identified.

Should a situation arise with an established provider where there are no longer employees available that meet the credentialing requirements, the provider and the PIHP are responsible for developing a "time-limited exception plan" appropriate to the situation to ensure that the established clients with the provider continue to receive services. An example of such a situation would be a provider that has one or more credentialed clinicians leave resulting in the remaining staff not being able to provide services to the clients. The PIHP and provider could then enter into an exception plan agreement where a qualified but non-credentialed person can provide services to those clients until credentialed staff are hired, return from leave, etc.

The length of the plan should be adequate to serve the immediate need of the affected clients but should not exceed 120 days in an initial agreement. For administrative efficiency, when providers participate in multiple PIHP provider panels, the affected PIHPs should jointly determine an appropriate exception plan. Once a plan is initiated, the PIHP must notify the department in writing specifying the situation and the action being taken to resolve it.

MCBAP Staff Certification Requirements – By Staff Function

Since October 1, 2008, all individuals performing staff functions outlined below must:

1) Be certified appropriate to their job responsibilities under one of the credentialing categories or an approved alternative credential; or
2) Have a registered development plan and be timely in its implementation; or
3) Be functioning under a time-limited exception plan approved by the PIHPas described earlier in this document.

Individuals under any of these three categories will be considered to meet MCBAP certification requirements. Note that a development plan is timely when there is evidence that steps or activities included in the development plan are being implemented and can be expected to be completed within a reasonable period of time. The supervisor of the individual is responsible for regularly monitoring the status of the development plan. MCBAP maintains a list of individuals who have active development plans and this can be accessed through their website at mcbap.com. All individuals who have an

active development plan and are working toward completion are considered to meet the staff certification requirements for providing substance use disorder services in Michigan.

Staff functions for which these requirements apply are Prevention Professionals, Prevention Supervisors, Treatment Specialists, Treatment Practitioners, and Treatment Supervisors. The following chart outlines certification, supervision, and licensure requirements. It is intended to assist in the determination of MCBAP certification requirements in the provider network, licensing requirements may still apply depending on the nature of the work duties and scope of practice.

Job Function and Description	MCBAP Certification Required for the Job Function	Supervision Required for the Job Function
Treatment Supervisors Commonly described as Supervisors, Managers, or Clinical Supervisors. This represents individuals directly supervising staff, including all levels (first, second line, etc) of clinical services.	• Certified Clinical Supervisor – Michigan (CCS-M) • Certified Clinical Supervisor – IC&RC (CCS) • Development Plan – Supervisor (DP-S) – approved development plan in place	Professional licensure requirements may apply, depending on the nature of the work duties and scope of practice.

Job Function and Description	MCBAP Certification Required for the Job Function	Supervision Required for the Job Function

Treatment Specialists Commonly described as clinicians, therapists, or counselors. This represents direct clinical treatment service provider staff not identified as specifically focused.	• Certified Alcohol and Drug Counselor – Michigan (CADC-M) • Certified Alcohol and Drug Counselor (CADC) • Certified Advanced Alcohol and Drug Counselor (CAADC) • Development Plan – Counselor (DP-C) – approved development plan in place • Certified Criminal Justice Professional – IC&RC – (CCJP) • Certified Co-Occurring Disorders Professional – IC&RC – (CCDP) – Bachelors level only • Certified Co-Occurring Disorders Professional Diplomat – IC&RC – (CCDP-D) – Masters level only	MCBAP supervisory credential – CCS-M or CCS, an approved alternative certification or a registered development plan to obtain the MCBAP credential.
Treatment Practitioners Commonly described as treatment staff providing direct service to clients like education and support; or they may be new to the field.	• A registered development plan that is timely in its implementation • Development Plan – Counselor (DP-C) – approved development plan in place	MCBAP supervisory credential – CCS-M or CCS, an approved alternative certification or a registered development plan to obtain the MCBAP credential.
Prevention Supervisors Commonly described as prevention program supervisors and represent individuals responsible for overseeing prevention staff and/or prevention services.	• Certified Prevention Consultant – Michigan (CPC-M) • Certified Prevention Consultant – IC&RC (CPC-R) • Certified Prevention Specialist – Michigan (CPS-M) • Certified Prevention Specialist – IC&RC (CPS) – only if credential effective for three (3) years	No state requirements specified.
Prevention Professionals Commonly described as Program or Prevention Coordinator, Prevention Specialist or Consultant, or Community Organizer and have responsibility for implementing a range of prevention plans, programs, and services.	• Certified Prevention Specialist – Michigan (CPS-M) • Certified Prevention Consultant – Michigan (CPC-M) • Certified Prevention Specialist – IC&RC (CPS) • Certified Prevention Consultant – IC&RC (CPC-R) • Development Plan – Prevention (DP-P) – approved development plan in place	Supervision by MCBAP prevention credentialed staff or an approved alternative certification.

Supervision Requirements for Non-Certified Staff

Individuals with staff functions outlined below are not required to be MCBAP certified, but are required to be supervised by MCBAP certified staff. Individuals with a development plan for counseling (DP-C) or prevention (DP-P) cannot function in the role of supervisor for non-certified staff.

Specifically Focused Treatment Staff
This category includes Case Managers, Recovery Support Staff, as well as staff who provide ancillary health care services such as nurses, occupational therapists, psychiatrists, and children's services staff in women's specialty programs. Licensing requirements may apply depending on the nature of the work duties and scope of practice.
Specifically Focused Prevention Staff Staff that consistently provide a specific type of prevention service. They do not have responsibilities for implementing a range of prevention plans, programs, or services.
Treatment Adjunct Staff Commonly described as: Resident Aide, Pharmacy Techs or Child Care Aides or program aides/techs. Adjunct staff are involved with the client but not at a clinical treatment services level. It is recognized that some treatment adjunct staff provide didactic or skill development services. Licensing requirements may apply to adjunct staff depending on the nature of the work duties and scope of practice; they may also work under the direction of appropriately licensed and/or credentialed staff.
Interns for the Provision of Services Interns are individuals who, as part of an educational curriculum while in the process of obtaining a degree related to the substance use disorder field, provide prevention or treatment services to clients. These services must be provided under the supervision of a MCBAP treatment credentialed staff (or an approved alternative certification) and any specific licensing requirements for the degree being sought. All services provided by interns may be allowable and billable as long as the intern is being appropriately supervised.

The MCBAP certification requirements *do not replace or supersede state licensure scope of practice and supervision requirements* for health care professionals such as social workers, counselors, or psychologists.

Supervision Requirements for Clinical Staff

Individual/Clinical Supervision – Refers to the intervention that is provided by a senior member of a profession to a junior member, or members, of the same profession.

This service is focused on enhancing the professional functioning of the junior member(s) and monitoring the quality of the professional services offered to clients by the junior member(s).

Supervision can be provided by a variety of methods like individual, group, live and recorded observation, and should include a review of documentation. Supervision activities are recorded outside of client records and are generally reflected in a log. Supervision activities that are recorded in client records involve the review and co- signing of progress notes, assessments, and treatment plans, only of those individuals who are providing clinical services as part of an internship placement through an institution of higher learning.

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

- Certified Prevention Consultant – Michigan (CPC-M)
- Certified Prevention Consultant – IC&RC (CPC-R)
- Certified Prevention Specialist – Michigan (CPS-M)
- Certified Prevention Specialist – IC&RC (CPS) – only if credential effective for three (3) years
- Certified Health Education Specialist (CHES) through the National Commission for Health Education Credentialing (NCHEC)
- Certified Clinical Supervisor – Michigan (CCS-M)
- Certified Clinical Supervisor – IC&RC (CCS)
- Development Plan – Supervisor (DP-S) – approved development plan in place
- For medical doctors: *American Society of Addiction Medicine (ASAM)*
- For psychologists: *American Psychological Association (APA)*

Due to the variety of professional services that are provided within the substance use disorder treatment field, a clinical supervisor may in fact, not have what is viewed as a "clinical background" in terms of education and training. This could result in a situation where a CCS, with no formal education in clinical work, is supervising the work of clinical staff (Master's prepared) providing psychotherapy. It is recommended that the supervisor have the appropriate education in the area where clinical supervision is being provided. In situations where this is not possible, due to staffing levels or the general staffing make up of an organization, the CA needs to approve the supervision process of the provider or enter into a plan with the provider that is outlined in the "Considerations Due To Availability of Certified Supervisory Staff" section below.

Certification Requirements for Temporary or Supervisory Assignments

Cross-over work assignments occur in those situations when an individual staff's roles and responsibilities have different MCBAP certification requirements on a temporary, time-limited basis (less than 120 days). Temporary work assignments include, for example, working out of class, temporary assignments to a higher or different position during the time required to fill a vacancy, providing coverage for a staff person on leave status, or similar situations. Examples of temporary work assignments are: assignment of a treatment clinician to clinical supervisory responsibilities, or a prevention professional assigned to supervisory prevention activities due to a vacant position or employee leave of absence.

During the temporary work assignment period, the individual performing the duties of the absent/vacant staff position will not be required to meet the MCBAP certification requirement for that temporary position. However, the individual with the temporary work assignment must have the certification or development plan appropriate to their current roles and responsibilities. For example, an individual temporarily assigned to clinical supervision would be required to be treatment-certified and an individual assigned to prevention supervisory responsibilities would be expected to be prevention- certified.

When the provider does not have any suitable employee available, or does not have the capacity to meet these requirements, the provider and the PIHP are responsible for developing and implementing a "time-limited exception plan." The PIHP and provider should enter into an exception plan agreement where a qualified but non-credentialed person can provide adequate and appropriate supervision services to those credentialed staff currently providing services to clients. The length of the plan should be adequate to serve the immediate need of the provider and clients but should not exceed 120 days in an initial agreement.

Supervisory exception plans may include purchase of supervisory services on a short- term basis, cross-PIHP or provider staff support or other actions appropriate to the situation and health care professional licensure requirements. For administrative efficiency, when providers participate in multiple PIHP provider panels, the affected PIHP s should jointly determine an appropriate plan. Once a plan is initiated, the PIHP must notify the department in writing specifying the situation in detail and the action being taken to resolve it.

Considerations Due To Availability of Certified Supervisory Staff

It is expected that certified supervisory staff may not be available during the implementation period, or the size/scope of some providers (i.e. single provider in a rural setting) result in shared supervision of either prevention and treatment programs or other unique arrangements. In these situations, the responsible PIHP and provider must develop a plan that recognizes that general supervisory responsibilities (such as approval of time off, etc) are at the discretion of the provider. However, a plan addressing how "content specialty" and clinical supervision will be provided must be developed and implemented. The plan as feasible and appropriate to the

situation may consider hiring qualifications for new staff, supervised practical training, use of mentors or consultants, use of regional/other resources, development of a regional cadre for the content area or continuing education. Once a plan is initiated, the PIHP must notify the department in writing specifying the situation in detail and the action being taken to resolve it.

Diversity and Workforce Development

The development of a diverse pool of candidates and a workforce that is representative of the community and service population is valued and encouraged as is the development of career ladders that assist individuals in gaining the knowledge and skills that enable career advancement. The development of opportunities for peers as mentors and recovery specialists is also encouraged.

III. STAFF QUALIFICATIONS FOR SUD PREVENTION SERVICES

The staff qualifications that follow reflect changes that went into effect October 1, 2008.

Definitions

Prevention Professional:

An individual who has one of the following Michigan specific (MCBAP) or International Certification & Reciprocity Consortium (IC&RC) credentials:

- Certified Prevention Specialist – Michigan (CPS-M)
- Certified Prevention Consultant – Michigan (CPC-M)
- Certified Prevention Specialist – IC&RC (CPS)
- Certified Prevention Consultant – IC&RC (CPC-R)

OR – An individual who has an approved alternative certification:

- Certified Health Education Specialist (CHES) through the National Commission for Health Education Credentialing (NCHEC)

OR – An individual who has a registered development plan for a prevention credential, and is timely in its implementation leading to certification. Individuals with a prevention development plan will utilize the following to identify their credential status:

- Development Plan – Prevention (DP-P)

Prevention Supervisor:

An individual who has one of the following Michigan specific (MCBAP) or International Certification & Reciprocity Consortium (IC&RC) credentials:

- Certified Prevention Consultant – Michigan (CPC-M)
- Certified Prevention Consultant – IC&RC (CPC-R)
- Certified Prevention Specialist – Michigan (CPS-M)
- Certified Prevention Specialist – IC&RC (CPS) – only if credential effective for three (3) years

OR – An individual who has an approved alternative certification:

- Certified Health Education Specialist (CHES) through the National Commission for Health Education Credentialing (NCHEC)

Individuals must utilize the appropriate credential acronym designated in this document when applying signatures for any required billable services.

IV. STAFF QUALIFICATIONS FOR SUD TREATMENT SERVICES

The staff qualifications that follow reflect changes that went into effect October 1, 2008.

Definitions

Substance Abuse Treatment Specialist (SATS):

An individual who has licensure in one of the following areas, AND is working within his or her licensure-specified scope of practice:

Physician (MD/DO), Physician Assistant (PA), Nurse Practitioner (NP), Registered Nurse (RN), Licensed Practical Nurse (LPN), Licensed Psychologist (LP), Limited Licensed Psychologist (LLP), Temporary Limited Licensed Psychologist (TLLP), Licensed Professional Counselor (LPC), Limited Licensed Counselor (LLC), Licensed Marriage and Family Therapist (LMFT), Limited Licensed Marriage and Family Therapist (LLMFT), Licensed Masters Social Worker (LMSW), Limited Licensed Masters Social Worker (LLMSW), Licensed Bachelor's Social Worker (LBSW), or Limited Licensed Bachelor's Social Worker (LLBSW);

AND they have a registered development plan and are timely in its implementation leading

to certification. Individuals with a counselor development plan will utilize the following to identify their credential status:

- Development Plan – Counselor (DP-C)

OR – they are functioning under a time limited exception plan approved by the PIHP, as detailed in this document.

OR – An individual who has one of the following Michigan specific (MCBAP) or International Certification & Reciprocity Consortium (IC&RC) credentials:

- Certified Alcohol and Drug Counselor – Michigan (CADC-M)
- Certified Alcohol and Drug Counselor – IC&RC (CADC)
- Certified Advanced Alcohol and Drug Counselor – IC&RC (CAADC)
- Certified Criminal Justice Professional – IC&RC (CCJP)
- Certified Co-Occurring Disorders Professional – IC&RC (CCDP) – Bachelors level only
- Certified Co-Occurring Disorders Professional Diplomat – IC&RC (CCDP-D) – Masters level only

OR – An individual who has an approved alternative certification:

- For medical doctors: *American Society of Addiction Medicine (ASAM)*
- For psychologists: *American Psychological Association (APA)*
- Certification through the *Upper Midwest Indian Council on Addiction Disorders (UMICAD)*

A Physician (MD/DO), Physician Assistant (PA), Nurse Practitioner (NP), Registered Nurse (RN) or Licensed Practical Nurse (LPN) who is not providing treatment services to clients beyond the scope of practice of their licensure are considered to be Specifically Focused Treatment Staff and are not required to obtain the MCBAP credentials. If one of these individuals wants to provide substance use disorder treatment services to clients, outside the scope of their licensure, then the MCBAP certification requirements apply.

Substance Abuse Treatment Practitioner (SATP):

An individual who has a registered MCBAP certification development plan that is timely in its implementation AND is supervised by an individual with a CCS-M, CCS, or a DP-S. Individuals with a counselor development plan will utilize the following to identify their credential status:

- Development Plan – Counselor (DP-C)

Treatment Supervisor:

An individual who has one of the following Michigan specific (MCBAP) or International Certification & Reciprocity Consortium (IC&RC) credentials:

- Certified Clinical Supervisor – Michigan (CCS-M)
- Certified Clinical Supervisor – IC&RC (CCS)

OR – An individual who has an approved alternative certification:

- For medical doctors: American Society of Addiction Medicine (ASAM)
- For psychologists: American Psychological Association (APA)

OR – An individual who has a registered development plan, for the supervisory credential and is timely in its implementation leading to certification. Individuals with a supervisor development plan will utilize the following to identify their credential status:

- Development Plan – Supervisor (DP-S)

Individuals must utilize the appropriate credentials acronym designated in this document when applying signatures for any required billable services.

V. Other Staff-Related Definitions

Individual Licensure Requirements – Refers to the requirements set forth in the public health code for each category of licensed professions. The licensed individual is responsible for ensuring that he/she is functioning within the designated scopes of service and is involved in the appropriate supervision as designated by the licensing rules of his/her profession.

Clinical Addiction Services – The services in substance use disorder treatment that involve individual or group interventions, that focus on providing education, assisting with developing insight into behaviors and teaching skills to understanding and change those behaviors.

Individual Therapy – The actions involved in assessment, diagnosis, or treatment of mental, emotional, or behavioral disorders, conditions, addictions, or other bio- psychosocial problems; and may include the involvement of the intra-psychic, intra- personal, or psychosocial dynamics of individuals. This requires specially trained and educated clinicians to perform these functions.

Other Services – Those services in substance use disorder treatment that involve directing, assisting, and teaching client skills necessary for recovery from substance use disorders. Specially focused staff or recovery coaches generally provide these services.

Program Supervision – An administrative function that ensures agency compliance with laws, rules, regulations, policies, and procedures that have been established for the provision of substance use disorder prevention and treatment services.

Treatment Billing Codes Based on Qualifications

All services provided by a SATS or SATP must be performed under appropriate supervision for billing to occur. Prevention billing is maintained by a statewide agreement and data system.

Billing Code	Code Description	Substance Abuse Treatment Specialist (SATS)	Substance Abuse Treatment Practitioner (SATP)
H0001	Alcohol and/or drug assessment face-to-face service for the purpose of identifying functional and treatment needs and to formulate the basis for the Individualized Treatment Plan	X	X
H0004	Behavioral health counseling and therapy, per 15 minutes	X	X

Billing Code	Code Description	Substance Abuse Treatment Specialist (SATS)	Substance Abuse Treatment Practitioner (SATP)
H0005	Alcohol and/or drug services; group counseling by a clinician	X	X
H0010	Alcohol and/or drug services; sub-acute detoxification; medically monitored residential detox (ASAM Level III.7-D)	X	X
H0012	Alcohol and/or drug services; sub-acute detoxification; clinically monitored residential detox; non-medical or social detox setting (ASAM Level III.2-D)	X	X
H0014	Alcohol and/or drug services; ambulatory detoxification without extended on-site monitoring (ASAM Level I-D)	X	X

H0015	Alcohol and/or drug services; intensive outpatient (from 9 to 19 hours of structured programming per week based on an individualized treatment plan), including assessment, counseling, crisis intervention, and activity therapies or education	**X**	**X**
H0018	Alcohol and/or drug services; short term residential (non-hospital residential treatment program)	**X**	**X**
H0019	Alcohol and/or drug services; long-term residential (non-medical, non-acute care in residential treatment program where stay is typically longer than 30 days)	**X**	**X**
H0022	Early Intervention	**X**	**X**
H2035	Substance abuse treatment services, per hour	**X**	**X**
H2036	Substance abuse treatment services, per diem	**X**	**X**
T1012	Peer recovery and recovery support *	**X**	**X**
90804 - 90815	Psychotherapy (individual) **	**X**	
90826	Interactive individual psychotherapy **	**X**	
90847	Family psychotherapy **	**X**	
90853	Group psychotherapy **	**X**	
90857	Interactive group psychotherapy **	**X**	
0906	Intensive Outpatient Services – Chemical dependency	**X**	**X**

* *Specially focused treatment staff may also provide and bill for this service.*
** *Appropriate licensure may still apply.*

V. TECHNICAL ADVISORIES

Contract Technical Advisory #01 Local Advisory Council Guidelines—
Issued August 9, 1990; Reissued September 18, 2006

Treatment Technical Advisory #01 Suboxone® Use in an Opioid Treatment Program—
Issued December 1, 2005

Treatment Technical Advisory #05 Welcoming—
Issued October 1, 2006

Treatment Technical Advisory #06
Counseling Requirements for Clients Receiving Methadone Treatment— Issued August 10, 2007

Treatment Technical Advisory #07 Peer Recovery/Recovery Support— Issued March 17, 2008

Treatment Technical Advisory #08
Enhanced Women's Services— Issued January 31, 2012

Treatment Technical Advisory #09 Early Intervention—
Issued November 30, 2011

Treatment Technical Advisory #11 Recovery Housing Amendment #1

STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

JENNIFER M. GRANHOLM
GOVERNOR

JANET OLSZEWSKI
DIRECTOR

MEMORANDUM

Date: September 18, 2006

To: Regional Coordinating Agencies

From: Donald L. Allen, Jr., Director
Office of Drug Control Policy

Subject: Technical Advisory (TA)

Attached is the finalized document: *Contract Technical Advisory #01 – Local Advisory Council Guidelines.* This is an update to the 1990 document currently required by contract and will go into effect on October 1, 2006.

This advisory was distributed to the field for comments on 7/13/06. Comments from Northern and Pathways were received during the review period, ending 9/11/06, and were considered in this final document.

If you have any questions or need further clarification on any issue in this advisory, please contact Mark Steinberg at (517) 335-0180 or SteinbergM@michigan.gov.

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
OFFICE OF DRUG CONTROL POLICY

CONTRACT TECHNICAL ADVISORY # 01

SUBJECT: Local Advisory Council Guidelines

ISSUED: August 9, 1990, revised October 1, 2006

PURPOSE:

To provide guidelines regarding the structure and membership of the Local Advisory Council.

SCOPE:

This advisory applies to Substance Abuse Regional Coordinating Agencies (CAs).

BACKGROUND:

Section 6226 (3) of Public Act 368 of 1978 states that a "coordinating agency shall have a local advisory council consisting of representatives of public and private treatment and prevention programs and private citizens in accordance with the guidelines established by the Administrator".

RECOMMENDATIONS:

Purpose of the Council

Each local advisory council should:

a. Seek to ensure the quality of services;

b. Seek to ensure that the services made available through the CA are accessible and responsive to their community's needs, that services are available to all segments of the community, and that the services are comprehensive and delivered in a culturally competent manner;

c. Provide a mechanism for efforts to expand and coordinate resources and activities with other agencies, community organizations and individuals to support the mission of the CA;

d. Provide opportunity for public comment on matters relevant to substance abuse prevention and treatment within the community; and

e. Provide their community a forum to discuss substance abuse services and problems throughout the service area.

Each local advisory council may:

a. Comment on the application and issuance and renewal of substance abuse services licenses, opportunities for comment may include web based means; and

b. Review and comment not less than biannually on the progress and effectiveness of services in the region and resource development partnerships.

Structure of the Council

The Advisory Council membership should include representation from the following sectors (not in any priority order):

a. Public and private substance abuse prevention, treatment or recovery providers including representation from the CA provider panel;

b. Individuals who are or have been directly served by substance abuse prevention, treatment, and recovery programs;

c. Local agencies or other stakeholders such as law enforcement, education, related services agencies such as housing, employment assistance or other health and social services agencies including local foundations, United Way as well as advocacy-oriented agencies and organizations; and

d. The general public, including civic organizations and the business community representing an interest in and willingness to advocate for prevention and treatment services for persons with, or at risk of substance use disorders.

Administration of the Council

Membership is required to be representative of the diversity of the CA catchment area. CAs must seek to include representation from underserved populations.

Note: the CA governing board may also function as the Advisory Council so long as the duties and membership guidelines are met.

Information regarding the Advisory Council must initially be submitted with the CA's designation material to the Michigan Department of Community Health, Office of Drug Control Policy (MDCH/ODCP) and must be resubmitted as changes occur. The information submitted must include:

a. Exact title of the council;

b. Membership roster including expiration dates of terms, place of residence, professional position and/or other pertinent information to reflect the groups represented;

c. Method of selecting membership, including opportunities for new council members and average term duration not to exceed six years, unless an exception is approved by the state substance abuse authority (ODCP); and

d. Council by-laws or charter.

The council by-laws or charter is expected to be approved by the Governing Board of the CA, and provide a process by which to reconcile differences between council and governing board in a manner reflective of the best interests of the community being served.

Alternative Method. In recognition that some CAs may satisfy the recommendations contained in this advisory through an alternative arrangement, the CA may request a waiver. A waiver request must provide sufficient information to demonstrate that the purpose of the Advisory Council will be met, that representation through alternative means satisfies the content of this guideline and that their governing board has approved the alternative method. Waiver approval of the alternative method by the state substance abuse authority (ODCP) is required.

Advisory Council Costs

Reasonable costs associated with the Advisory Council, or an approved alternative method that meets the intent and purpose of this advisory, will be considered eligible for MDCH/ODCP funding as contained in the annual allocation consistent with applicable Federal Office of Management and Budget (OMB) Circulars and general contract requirements. Members may be reimbursed for reasonable costs associated with meeting participation such as for example, mileage or meals when these are consistent with the policies of the CA with regard to reimbursement standards. State administered funds may not be used to reimburse employees of governmental or other agencies to the extent they receive reimbursement for the same expenses from their employers. State administered funds may not be used for payment of per diems for Advisory Council members. For these purposes, a per diem means a payment for meeting attendance.

REFERENCES:

Public Health Code, MCL 1978 PA368, Article 6, Part 62, Section 333.6226, Michigan Legislature, 1977-1978 Legislative Session, Lansing, MI. (September 30, 1978)

APPROVED BY: Donald Allen

Donald L. Allen, Jr., Director
Office of Drug Control Policy

JENNIFER M. GRANHOLM
GOVERNOR
One Michigan

STATE OF MICHIGAN
OFFICE OF DRUG CONTROL POLICY
Department of Community Health

JANET OLSZEWSKI
DIRECTOR
Department of Community Health

DATE: November 21, 2005

TO: Opioid Treatment Programs
Regional Coordinating Agencies

FROM: Doris Gellert, Director
Bureau of Substance Abuse and Addiction Services

SUBJECT: **Suboxone® Use in an Opioid Treatment Program**

Attached is "Treatment Advisory 1: Suboxone® Use in an Opioid Treatment Program." This advisory addresses questions from Opioid Treatment Programs (OTPs) and regional coordinating agencies (CAs) regarding limits for prescribing or dispensing Suboxone®.

Contact Marilyn Miller, Treatment Specialist at 517-241-2608, 517-335-2121 fax, or email millermar@michigan.gov if you have any questions or concerns.

cc: Irene Kazieczko

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

Substance Abuse Technical Advisory 1: Suboxone® Use in an Opioid Treatment Program

Issue Date: December 1, 2005

Purpose

This advisory is to clarify the issue of the maximum number of patients for prescribing or dispensing Suboxone® at an Opioid Treatment Program (OTP).

Scope

Suboxone® may be obtained by clients in two ways through an OTP.

1) The OTP physician can write a prescription for the client to fill at a pharmacy, or
2) the medication may be dispensed from an OTP, like methadone.

OTP physicians and programs must consider the best interest of the client and safety to the public when determining by which method a client should receive Suboxone®

Counseling requirements are the same for clients receiving physician prescribed Suboxone® as they are for those receiving Suboxone® from an OTP. Administrative Rules of Substance Abuse Service Programs in Michigan state:

> R325.14419(2): "A client record shall contain, at a minimum, all of the following information . . . (g) twice monthly progress reports by the counselor, signed and dated . . ."

Prescribing for External Fill at a Pharmacy-30 Patient Maximum Per Physician

Prescribing Suboxone® is limited to physicians who have obtained the waiver from the Substance Abuse and Mental Health Services Administration (SAMHSA) for prescribing buprenorphine-containing products and who have a Drug Enforcement Administration (DEA) registration. When prescribing Suboxone® to be filled at a pharmacy, the physician is limited to a maximum of 30 active clients at a time. The 30 maximum number of clients includes the total number of clients from all locations in which the physician works (OTP, private office, clinic, etc.). Requirements for prescribing buprenorphine-containing products are listed in the Drug Addiction Treatment Act of 2000 (PL 106-310), Section 3502. Clients are automatically approved for off-site dosing. Physicians should select clients for Suboxone® for external fill at a pharmacy based on stability of the client for off-site dosing rather than the chronological order in which the clients were admitted to treatment.

Dispensing from an OTP

When a client will be obtaining Suboxone® through an OTP, a physician's order for dispensing the medication at the OTP will be necessary. There is no limit to the number of clients that can be dispensed Suboxone® through an OTP, however the regulations regarding how the client receives this medication are more stringent than those who have obtained a prescription for external fill at a pharmacy. Suboxone® dispensed from an OTP must adhere to 42 CFR, Part 8.12 of the federal regulations as well as MDCH "Treatment Policy #4-Revised: Off-Site Dosing of Opioid Treatment Medication-Methadone." However, because Suboxone® is a Class III Controlled Substance and methadone is a Class II Controlled Substance, an accelerated reduced attendance schedule can be requested using the SAMHSA Exception Request and Record of Justification Form (SMA 168). Weekly attendance after one week in treatment would be considered reasonable. Suboxone® should be specified in the "Other" category on the exception request. This request needs both MDCH and CSAT/DPT approval.

JENNIFER M. GRANHOLM
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

JANET OLSZEWSKI
DIRECTOR

DATE: September 20, 2006

TO: Regional Coordinating Agencies

FROM: Donald L. Allen, Jr., Director
Office of Drug Control Policy

SUBJECT: **Welcoming Technical Advisory**

Attached is Technical Advisory #5 – Welcoming that will go into effect October 1, 2006.

This technical advisory (TA) was submitted to coordinating agencies for comment and none were presented by the due date. The attached is the final version of this TA.

Should you have any questions or need further clarification of this advisory, please contact Joyce Washburn at (517) 335-5247 or by email at washburnjoy@michigan.gov.

Attachment

TREATMENT TECHNICAL ADVISORY # 05

SUBJECT: Welcoming

ISSUED: October 1, 2006

PURPOSE:

The purpose of this technical advisory is to establish expectations for the implementation of a welcoming philosophy.

SCOPE:

This technical advisory applies to the Regional Substance Abuse PIHPs and their provider network, as administered through the Michigan Department of Health & Human Services, Office of Recovery Oriented Systems of Care (MDHHS0OROSC).

It is expected that all CA and provider network staff involved in the provision of substance abuse services understand and take action to operate within these welcoming principles. These actions consist of reviewing business practices, identifying areas in need of improvement, and implementing identified changes.

BACKGROUND:

A welcoming philosophy is based on the core belief of dignity and respect for all people, while, in turn, following good business practice. The concept of welcoming became popular in the 1990s, when there was an increased emphasis on co-occurring disorder treatment. In this context welcoming was determined to be an important factor in contributing to successful client outcomes.

The goal of addiction treatment is to move individuals along the path of recovery. There are two main features of the recovery perspective. It acknowledges that recovery is a long-term process of internal change and it recognizes that these internal changes proceed through various stages. As addiction is a chronic disease, it is characterized by acute episodes or events that precipitate a heightened need for an individual to change their behavior. It is important for the system to understand and support the treatment-seeking client by providing an environment including actions/behavior that foster entry and engagement throughout the treatment process and supports recovery.

The Network for the Improvement of Addiction Treatment (NIATx) has expanded the application of welcoming principles to include all customers of an agency (agency staff, referral sources, client families). This technical advisory concurs with this expanded perspective. The NIATx "Key Paths to Recovery" goals of reduced waiting, reduced no shows, increased admissions, and increased continuation in treatment, incorporate an expectation for a welcoming philosophy.

RECOMMENDATIONS:

Welcoming is conceptualized as an accepting attitude and understanding of how people 'present' for treatment. It also reflects a capacity on the part of the provider to address the client's needs in a manner that accepts and fosters a service and treatment relationship. Welcoming is also considered a best practice for programs that serve persons with co-occurring mental health and substance use disorders.

The following principles list the characteristics/attitudes/beliefs that can be found at a program or agency that is fostering a welcoming environment:

General Principles Associated with Welcoming

- Welcoming is a continuous process throughout the agency/program and involves access, entry, and on-going services.
- Welcoming applies to all "clients" of an agency. Beside the individual seeking services and their family, a client also includes the public seeking services; other providers seeking access for their clients; agency staff; and the community in which the service is located and/or the community resides.
- Welcoming is comprehensive and evidenced throughout all levels of care, all systems and service authorities.
- A welcoming system is 'seamless'. It enables service regardless of original entry point, provider and current services.
- In a welcoming system, when resources are limited or eligibility requirements are not met, the provider ensures a connection is made to community supports.
- A welcoming system is culturally competent and able to provide access and services to all individuals seeking treatment.

Welcoming – Service Recipient

- There is openness, acceptance, and understanding of the presenting behaviors and characteristics of persons with substance use disorders.
- For persons with co-occurring mental health problems, there is openness, acceptance, and understanding of their presenting behaviors and characteristics.
- Welcoming is recipient-based and incorporates meaningful client participation and 'client satisfaction' that includes consideration to the family members/significant others.
- Services are provided in a timely manner to meet the needs of individuals and/or their families.
- Clients must be involved in the development of their treatment plans and goals.

Welcoming – Organization

- The organization demonstrates an understanding and responsiveness to the variety of help-seeking behaviors related to various cultures and ages.

- All staff within the agency integrates and participates in the welcoming philosophy.
- The program is efficient in sharing and gathering authorized information between involved agencies rather than having the client repeat it at each provider.
- The organization has an understanding of the local community, including community differences, local community involvement and opportunities for recovery support and inclusion by the service recipient.
- Consideration is given to administrative details such as sharing paperwork across providers, ongoing review to streamline paperwork to essential and necessary information.
- A welcoming system is capable of providing follow-up and assistance to an individual as they navigate the provider and the community network(s).
- Welcoming is incorporated into continuous quality improvement initiatives.
- Hours of operation meet the needs of the population(s) being served.
- Personnel that provide the initial contact with a client receive training and develop skills that improve engagement in the treatment process.
- All paperwork has purpose and represent added value. Ingredients to managing paperwork are the elimination of duplication, quality forms design and efficient processing, transmission, and storage.

Welcoming – Environmental and Other Considerations

- The physical environment provides seating, space, and consideration to privacy, a drinking fountain and/or other 'amenities' to foster an accepting, comfortable environment.
- The service location is considered with regard to public transportation and accessibility.
- Waiting areas include consideration for family members or others accompanying the individual seeking services.

Staff Competency Principles

- Skills and knowledge appropriate to staff and their roles throughout the system (reception, clinical, treatment support, administrative).
- Staff should have the knowledge and skill to be able to differentiate between the person and their behaviors.
- Staff should be respectful of client boundaries in regards to personal questions and personal space.
- Staff uses attentive behavior, listening with empathy not sympathy.

Performance Indicators

PIHPs are expected to include a provision in their provider network contracts requiring welcoming principles be implemented and maintained.

Client satisfaction surveys are expected to incorporate questions that address the 'welcoming' nature of the agency and its services.

PIHPs include consideration to welcoming principles in their provider network site visit protocols. MDHHS/OROSC may review these provider network protocols during their visits to the PIHP.

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5 Promising Practices Increasing Admissions. Retrieved July 6, 2006, from Network for the Improvement of Addiction Treatment website: www.NIATx.net

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Owens, Betta H. (2006). *Network for the Improvement of Addiction Treatment Update.* Retrieved July 6, 2006, from Network for the Improvement of Addiction Treatment website: www.NIATx.net

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White, William. (2005). *Recovery Management: What If We Really Believed That Addiction Was A Chronic Disorder?* Retrieved from Great Lakes Addiction Technology Transfer Center website: http://www.glattc.org

APPROVED BY: __*SIGNED*_____

Donald L. Allen, Jr., Director
Office of Drug Control Policy

STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

JENNIFER M. GRANHOLM
GOVERNOR

JANET OLSZEWSKI
DIRECTOR

DATE: August 10, 2007

TO: Regional Coordinating Agencies
Opioid Treatment Programs

FROM: Donald L. Allen, Jr., Director
Office of Drug Control Policy

SUBJECT: Technical Advisory – 06, Counseling Requirement for Clients Receiving Methadone Treatment

Attached is Technical Advisory #6 – Counseling Requirements for Clients Receiving Methadone Treatment that becomes effective August 10, 2007. The draft policy was submitted to coordinating agencies and opioid treatment programs on March 6, 2007, with a 60-day comment period. Comments from the Michigan Association of Substance Abuse Coordinating Agencies, Clinton-Eaton-Ingham Substance Abuse Services Program and Project Rehab-Life Guidance Services were received and taken into consideration for the final document.

If you have any questions, please contact Marilyn Miller, State Methadone Authority, at millermar@michigan.gov or by phone at 517-241-2608.

Attachment

cc: Division of Licensing and Certification

TREATMENT TECHNICAL ADVISORY # 06

SUBJECT: Counseling Requirement for Clients Receiving Methadone Treatment

ISSUED: August 10, 2007

PURPOSE:

The purpose of this technical advisory is to clarify the substance abuse administrative rule specific to the counseling requirements for clients receiving methadone as part of their substance abuse treatment.

SCOPE:

This technical advisory provides direction to all Opioid Treatment Programs (OTPs) in Michigan that receive public funds and can be utilized by non-funded programs for guidance, as well.

BACKGROUND:

Effective July 5, 2006, The Michigan Department of Health & Human Services Administrative Rules for Substance Abuse Service Programs was revised in several areas for the first time since their inception in 1981. One of the rule changes involved the requirements for counseling services for clients receiving treatment through a methadone program. The new language for counseling requirements is as follows:

> Per R325.14419 (2) (g), if the client's treatment plan identifies a need for counseling services and includes the provision of these services, then signed and dated progress reports by the counselor must be included in the clinical record.

The previous rule language for this section read as follows:

> "Twice monthly progress reports by the counselor, signed and dated."

The change in this rule was meant to emphasize the importance of individualized care for clients receiving medication-assisted treatment in an OTP and that duration and frequency of counseling must be based on medical necessity. The previous language established universal counseling criteria for all clients without consideration of individual needs. As a result, clients could receive counseling services that were not needed or could have been inadequate to meet the needs of the clients based on the interpretation of this rule.

RECOMMENDATIONS:

The following recommendations are being made to assist programs in making the adjustment to this rule change and offer direction on how to provide needed services to clients. These recommendations seek to emphasize individualized treatment and the need for counseling services to be based on medical necessity. Further, these recommendations will also provide guidance for programs on how client recovery can be supported in ways other than individual counseling. The justification for the counseling services must be in the treatment plan with specific goals and objectives indicating why the services are being provided and what is going to be accomplished. The recommendations and guidance are as follows:

1. The amount and duration of counseling for the client should be determined based on medical necessity as well as the individual needs of the client and not on arbitrary criteria such as predetermined time, funding source, philosophy of the program staff, or payment limits. Decisions on counseling should be determined in collaboration with the client, the program physician, the client's primary counselor and the clinical supervisor. This decision-making process should be documented in the clinical record and the treatment plan should reflect the decisions that are made.

2. Counseling services must be included in the treatment plan. The treatment plan and the treatment plan reviews not only serve as tools in guiding treatment, they help in the administrative function of service authorizations. Decisions concerning the duration of stay, intensity of counseling, transfer, discharge, referrals, and authorizations are based on individualized determination of need and on progress toward treatment goals and objectives. The client's need for counseling, in terms of quantity and duration, must be reflected in the treatment plan and the need that is being addressed in the counseling must be identified by a comprehensive biopsychosocial assessment. The Michigan Department of Health & Human Services/Office of Recovery Oriented Systems of Care Treatment Policy #6-Individualized Treatment Planning can be used as a guide to assist with this process.

3. As client needs change throughout treatment, adding counseling services or increasing the frequency of contacts is not always the right answer. Many times support services can be added or modified as necessary to assist the client in meeting his/her goals without having to immediately depend on individual counseling services. These modifications may be the addition of specialized treatment groups or community support services. Attendance at community support groups should be incorporated into the client's treatment plan. This will enhance the formal counseling, if it is being provided, and help the client develop on-going support as they complete counseling. Peer recovery support should also be included when necessary and available. Case management and referrals for medical and dental care, housing, vocational education and employment, resolutions of legal issues, parenting classes, family reunification, etc. should be incorporated into the treatment plan when the client is at an appropriate stage of change and is ready to address these needs. Special needs of clients can be coordinated with another licensed substance abuse treatment provider. These services may include residential care and

specialized prenatal care or specialized women's services, depending on the need of the client. Assisting the client in maintaining recovery goes beyond counseling services and ensuring that all other needs are appropriately met is an important component of success.

4. As a client progresses through treatment, there may be a time when the maximum therapeutic benefit of counseling has been achieved. At this point, the client may be appropriate to enter the methadone only (medical maintenance) phase of treatment if it has been determined that ongoing use of the medication is medically necessary and appropriate for the client. To assist the OTP in making this decision, TIP 43 "Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs" offers the following criteria to consider when making the decision to move to medical maintenance:

    a. Absence of a significant, unstable co-occurring disorder.
    b. Abstinence from all illicit drugs and from abuse of prescription drugs for a period of at least six months prior to entry into methadone only status.
    c. No alcohol use problem.
    d. Ability to maintain stability in their current living environment.
    e. Stable and legal source of income.
    f. Involvement in productive activities as defined in their individual plan of service; e.g., employment, school, volunteering.
    g. No new criminal or legal involvement for one year prior to the methadone only phase.
    h. Adequate social support system, including but not limited to, self-help groups and sponsorship.

    These guidelines are not inclusive of all of the areas to be considered when making this decision. It is important to review each client on an individual basis when making this decision and document in the medical record how the decision was made to move to medical maintenance.

5. If a client has received counseling and successfully completed it, the client may receive counseling again as long as it is based on the needs of the client and it is determined to be medically necessary. Being involved in medical maintenance does not preclude the client from again receiving or starting counseling services.

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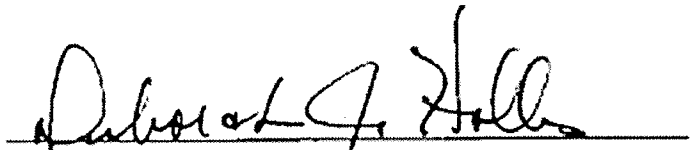

Deborah J. Hollis, Director
APPROVED BY: Bureau of Substance Abuse and Addiction Services

RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

JAMES K. HAVEMAN
DIRECTOR

MEMORANDUM

DATE: October 11, 2012

TO: Regional Substance Abuse Coordinating Agency Directors

FROM: Deborah J. Hollis, Director
Bureau of Substance Abuse and Addiction Services

SUBJECT: Technical Advisory on Peer Recovery Support Services

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Enclosed is Technical Advisory #07 *Peer Recovery Support Services.* Developed by a multi-disciplinary group of individuals from the substance use disorder service field as part of the ROSC transformation process, this document was distributed for review and comment on April 16, 2012. Comments were received from one coordinating agency and a peer from the same region; they focused on various components of language and descriptors used in the document. These comments were used to ensure that descriptors for affiliation support included faith-based recovery, that peer recovery associates could provide emotional support as part of their role, and that supervision for peers did not include any reference to it being "clinical" in nature.

Technical Advisory #07 *Peer Recovery Support Services* is now complete and has an effective date of September 1, 2012. It replaces the previous technical advisory of the same number, titled *Peer Recovery/Recovery Support Services*, which was released in March of 2008. This updated advisory addresses the development and use of peer delivered support services and does not address the general concept of recovery support services like the first version. This advisory provides direction for the training and establishment of two levels of peer delivered support services, the recovery coach and the recovery associate.

It should be noted that, although this advisory provides guidelines to the field with current information relative to the delivery of peer support services, changes in many areas may be required as behavioral health integration moves forward.

If you have any questions with regard to Technical Advisory #07, please contact Lisa Miller at MillerL12@michigan.gov or 517.241.1216.

TREATMENT TECHNICAL ADVISORY #07

SUBJECT: Peer Recovery Support Services

ISSUED: March 17, 2008, revised July 16, 2012

EFFECTIVE: September 1, 2012

PURPOSE:

The purpose of this technical advisory (TA) is to provide guidelines to the substance use disorder (SUD) field pertaining to the nature and structure of peer recovery support services and peer recovery support persons. The TA includes the type of position and perspective on potential kinds of responsibilities; and the identification of training and key elements to be within the training.

This TA will provide information on the nature of peer recovery support services (PRSS) for the state of Michigan's publically funded SUD service system. It further establishes the differences between the two types of peers who would function within the SUD service system, and potentially within other collaborative partner organizations. The TA presents information that will clarify the types of support services provided by trained peer recovery support personnel, as well as the level and nature of training needed to attain the skills and capacity to function effectively when providing PRSS. Additionally, this TA is intended to create a level of continuity within the state with regard to PRSS and the peers who provide these services.

This TA should be viewed as an initial step in formalizing PRSS for the SUD service system. It should be expected that, as integration moves forward within the behavioral health system, required training and education, the delivery of services, and even the titles of those providing services may change to be consistent with the needs of integration.

SCOPE:

This TA impacts PIHPs and the publically funded provider network.

BACKGROUND:

Peer recovery and recovery support services were added to the administrative rules for substance use disorders when the rules were revised in 2006. This revision recognized peer recovery and recovery supports as an expansion of the existing licensing categories that cover treatment and prevention services in Michigan. The Michigan Department of Health & Human Services, Office of Recovery Oriented Systems of Care (formerly the Office of Drug Control Policy) formed a workgroup in January 2007 for the

purpose of developing standards and implementation guidelines for the new licensing category: Peer Recovery/Recovery Supports.

This program category was intended to recognize and thereby permit the implementation of peer recovery support programs for persons with substance use disorders in Michigan. This licensing category was developed to allow programs to provide services to assist individuals in the process of recovery through program models such as using peers and other professionals in a community setting and providing a location and other supports for activities of the recovery community. Peer recovery and recovery support services are designed to include prevention strategies and support services to attain and maintain recovery and prevent relapse.

As a result of the recovery oriented system of care (ROSC) transformation in Michigan, as well as the evolution of peer support services and what they are perceived to be, BSAAS convened a second workgroup in late 2010 to review and amend the guidelines for Peer Recovery/Recovery Support Services. The content of this document was developed by the ROSC Transformation Steering Committee Peer-Based Recovery Support Workgroup, a group of individuals who work to assist people with their recovery process by utilizing a broad array of SUD services and supports. These individuals work in various capacities and within the numerous factions found in a ROSC. Throughout the development process, the group utilized sources of information from some of the best known experts, individuals, and organizations operating within federal and state domains, who are engaged in the development and implementation of a ROSC, specifically with regard to the provision of PRSS. Considerable thought, energy, and commitment contributed to this process, leading to the end goal of creating a sustainable tool to further the establishment by regulating and utilizing PRSS within a ROSC.

Terms and Definitions

The following terms and definitions are provided for understanding their application within the content of this document:

Peer - A person in a journey of recovery who identifies with an individual based on a shared background and life experience.

Peer Recovery Associate - The name given to individuals who assist the peer recovery coach by engaging in designated peer support activities. These persons have been provided an orientation and brief training in the functional aspect of their role by the entity that will utilize them to provide supports. These individuals are not trained to the same degree as the peer recovery coach.

Peer Recovery Coach - The name given to peers who have been specifically trained to provide advanced peer recovery support services in Michigan. A peer recovery coach works with individuals during their recovery journey by linking them to the community and its resources. They serve as a personal guide or mentor, helping the individual overcome personal and environmental obstacles.

Recovery Community - Persons having a history of alcohol and drug problems who are in or seeking recovery, including those currently in treatment; as well as family members, significant others, and other supporters and allies (SAMHSA, 2009b).

Recovery Support Services - Non-clinical services that assist individuals and families to recover from alcohol or drug problems. They include social support, linkage to, and coordination among, allied service providers, and a full-range of human services that facilitate recovery and wellness contributing to an improved quality of life. These services can be flexibly staged and may be provided prior to, during, and after treatment. RSS may be provided in conjunction with treatment, or as separate and distinct services, to individuals and families who desire and need them. Professionals, faith-based and community-based groups, and other RSS providers are key components of ROSC (SAMHSA, 2009b).

RECOMMENDATIONS:

Peer Recovery Support Services – Core Values

Within PRSS it is recognized that individuals in recovery, their families, and their community allies are critical resources that can effectively extend, enhance, and improve formal treatment services. PRSS are designed to assist individuals in achieving personally identified goals for their recovery by selecting and focusing on specific services, resources, and supports. These services are available within most communities employing a peer-driven, strength-based, and wellness-oriented approach that is grounded in the culture(s) of recovery and utilizes existing community resources.

PRSS emphasize strength, wellness, community-based delivery, and the provision of services by peers rather than SUD service professionals. As such, these services can be viewed as promoting self-efficacy, community connectedness, and quality of life, which are important factors to sustained recovery.

This TA recognizes five core values developed by the Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Substance Abuse Treatment (CSAT), and adds a sixth value:

- **Keeping recovery first** – Placing recovery at the center of the effort, grounding peer services in the strengths and inherent resiliency of recovery rather than in the pathology of substance use disorders.

- **Cultural diversity and inclusion** – Developing a recovery community peer support services program that honors different routes to recovery and has leaders and members from many groups at all levels within the organization.

- **Participatory process** – Making sure the recovery community directs, or is actively involved in, project design and implementation, so that recovery community members can identify their own strengths and needs, and design and deliver peer services that address them.

- **Authenticity of peers helping peers** – Drawing on the power of example, as well as the hope and motivation, that one person in recovery can offer to another; providing opportunities to give back to the community, and embracing the notion that both people in a relationship based on mutuality can be helped and empowered in the process.

- **Leadership development** – Building leadership abilities among members of the recovery community so that they are able to guide and direct the service program and deliver support services to their peers. (SAMHSA, 2009b)

- **Supporting integrated mental health and SUD services** – Assuring that individuals with co-occurring substance use and mental health disorders receive integrated healthcare.

Types of Peer Recovery Support Services

The CSAT Recovery Community Support Program's PRSS Projects have developed and piloted a variety of peer services. These pilots have concluded that not all programs can provide all services, and that some peer leaders can provide one or more services. The placement of peers varies from recovery centers, stand-alone peer programs, traditional treatment and prevention programs, and other sites that may include: hospitals, correctional programs/institutions, mental health programs/facilities, doctors' offices, veterans' services, and counseling services (for profit and non-profit). The location where peers provide services can also vary from community-based to office-based. Activities are targeted to individuals and families at all places along the path to recovery. This would include outreach to individuals who are still active in their disorder and or addiction, up to and including individuals who have been in recovery for several years.

PRSS can consist of a limitless array of services depending on the agency providing the services, the funding source for the services, the training of the peers within the agency, and the individual, family, or community being served. The different kinds of activities have been divided into four service categories: emotional support, informational support, instrumental support, and affiliational support (SAMHSA, 2009a). Table 1 identifies and describes the types of support and provides a brief number of examples for each support type.

Table 1-Type of Social Support and Associated Peer Recovery Support Services

Type of Support	Description	Peer Support Service Examples
Emotional	Demonstrate empathy, caring, or concern to bolster a person's self-esteem and confidence.	• Peer mentoring • Peer-led support groups
Informational	Share knowledge and information and/or provide life or vocational skills training.	• Parenting class • Job readiness training • Wellness seminar
Instrumental	Provide concrete assistance to help others accomplish tasks.	• Child care • Transportation • Help accessing community health and social services
Affiliational	Facilitate contacts with other people to promote learning of social and recreational skills, create community, and acquire a sense of belonging.	• Recovery centers • Sports league participation • Alcohol- and drug-free socialization opportunities • Faith-based

(SAMHSA, 2009b)

Using the four SAMHSA types of support as a basis, an enhanced list of broad-ranging activities that peers could provide has been compiled. Although this list is meant to be as thorough as possible, other activities may be identified. As long as these activities fit the definition of PRSS, as stated earlier in this document, they would be appropriate to add to this compilation. Table 2 provides the expanded compilation of activities by the earlier identified types of support.

Table 2 - Activities by Service Categories and Types of Support

type of Support	Service Category
Emotional	Listening to problems (identify resources to meet the need)
	Leading/mentoring/coaching
	Leading support groups
	Relating stories
	Offering hope
	Validating client experience
	Supporting self-assessment (identify where an individual is and where they want to go)
	Walking with the individual (find out the comfort level to complete a task or attend an event)
	Advocating
	Empowering

type of Support	Service Category
Informational	Peer-led resource connector programs Health and wellness classes and workshops Education and career planning classes and workshops Leadership development classes and workshops System navigation (assisting someone to work through the layers/regulations of a system to obtain services that are needed) One-on-one teaching Recovery plan development Personal (individual) development Problem-solving Pursuing education Life-skills classes, workshops, and trainings including: ➢ Dental ➢ Mental health ➢ Physical health ➢ Nutrition ➢ Legal Keep recovery first (the importance of working one's own recovery path needs to be of paramount importance) Various groups for instruction: ➢ Parenting ➢ 12-Step Literacy ➢ Navigating the 12-Steps ➢ Stress management ➢ Conflict resolution ➢ Trauma ➢ Job skills ➢ Social skills in recovery ➢ Others as needed

type of Support	Service Category
Instrumental	Direct instrumental services (connections to get a person's most basic needs met, i.e., food banks, clothing banks, housing/shelter) Make warm connections to services and referrals (making an in-person introduction or on-sight delivery to a site for needed services/support)
	Open doors for an individual (making face-to-face contact with a person or organization on behalf of the individual seeking assistance) Hands-on advocating (taking responsibility to take another's banner and push for them so that systems can bend or change to meet that person's needs) Navigate community resources (teaching individuals about the who, what, where, and why of community services, so that they understand where to turn, where to go and who to talk with) Follow up on referrals Outreach – recovery checkups Arrange regular (weekly, etc.) meetings with individuals
Affiliational	Alcohol- and other drug-free social/recreational activities Recovery centers Engagement centers Drop-in centers Recovery community connections Social/recreational activities Cultural activities – music, arts, theatre and poetry, picnics, networking, etc. Faith-based recovery supports

(SAMHSA, 2009b)

Michigan's Two Types of Peer Support Roles

Michigan will utilize two types of peer roles in the provision of PRSS. They are:

1) Peer Recovery Coach:

- Receives a specialized level of training around a specific variety of skill sets designed to support an enhanced level of interaction with the individuals with whom they work.
- Receives training most often outside of the given work environment.
- Operates and works effectively within any of the four types of support activities – emotional, informational, instrumental, and affiliational.

2) Peer Recovery Associate:
   - Receives a more generalized training typically provided by the entity in which they will ultimately work.
   - Provides the types of interactions designed to meet more immediate needs and facilitate access to generalized community services.
   - Operates typically within affiliational and instrumental types of activities, may include limited emotional support.

   As a recovery associate gains comfort working with peers, and strengthens their skill level regarding effective interaction and boundary identification, this individual may consider training to become a recovery coach.

Peers can be employed full- or part-time with an agency or volunteer to provide support services. All peer recovery associates, whether they are paid employees or volunteers, should have some basic training in order to assure the provision of quality services, and to assure that their activities "do no harm" to either themselves or the individuals being served. All peer recovery coaches will be required to participate in a designated peer recovery coach training.

Training Peer Recovery Coaches and Peer Recovery Associates

In order to provide services, a peer recovery coach or a peer recovery associate must meet certain qualifications based on experience and education. In Michigan, peer recovery associates must receive training appropriate to the tasks in which they will engage. Associates will be selected by the agencies in which they will provide support services. The nature of the services to be provided will directly influence the selection of the peers and the content of training that the peers will receive. The actual training and its content will be at the discretion of the hiring agency. However, there are minimum criteria that should be included in the training, such as:

- Gaining knowledge of community resources.
- Listening skills.
- Taking a non-judgmental stance (the ability to respond positively and provide assistance to an individual regardless of personal opinions, experiences, and choices).
- Understanding of confidentiality.
- Establishing boundaries.

- Possessing an attitude that there are many paths to recovery – none any better than another.

In order to be a peer recovery coach, individuals will need to complete a designated training. To accomplish the goal of training and preparing peer recovery coaches, a model curriculum, the Connecticut Community for Addiction Recovery (CCAR) Peer Recovery Coach Training course, has been identified. The CCAR training will provide individuals with the desired standard of preparedness to become a peer recovery coach and provide the tools necessary to perform the job. The CCAR training has a sound curriculum, good outcomes and high acclaim from the state of New York, Iowa, and Georgia, who all have been using the CCAR training and curriculum. Upon conclusion of this training, participants will receive a certificate indicating that they have successfully and satisfactorily completed the designated training and are qualified as a peer recovery coach to provide PRSS in Michigan. If the CCAR training is not utilized, the certifying program that is used must minimally include the same key focal elements found in the CCAR training.

To complete the entire scope of these elements, an average training would encompass 40 hours. The following elements from the CCAR training are to be incorporated into all peer recovery coach trainings:

- Comprehensive overview of the purpose and tasks of a recovery coach.
- Tools and resources useful in providing recovery support services.
- Skills needed to link people to needed supports within the community that promote recovery.
- Basic understanding of substance use and mental health disorders, crisis intervention, and how to respond in a crisis situation.
- Skills and tools for effective communication, motivational enhancement strategies, recovery action planning, cultural competency, and recovery ethics.
- Clarity regarding the fact that recovery coaches do not provide clinical services. They do, however, work with people experiencing difficult emotions and physical states.

The training must help the individual:

- Describe the roles and functions of a recovery coach.
- List the components of a recovery coach.
- Build skills to enhance relationships.
- Discuss co-occurring disorders and medication-assisted recovery.
- Describe stages of changes and their applications.
- Address ethical issues.
- Experience wellness planning.
- Practice newly acquired skills.

Training modules must include:

- How to create a safe environment.
- What recovery is (components of recovery, recovery core values, and guiding principles of recovery).
- Skills to enhance relationships.
- Listening and communication skills.
- Values and differences.
- Skills to address transference/countertransference.

- Skills to manage sexual harassment.
- Crisis intervention.
- Stigma and labels.
- How to tell your own stories.
- Issues of self-disclosure.
- Referral skills.
- Pathways to recovery.
- Stages of change.
- Motivational interviewing.
- Cultural competence.
- Privilege and power.
- Spirituality and religion.
- Resources and programs.
- Self-care.
- Boundary issues and respect.
- Recovery wellness planning.

Differences between a Peer Recovery Coach and a Peer Recovery Associate

There are significant differences within many facets of the training, preparation, and work provided by a peer recovery coach versus a peer recovery associate. The table below highlights some of the variants:

Peer Recovery Coaches	Peer Recovery Associates
Training	
Coaches are expected to complete 40 hours of CCAR training, or another like course as previously defined in this TA.	Associates are to receive a shorter training provided by the organization that will utilize their assistance on more basic elements of service and interaction (see page 9 for list of potential training elements).
Length of Time in Recovery	
An individual who is a peer coach should have two to four years of stable recovery.	An associate position could be offered to someone with a minimum of six months in recovery. Due to being in early recovery, the individual should be actively working their own recovery process and have an established support system outside of this role.
Level of Autonomy	
A coach may engage in solo outreach efforts and client interaction.	An associate will receive oversight by a recovery coach or supervisor.

Peer Recovery Coaches	Peer Recovery Associates
Breadth of Experience/Skill Level	
A coach is expected to have a much wider variety of skills and knowledge base.	The associate may be very specific to a particular task within the agency – example: follow-up calls.
Long Term Expectations	
Coaches may view their position as a paraprofessional with or without aspirations of continuing on with a degree(s).	Associate may or may not have further expectations. It may be their desire to "give back" to the recovery community.
Supervision Needs	
A recovery coach will have weekly (or more) supervision.	An associate may not need the same extent of "supervision" due to their limited role/responsibility.

Additional similarities/overlaps which may exist between a peer recovery coach and peer recovery associate include:

- Knowledge of community resources (resource broker).
- Position may be paid or unpaid.
- Expectation of recovery background.
- Leadership of peer-run groups.
- Engagement in tasks: referring, linking, educating.
- Importance of honoring that there are many pathways to recovery.

Unique Challenges to Peer Recovery Coaches and Associates

Peers, because they are in recovery, may face a unique challenge that many in the SUD service workforce do not. Due to the nature of this work, peers may be placed into situations, while they are providing services, where they might encounter others from their past who were their "using friends" or "dealers." Hence, it is important to understand how to act in situations when these negative encounters occur. Therefore, support for a peer who has a need because of these encounters should be available. Support can come from the supervisor, another more experienced peer, or other agency staff with whom the peer feels comfortable enough to discuss the issues.

The same is to be said for peer recovery coaches and associates with regard to the issue of relapse. It is well-known that addiction is a relapsing, chronic brain disease. Agencies that utilize peers, whether they are paid or unpaid, are therefore urged to recognize the nature of addiction and develop a non-punitive

policy in response to peer relapse. As a part of this advisory, the agency is further encouraged to work with the peer to develop a recovery re-engagement plan to facilitate the peer's return to recovery.

Supervision of Peer Recovery Staff

The employment of peers as recovery coaches and recovery associates will place additional responsibilities on agencies and their staff. There are several factors that must be considered to allow and support peers to function in their jobs. Supervision is as important for peers as it is for clinicians. Peers need the support and expertise a supervisor gives to be effective as a coach or an associate.

Peer recovery staff needs to be respected as equal members of an agency's staff. They are as much a part of an agency/organization as are support, clinical, and executive staff. Intentional and purposeful acknowledgement, role delineation, and supervision are critical to the blending of roles, rules, and regulations among staff. Peers come with a unique amount of knowledge and personal experience in addictions and other co-occurring disorders. This experience makes them a valuable part of the organization. It is important for management to orient existing staff to the roles that peers will have within the agency. This will prevent or reduce misunderstandings for all staff. A resource that is helpful in this regard is a document entitled, *Manual for Recovery Coaching and Personal Recovery Plan Developmen*t by David Loveland, Ph.D. and Michael Boyle, MA (2005).

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APPROVED BY: Deborah J. Hollis, Director
Bureau of Substance Abuse and Addiction Services

STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

RICK SNYDER
GOVERNOR

OLGA DAZZO
DIRECTOR

MEMORANDUM

DATE: January 20, 2012

TO: Regional Substance Abuse Coordinating Agency Directors
Michigan Association of Substance Abuse Coordinating Agencies President
Association of Licensed Substance Abuse Organizations President
Salvation Army Harbor Light Director

FROM: Deborah [illegible]his, Director
Bureau of Substance Abuse and Addiction Services

SUBJECT: Technical Advisory for Enhanced Women's Services Expectations

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Attached is the final version of Technical Advisory #08 – Enhanced Women's Services, which will go into effect on January 31, 2012.

A draft of this technical advisory (TA) was submitted to the coordinating agencies, Michigan Association for Substance Abuse Coordinating Agencies, Association of Licensed Substance Abuse Organizations, and Salvation Army Harbor Light on October 11, 2011, for a 30-day response period. Comments were received from network180, Lakeshore Coordinating Council and Kalamazoo Community Mental Health and Substance Abuse Services, and incorporated into the final document.

This TA focuses on establishing guidelines for enhanced women's services, as an adjunct to designated women's programs. Also attached are the reporting requirements for Enhanced Women's Services programming and instructions for the report. The report is in addition to current reporting requirements for designated women's programs. Because this is a new service opportunity, special care was taken to ensure that enhanced women's services operate the same across the state.

Should you have any questions or need further clarification on any issues in this advisory, please contact Angie Smith-Butterwick at smitha8@michigan.gov, or (517) 373-7898.

Attachments

DJH:ssb

c: Felix Sharpe

TREATMENT TECHNICAL ADVISORY #08

SUBJECT: Enhanced Women's Services

ISSUED: January 31, 2012

PURPOSE:

The purpose of this advisory is to provide guidance to the field on developing an intensive case management program for PIHPs and their designated women's programs. It is designed to incorporate long-term case management and advocacy programming for pregnant, and up to twelve months post-partum, women with dependent children who retain parental rights to their children.

SCOPE:

This advisory impacts the PIHP and its designated women's programs provider network.

BACKGROUND:

In 2008, the Michigan Department of Health & Human Services, Office of Recovery Oriented Systems of Care (OROSC) was awarded a four-year grant from the Center for Substance Abuse Prevention (CSAP) to implement the Parent-Child Assistance Program (PCAP), an evidence-based program developed at the University of Washington. PCAP is a three year case management/advocacy program targeted at high-risk mothers, who abuse alcohol and drugs during pregnancy, and their children. The eligiblity criteria for PCAP participation is women who are pregnant or up to six-months postpartum, have abused alcohol and/or drugs during the pregnancy, and are ineffectively engaged with community service providers.

Traditional case management services offered through designated women's programs tend to be for the duration of the woman's treatment episode and only office-based interventions. These interventions are frequently performed by the assigned clinician, and involve linking and referring the client to the next level of care or other supportive services that are needed. Enhanced Women's Services are designed to encourage providers to take case management to the next level for designated women's providers. This is a long-term case management and advocacy program, and outcomes such as increased retention, decreased use, increased family planning, and a decrease in unplanned pregnancies have shown that the extended support time and commitment to keeping women involved serves this population well.

The PCAP model shares the same theoretical basis, relational theory, as women's specialty services. Relational theory emphasizes the importance of positive interpersonal relationships in women's growth, development and definition of self, and in their addiction, treatment and recovery. It is the relationship between the woman and the advocate that is the most important

aspect of PCAP. The PCAP model uses both the Stages of Change model and motivational interviewing when working with individuals. The stage of change that the woman is at for each of the identified problem areas of her life is taken into consideration when developing the plan of service. The case manager/advocate uses motivational interviewing techniques to help the woman move along the path toward meeting her goals.

In September 2009, BSAAS embarked on a recovery oriented system of care (ROSC) transformational change initiative. This initiative changes the values and philosophy of the existing service delivery system from an acute crisis orientation to a long term stable recovery orientation. As part of this work, a set of guiding principles has been developed to describe the values and elements that Michigan wants this new system to have. The PCAP model, with its peer focus and strategies that include treatment, prevention, and recovery services delivered in a community-based setting, demonstrates the critical components of a ROSC. The long-term support gives clients a stable basis for a future healthy lifestyle without the need to use or abuse alcohol and drugs. PCAP also fits into identified practices in the ROSC transformation process, including peer-based recovery support services, strengthening the relationship with community, promoting health and wellness, expanding focus of services and support, using appropriate dose/duration of services, and increasing post-treatment checkups and support.

As part of sustaining evidence-based practices and core components of the PCAP model, and in response to interest in the program by current non-PCAP funded PIHPs, this technical advisory has been developed to provide guidance on implementing enhanced women's services in the state. This technical advisory identifies core components of PCAP needed for implementation of enhanced women's services, and should be considered as a supplement to the OROSC Women's Treatment Policy (OROSC Treatment Policy #12). In addition, implementation of these services can also serve as evidence of ROSC transformation.

Definitions

Case Management – a substance use disorder program that coordinates, plans, provides, evaluates, and monitors services of recovery, from a variety of sources, 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 the individualized treatment planning process.

Community Based – the provision of services outside of an office setting. Typically these services are provided in a client's home or in other venues, including while providing transportation to and from other appointments.

Core Components – those elements of an evidence-based program that are integral and essential to assure fidelity to a project, and that must be provided.

Crisis Intervention – a service for the purpose of addressing problems/issues that may arise during treatment and could result in the client requiring a higher level of care if intervention is not provided.

Face-to-Face – this interaction not only includes in-person contact, it may also include real-time video and audio linkage between a client and providers, as long as this service is provided within the established confidentiality standards for substance use disorder services.

Fetal Alcohol Spectrum Disorders (FASD) – an umbrella term describing the range of effects that can occur in an individual whose mother drank during pregnancy. These effects may include physical, mental, behavioral, and/or learning disabilities with possible lifelong implications. The term FASD is not intended for use as a clinical diagnosis. It refers to conditions such as fetal alcohol syndrome (FAS), fetal alcohol effects (FAE), alcohol-related neurodevelopment disorder (ARND), and alcohol-related birth defects (ARBD).

Individual Assessment – a face-to-face service for the purpose of identifying functional and treatment needs, and to formulate the basis for the Individualized Treatment Plan to be implemented by the provider.

Individual Treatment Planning – direct and active client involvement in establishing the goals and expectations for treatment to ensure the appropriateness of the current level of care, to ensure true and realistic needs are being addressed and to increase the client's motivation to participate in treatment. Treatment planning requires an understanding that each client is unique and each treatment plan must be developed based on the individual needs, goals, desires, and strengths of each client and be specific to the diagnostic impression and assessment.

Peer – an individual who has shared similar experiences of parenthood, addiction, or recovery.

Peer Advocate (for Enhanced Women's Services) – an individual with similar life experience who provides support to a client in accessing services in a community.

Peer Support – individuals who have shared experiences of addiction and recovery, and offer support and guidance to one another.

Recovery – a highly individualized journey of healing and transformation where the person gains control over his/her life. It involves the development of new meaning and purpose, growing beyond the impact of addiction or a diagnosis. This journey may include the pursuit of spiritual, emotional, mental, and physical well-being.

Recovery Planning – process that highlight's and organizes a person's goals, strengths and capacities to determine the barriers to be removed or problems to be resolved in order to help people achieve their goals. This should include an asset and strength-based assessment of the client.

Substance Use Disorder – a term inclusive of substance abuse and dependence, which also encompasses problematic use of substances.

RECOMMENDATIONS:

Components Required for Enhanced Women's Services Programming

1. Any Designated Women's Program is eligible to offer Enhanced Women's Services to the target population. Programs choosing to develop an Enhanced Women's Services program will be required to follow the guidelines of the Women's Treatment Policy (OROSC Treatment Policy #12), as well as those outlined in this technical advisory.

2. The Enhanced Women's Services model will use a three-pronged approach to target the areas where women have problems that directly impact the likelihood of future alcohol or drug-exposed births:
   - The first is to eliminate or reduce the use of alcohol or drugs. Individuals who are involved with Enhanced Women's Services are connected with the full continuum of substance use disorder services to help the woman and her children with substance use and abuse.
   - The second is to promote the effective use of contraceptive methods. If a woman is in control of when she becomes pregnant, there is a higher likelihood that the birth will be alcohol and drug-free. Referrals for family planning, connecting with a primary care physician, and appropriate use of family planning methods are all considered interventions for this aspect of programming.
   - The third is to teach the woman how to effectively use community-based service providers, including accessing primary and behavioral health care. The peer advocate teaches women how to look for resources and get through the formalities of agencies in order to access needed services, and how to effectively use the services.

3. Peer advocates in Enhanced Women's Services must be peers, to the extent that they are also mothers and may have experienced similar circumstances as their potential clients. They do not need to have a substance use disorder (SUD), or be in recovery from a SUD. Agencies should also follow their cultural competency plan for hiring peer advocates. The peer advocate must meet current state training or certification requirements applicable to their position. An additional list of training requirements is provided later in this document.

4. One of the core components of Enhanced Women's Services is transportation. The program requires that peer advocates be community-based and provide reasonable transportation services for their enrolled clients to relevant appointments and services. Beyond the transportation assistance that this provides to the woman, this has proven to be an excellent time to exchange information.

5. A second core component is the persistence with which the peer advocates stay in touch with their clients. A woman is not discharged from Enhanced Women's Services because she has not been in contact with her peer advocate for a month or more. It is expected that the peer

advocate will actively look for clients when they have unexpectedly moved, and will utilize emergency contacts provided by the client to re-engage her in services.

Enrollment Criteria

Any woman who is pregnant, or up to twelve months post-partum with dependent children, is eligible for participation in Enhanced Women's Services. This includes women who are involved with child welfare services and are attempting to regain custody of their children. If a woman enrolled in Enhanced Women's Services permanently loses custody of her children, and is not currently pregnant, she must be transferred to other support services, as she is no longer eligible for women's specialty services.

As identified in the Individualized Treatment Policy (OROSC Treatment Policy #06), treatment must be individualized based on a biopsychosocial assessment, diagnostic impression and client characteristics that include, but are not limited to age, gender, culture, and development. As a client's needs change, the frequency, and/or duration of services may be increased or decreased as medically necessary. Client participation in referral and continuing care planning must occur prior to a move to another level of care for continued treatment.

Service Requirements

In addition to the services provided through Women's Specialty Services, the following are requirements of Enhanced Women's Services:

1. Maintain engaged and consistent contact for at least 18 to 24 months in a home visitation/community based services model, expandable up to three years.
2. Provide supervision twice monthly.
3. Require maximum case load of 15 per peer advocate.
4. Continue services despite relapse or setbacks, with consideration to increasing services during this time.
5. Initiate active efforts to engage clients who are "lost" or drop out of the program, and efforts made to re-engage the client in services.
6. Coordinate service plan with extended family and other providers in the client's life.
7. Coordinate primary and behavioral health.
8. Utilize motivational interviewing and stages of change model tools and techniques to help clients define and evaluate personal goals every three months.
9. Provide services from a strength-based, relational theory perspective.
10. Link and refer clients to appropriate community services for clients and dependent children as needed, including schools.
11. Continue to offer services to a woman and her children no matter the custody situation, as long as mother is attempting to regain custody.
12. Provide community-based services; these are services that do not take place in an office setting.
13. Provide transportation assistance through peer advocates, including empowering clients to access local transportation and finding permanent solutions to transportation challenges.

Peer advocates' billable time for transporting clients to and from relevant appointments is allowable and encouraged.

14. Develop referral agreement with community agency to provide family planning options and instruction.
15. Screen children of appropriate age using the Fetal Alcohol Syndrome (FAS) Pre-screen form attached to the Fetal Alcohol Spectrum Disorders Policy (OROSC Treatment Policy #11).
16. Identify clients in Enhanced Women's Services programming with the "HD" modifier.

Education/Training of Peer Advocates:

Individuals working and providing direct services for Enhanced Women's Services must complete training on the following topics within three months of hire:

- Fundamentals of Addiction and Recovery*
- Ethics (6 hours)
- Motivational Interviewing (6 hours)
- Individualized Treatment and Recovery Planning (6 hours)
- Personal Safety, including home visitor training (4 hours)
- Client Safety, including domestic violence (2 hours)
- Advocacy, including working effectively with the legal system (2 hours)
- Maintaining Appropriate Relationships (2 hours)
- Confidentiality (2 hours)
- Recipient Rights (2 hours, available online)
  *Could be accomplished by successful completion of the MAFE if no other opportunity is available.

In addition, the following training must also be completed within the first year of employment:

- Relational Treatment Model (6 hours)
- Cultural Competence (2 hours)
- Women and Addiction (3 hours)
- FASD (including adult FASD) (6 hours)
- Trauma and Trauma Informed Services (6 hours)
- Gender Specific Services (3 hours)
- Child Development (3 hours)
- Parenting (3 hours)
- Communicable Disease (2 hours, available online)

Peer advocates must complete the above trainings as indicated. Any training provided by domestic violence agencies, the Michigan Department of Health & Human Services, or child abuse prevention agencies would be appropriate. If these trainings are not completed within the one-year time frame, the peer advocate would not be eligible to continue in the position until the requirements are met. Until training is completed, peer advocates must be supervised by another

individual who meets the training requirements and is working within the program. Documentation is required and must be kept in personnel files. Other arrangements can be approved by the OROSC Women's Treatment Coordinator. These hours are an approximation only, and based on P-CAP requirements and consideration of the needs of Michigan's population.

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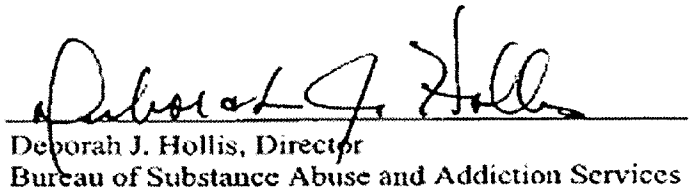

Deborah J. Hollis, Director
APPROVED BY: Bureau of Substance Abuse and Addiction Services

RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

OLGA DAZZO
DIRECTOR

MEMORANDUM

DATE: November 23, 2011

TO: Regional Substance Abuse Coordinating Agency Directors
Michigan Association of Substance Abuse Coordinating Agencies President
Association of Licensed Substance Abuse Organizations President
Salvation Army Harbor Light Director

FROM: Deborah J. Hollis, Director
Bureau of Substance Abuse and Addiction Services

SUBJECT: Technical Advisory for Early Intervention Expectations

Attached is the final version of Technical Advisory #09 – *Early Intervention*, which will go into effect on November 30, 2011.

The draft technical advisory (TA) #09 was submitted to the coordinating agencies (CAs), Michigan Association for Substance Abuse Coordinating Agencies, Association of Licensed Substance Abuse Organizations, residential providers, and the Salvation Army Harbor Light on April 13, 2011, for a 90-day response period. Comments were received from Macomb County Community Mental Health, and Oakland Substance Abuse Services, and incorporated into the final document.

This TA focuses on establishing minimal guidelines for early intervention treatment services, while keeping traditional prevention services intact. Because this is a new service category, special care was taken to allow enough variability so that CAs could tailor their early intervention programming to best meet the needs of their region.

Should you have any questions or need further clarification on any issues in this advisory, please contact Angie Smith-Butterwick at smitha8@michigan.gov, or (517) 373-7898.

Attachment

DJH:ssb

c: Felix Sharpe

TREATMENT TECHNICAL ADVISORY #09

SUBJECT: Early Intervention

ISSUED: November 30, 2011

PURPOSE:

The purpose of this advisory is to establish the process and expectations for Level 0.5 of the *American Society of Addiction Medicine's Patient Placement Criteria, 2nd Edition-Revised (ASAM PPC-2R)* in substance use disorder treatment.

SCOPE:

This advisory impacts all substance abuse PIHPs and their providers who offer substance use disorder (SUD) services.

BACKGROUND:

Substance abuse treatment early intervention programs are effective with clients who are considered risky users, those experiencing mild or moderate problems, as well as those who are experiencing some of the symptoms of abuse or dependence (DHHS CSAP, 2002). Early intervention services would also be appropriate for those individuals who are considered to be in the pre-contemplative stage of change.

Treatment and prevention service providers may offer early intervention services to clients who, for a known reason, are at risk for developing alcohol or other drug abuse or dependence, but for whom there is not yet sufficient information to document alcohol or other drug abuse or dependence. Those staff providing early intervention services must be supervised by appropriately credentialed staff. The goals of early intervention include:

- Increasing protective factors that promote a reduction in substance use.
- Improving a client's readiness to change.
- Preparing clients for the next level of treatment.
- Integrating new skills into clients' lives on a daily basis.

The Center for Substance Abuse Treatment's (CSAT) *Treatment Improvement Protocol (TIP) 35* (DHHS CSAT, 1999b), indicates providers can be helpful at any time in the change process by accurately assessing the client's readiness to change by utilizing the appropriate motivational strategies to assist their move to the next level. Clients already engaged in more intensive services (outpatient [OP], intensive outpatient [IOP], residential) should not receive early intervention services. However, clients who are at the level of contemplation that makes them appropriate for treatment may receive early intervention services as an interim service.

A workgroup was convened to determine standards for early intervention treatment. The workgroup was comprised of representatives from PIHPs, providers and the Office of Recovery Oriented Systems of Care.

Revisions to the *Substance Abuse Administrative Rules* have designated early intervention as a "substance abuse treatment service category." The Michigan Administrative Code, R325.14102(a)(1), defines early intervention as a specifically focused treatment program, including stage-based intervention for individuals with substance use disorders as identified through a screening or assessment process, and individuals who may not meet the threshold of abuse or dependence.

ASAM PPC-2R defines early intervention as "services that explore and address any problems or risk factors that appear to be related to the use of alcohol and other drugs and that help the individual to recognize the harmful consequences of inappropriate use. Such individuals may not appear to meet the diagnostic criteria for a substance use disorder, but require early intervention for education and further assessment," (Mee-Lee et. al., 2001). Ideally, early intervention services in Michigan will follow *ASAM PPC-2R* criteria while staying within the guidelines of the administrative rules.

It is important to note that, while this is a new service category for the treatment field, the prevention field has been providing this type of service for some time. "Prevention" refers to this level of service as 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). Individuals eligible for PIR services are identified as having indulged in illegal or age inappropriate use of tobacco, alcohol and/or illicit drugs. These individuals are screened to determine if their behavior can be reversed through education. Designed to increase and enhance protective factors that reduce and prevent SUDs, the assessment for, and the implementation of PIR services, may be population-based or focused on the individual. These potential participants of PIR services do not meet the threshold for substance abuse or dependence, and no diagnosis is made. PIR services include, but are not limited to, interventions such as, employee assistance programs, and student assistance and education programs targeting persons charged with driving under the influence (DUI), or driving while intoxicated. The Institute of Medicine's "Continuum of Care" model (Institutes of Medicine, 1994), classifies prevention interventions based on their target populations. For example, PIR interventions targeting individuals using substances, but not diagnosed with a substance use disorder, would be classified as "case identification" services, also described as "early intervention."

Early intervention as a treatment service provides an intervention that is appropriate for the individual and their stage of change, as well as access to clinical services. Clients are screened on an individual level only, and a diagnosis is required, at least on a provisional basis. Intervention plans, or at minimum a participation goal, are developed for this level of service. Participants are not required to meet abuse or dependence thresholds for early intervention services.

DEFINITIONS:

- **Community Group Activist/Recovery or Other Volunteer:** Not recognized as a credential category; responsibilities determine credentialing requirement.
- **Intervention Plan:** A minimal plan that sets forth the goals, expectations, and implementation procedures for an intervention. Specific activities that intend to change the knowledge, attitudes, beliefs, behaviors, or practices of individuals.
- **Prevention Professional:** An individual who has licensure as identified in the *Credentialing and Staff Qualifications* portion of the Michigan Department of Health & Human Services (MDHHS) CA contract, **AND** is working within his or her licensure-specified scope of practice, or an individual who

has an approved certification. These individuals have responsibility for implementing a range of prevention plans, programs and services.

- **Specially Focused Staff:** Individuals responsible for carrying out specific activities relative to treatment programs and are not responsible for clinical activities. May include case managers or AMS staff. Staff works under the direction of specialists or supervisors. Certification is not required, although appropriate licensure may be required depending on the scope of practice.
- **Stages of Change:**
  - **Pre-contemplation:** clients are not considering change at this stage, and do not intend to change behaviors in the foreseeable future.
  - **Contemplation:** clients have become aware that a problem exists, may recognize that they should be concerned about their behavior, but are typically ambivalent about their use, and changing their behavior.
  - **Preparation:** clients understand that the negative consequences of continued substance use outweigh any perceived benefits and begin specific planning for change. They may begin to set goals for themselves, and make a commitment to stop using.
  - **Action:** clients choose a strategy for change and actively pursue it. This may involve drastic lifestyle changes and significant challenges for the client.
  - **Maintenance:** clients work to sustain sobriety and prevent relapse. They become aware of situations that will trigger their use of substances and actively avoid those when possible.
- **Substance Abuse Treatment Specialist (SATS):** An individual who has licensure as identified in the *Credentialing and Staff Qualifications* portion of the MDHHS PIHP contract, **AND** is working within his or her licensure-specified scope of practice, **OR** an individual who has an approved certification. These are clinical staff providing substance use disorder treatment and counseling, and are responsible for the provision of treatment programs and services.*
- **Substance Abuse Treatment Practitioner (SATP):** An individual who has a registered Michigan Certification Board for Addiction Professionals (MCBAP) certification development plan, that is timely in its implementation, **AND** is supervised by an individual with a Certified Clinical Supervisor credential through MCBAP or a registered development plan to obtain the supervisory credential, while completing the requirements of the plan (6000 hours).*

  **** The above definitions can be found in the SUD Services Policy Manual included in the MDHHS PIHP contract agreement. Please refer to the contract agreement for a full description of the credentialing requirements.***

RECOMMENDATIONS:

Clients who are appropriate for this level of treatment, at the very least, shall meet the criteria in the current edition of the *ASAM PPC-2R*, for level 0.5 or its equivalent. The criteria are as follows:

- The individual who is appropriate for level 0.5 services shows evidence of problems and risk factors that appear to be related to substance use, but do not meet the diagnostic criteria for a Substance-Related Disorder, as defined in the current Diagnostic and Statistical Manual (DSM).
- Dimensions 1, 2, and 3: concerns are stable or being addressed through appropriate services.

- Dimensions 4, 5, and 6: one of the following specifications in these dimensions must be met.
  - Dimension 4: the individual expresses a willingness to gain an understanding of how his/her current alcohol or drug use may be harmful or impair the ability to meet responsibilities and achieve goals.
  - Dimension 5: the individual does not understand the need to alter his/her current pattern of use, *or* the individual needs to acquire the specific skills needed to change his/her current pattern of use.
  - Dimension 6: the individual's social support system consists of others whose substance use patterns prevent them from meeting responsibilities or achieving goals, or the individual's family members are abusing substances which increases the individual's risk for a substance use disorder, or the individual's significant other holds values regarding substance use that create a conflict for the individual, or the individual's significant other condones or encourages inappropriate use of substances.

Services should be focused on meeting the client where they are within the stages of change. Some clients may be appropriate for a higher level of care, but uncomfortable engaging in formal treatment, or at a stage of change that may not significantly benefit from formal treatment services. In this instance, early intervention services would be allowable. Clients may be screened through the local Access Management System (AMS) and, if appropriate, referred for early intervention services at the provider of their choice. However, clients may also be screened through the early intervention program, as determined by the appropriate coordinating agency. Treatment providers will perform, at minimum, a screening to determine appropriate services for the client, as well as to measure future progress. The treatment provider and the client will then establish goals to achieve during the course of treatment/intervention. Clients may then be offered an appropriate intervention, based on their established goals. Some clients will require referral for further assessment or to another level of treatment due to emerging concerns.

Early intervention services should be time-limited and short-term, and may be used as a stepping-stone to the next level for those clients who need it. Early intervention may also be used as an interim service, while an individual waits for their assessed level of care to become available.

Allowable Services in Early Intervention

- **Group:** Prevention and/or treatment occurring in a setting of multiple persons with similar concerns/situations gathered together with an appropriately credentialed staff that is intended to produce prevention of, healing or recovery from, substance abuse and misuse. Group models used in early intervention prevention and treatment are not intended to be psychotherapeutic or limited, and may include:
  - **Educational groups**, which educate clients about substance abuse.
  - **Skill development groups**, which teach skills needed to attain and sustain recovery, for example: relapse triggers and tools to sustain recovery.
  - **Support groups**, which support members and provide a forum to share information about engaging in treatment, maintaining abstinence and managing recovery. These may be managed by peers or credentialed staff.
  - **Interpersonal process groups**, which look at major developmental issues that contribute to addiction or interfere with recovery.
- **Individual:** One-on-one education and/or counseling between a provider and the client.

- **Alcohol and Drug Education:** May occur in a group setting as outlined above (educational groups), or may be used as independent study, with the provider giving "assignments" to be discussed at the next session.

- **Referral/Linking/Coordination of Services:** Office-based service activity performed by the primary service provider to address needs identified, and/or to ensure follow-through with outside services/community resources, and/or to establish the client with other substance use disorder services.

Please note that the above services are offered in many treatment settings, and may be utilized for those clients seeking early intervention services. However, in order to be billed as an early intervention service, a program must have a license for early intervention.

Clients may engage in more than one of the above interventions at a time, based upon individual need. If it becomes evident that a client is in need of a higher level of care, arrangements should be made to transfer that client into the appropriate level of service. Also to be taken into consideration at that point, is the client's readiness to change and willingness to engage in treatment.

The transferring of clients between treatment providers and counselors often results in client dropout. Thus, what is frequently termed a "warm hand-off," connecting the client with the new provider/therapist directly by way of a three-way call or other appropriate communication, is preferred when transitioning clients.

Eligibility

Prevention: Persons identified and assessed as having indulged in illegal or age inappropriate use of tobacco, alcohol and/or illicit drugs that do not meet the threshold for substance abuse or dependence, and for whom no diagnosis is made; i.e., college or military substance abuse; alcohol, tobacco, and illicit drug–impaired driving; children of alcoholics; children of substance abusing parents; Fetal Alcohol Spectrum Disorder; and HIV/AIDs.

Treatment: As previously noted, clients seeking this level of care, must meet, at a minimum, Level 0.5 of the *ASAM PPC-2R*, and be experiencing some problems and/or consequences associated with their substance use. For example, those who are seeking services related to a first time DUI charge would not be eligible without also meeting ASAM criteria. Clients already engaged in more intensive services, or at a level of contemplation that makes them appropriate for treatment, should not receive early intervention services. However, those clients waiting for treatment services may access early intervention as an interim service.

Funding

Funding for early intervention services comes from treatment and prevention. However, early intervention services performed or provided within a prevention program shall not be funded with Community Grant dollars. The Healthcare Common Procedure Coding System for early intervention services provided with treatment funding is *H0022*, which encompasses many of the allowable services. The Medicaid Provider Manual lists early intervention as an allowable service (12.1.B, 2011).

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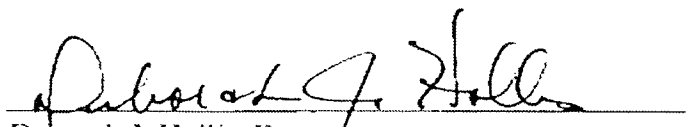
APPROVED BY:



Deborah J. Hollis, Director
Bureau of Substance Abuse and Addiction Services

TREATMENT TECHNICAL ADVISORY #11

SUBJECT: Recovery Housing

ISSUED: July 31, 2015

EFFECTIVE: October 1, 2015

PURPOSE:

The purpose of this advisory is to provide guidance to the field on developing and supporting recovery housing for *Prepaid Inpatient Health Plans (PIHPs)* and interested programs.

SCOPE:

This advisory impacts *PIHPs* and their provider network.

BACKGROUND:

The Michigan Department of Health and Human Services, Office of Recovery Oriented Systems of Care (OROSC) began researching opportunities for recovery housing in late 2011. A request was sent to all states and several of the former coordinating agencies, for information regarding their recovery housing standards and structures. In addition, the *National Association of Recovery Residences' (NARR)* standards were reviewed. Many states endorsed the *Oxford House* model, while others had a combination of housing options available for their recovery population. States that have been awarded *Access to Recovery Grants* had developed extensive standards to monitor recovery housing and funding that went along with it.

Clarification regarding using *Substance Abuse Block Grant (SABG)* funds for recovery housing was sought from the *Center for Substance Abuse Treatment*. *SABG* funds may not be used to fund an individual's lodging in recovery housing. However, *SABG* funding can be used in conjunction with a treatment service category to provide room and board for any individual, to the extent that it is integral to the treatment process. In addition, the *SABG* set aside for pregnant and parenting women does allow payment to provide housing eligible women. Recovery Housing for the pregnant and parenting population will ideally be offered through a designated program to ensure that all of their needs are met.

Definitions

OROSC has defined "recovery housing" as follows:

> *Recovery housing provides a location where individuals in early recovery from a behavioral health disorder are given the 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. (Excerpt from the proposed *Substance Use Disorder Benefit Package* for the state of Michigan).

RECOMMENDATIONS:

From the review of standards available nationally, OROSC determined that there were certain aspects of the establishment and maintenance of recovery housing that was necessary for success. They are as follows:

- Maintain an alcohol-and illicit-drug-free environment.
- Maintain a safe, structured, and supportive environment.
- Set clear rules, policies, and procedures for the house and participating residents.
- Establish an application and screening process for potential residents.
- Endeavor to be good neighbors and get residents involved in their community.

Recovery Housing Standards

After careful consideration of the options available, OROSC has come to the determination that the levels of recovery housing and standards identified by *NARR* most closely fit the vision of recovery housing for Michigan. The levels are as follows:

- **Level I - Peer Run** – staff positions within the residence are not paid; setting is generally single family residences; services include drug screenings and house meetings; and residence is democratically run with policies and procedures.
- **Level II - Monitored** – staff consists of at least one compensated position within the house; setting is primarily single family residences, potentially apartments or other types of dwellings; services include house rules, peer run groups, drug screens, and house meetings; and residence is administered by house manager with policies and procedures.
- **Level III - Supervised** – staff includes a facility manger, certified staff or case manager(s); setting is all types of residential; services include clinical services accessed in the community, service hours within the house, and in-house life skill development; and residence has administrative oversight with policies and procedures.
- **Level IV - Service Provider** – staff are credentialed; setting is all types of residential, often a step down phase within care continuum of a treatment center; services include in-house clinical services and life skill development; and residence has clinical and administrative supervision with policies and procedures.

The following are samples of the standards identified by *NARR*; they are representative of the interests and activities that OROSC supports. Recovery residences must:

- Identify clearly the responsible person(s) in charge of the recovery residence to all residents.
- Collect and report an accurate process and outcome data for continuous quality improvement.
- Maintain an accounting system that fully documents all resident's financial transactions, such as, fees, payments, and deposits.

- Use an applicant screening process that helps maintain a safe and supportive environment for a specific group of persons in recovery.
- Foster mutually supportive and recovery-oriented relationships between residents and staff through peer-based interactions, house meetings, community gatherings, recreational events, and other social activities.
- Encourage each resident to develop and participate in his/her own personalized recovery plan.
- Provide non-clinical, recovery support and related services.
- Encourage residents to attend mutually supportive, self-help groups, and/or outside professional services.
- Maintain the interior and exterior of the property in a functional, safe, and clean manor that is compatible with the neighborhood.
- Provide rules regarding noise, smoking, loitering, and parking that are responsive to a neighbor's reasonable complaints.

The full *NARR* standards can be found at http://narronline.org/wp-content/uploads/2013/09/NARR-Standards-20110920.pdf

In addition to the standards developed by *NARR*, recovery residences should maintain a prevention license through the Michigan Department of Licensing and Regulatory Affairs. This will help ensure a minimum level of housing standards throughout the state.

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APPROVED BY:

Deborah J. Hollis, Director
Bureau of Substance Abuse and Addiction Services

VI. TREATMENT REQUIREMENTS

Treatment
Policy #02
Acupuncture
—
Effective May 1, 1994; Reissued March 2007

Treatment
Policy #06

Individualized Treatment and Recovery Planning—
Effective April 2, 2012

Treatment Policy
#07 Access Management
System— Effective
November 1, 2006 has
been replaced by
contract attachment
P4.1.1 Access
Management System
Amendment #1

Treatment Policy #08

Substance Abuse Case Management Program
Requirements—

Effective January 1, 2008

Treatment Policy #09

Outpatient Treatment Continuum of Services
Effective January 1, 2017

Treatment Policy #10

Residential
Treatment
Continuum
of Services

Effective
Jan. 16, 2017

Treatment Policy #12
Women's Treatment
Effective October 1, 2010

MEMORANDUM

DATE: October 19, 2012

TO: Regional Substance Abuse Coordinating Agency Directors

FROM: Deborah J. Hollis, Director
Bureau of Substance Abuse and Addiction Services

SUBJECT: Revised Treatment Policy #02: *Acupuncture*

Attached is the final version of Treatment Policy #02: *Acupuncture*. This policy will become effective November 1, 2012.

A draft of this policy was sent to all substance abuse coordinating agencies for review on August 24, 2012. Comments and feedback were received from Macomb County Community Mental Health, which were utilized to finalize this policy. The feedback expressed the desire for clarification regarding the ability of an acupuncture detoxification specialist to bill for services, and at what point they were eligible to bill. Clarification is provided within the policy.

If you have any questions or need further clarification, please contact Angie Smith-Butterwick, at smitha8@michigan.gov or 517-373-7898.

DJH/asb

Attachment

TREATMENT POLICY #02

SUBJECT: Acupuncture

ISSUED: May 1, 1994, revised June 2001, March 2007, and July 2012

EFFECTIVE: November 1, 2012

PURPOSE:

To establish standards for the use of acupuncture when used as an adjunct therapy in substance use disorder treatment.

SCOPE:

The Office of Recovery Oriented Systems of Care will allow community grant expenditures for acupuncture as an adjunct therapy in any substance use disorder treatment setting. Acupuncture may be used to support drug-free or medication-assisted treatment (MAT).

BACKGROUND:

In 1972, the use of auricular acupuncture for acute drug withdrawal was developed in Hong Kong. Shortly thereafter, Michael Smith, M.D., a psychiatrist at Lincoln Hospital in the South Bronx, New York City, started using it extensively. Dr. Smith developed a five-point auricular protocol, which has been adopted by the National Acupuncture Detoxification Association (NADA). The following ear points are used in the protocol: liver, kidney, lung, sympathetic nervous system, and shen men (spirit gate). Stimulation of these ear points reduces stress and anxiety, which allows the patient to be more receptive to counseling. It also lessens depression and insomnia, and alleviates the craving for substances, thus aiding in recovery. It should be noted that the term "detoxification" is used as an eastern or Traditional Chinese Medicine (TCM) concept and is based on the principle that illnesses can be caused by the accumulation of toxic substances (toxins) in the body. Eliminating existing toxins and avoiding new toxins are essential parts of the healing process. Used in this manner, detoxification principles should be implemented throughout the treatment continuum and to prevent relapse rather than only in the initial stage of treatment.

Auricular acupuncture offers a low-cost way to enhance outcomes and lower the total cost of substance abuse treatment. It has been shown to be effective in relieving the symptoms of withdrawal from alcohol, heroin, and crack cocaine; making patients more receptive to treatment; reducing or eliminating the need for MAT; and lessening the chances of relapse. Some clients experience a decrease in depression and anxiety symptoms as a result of acupuncture, which can contribute to their success in recovery. Studies have also shown success in decreasing the

symptoms of post-traumatic stress disorder in veterans in the United States and refugees abroad. Auricular acupuncture has been used successfully in treating pregnant substance abusing women and drug-exposed infants who are experiencing withdrawal.

Non-auricular acupuncture points can also be used as part of an individualized acupuncture treatment plan when performed by a registered acupuncturist.

Acupuncture may be performed as an adjunct therapy to any treatment modality in any setting. Counseling, 12-step programs, relapse prevention, referral for supportive services, and life skills training are all components of a comprehensive program that can include acupuncture. Auricular acupuncture for substance use disorder treatment appears to work best in a group setting. In keeping with the philosophy of TCM, the patient is encouraged to be actively involved in his/her own treatment and to see substance abuse holistically, as part of total emotional, physical, and spiritual health, and to recognize the relationship his/her disorder has to other people and the environment.

REQUIREMENTS:

Michigan Law

Acupuncture may be performed by the following individuals: a) Medical Doctor, b) Doctor of Osteopathy, and c) Registered Acupuncturist. An individual who holds a Certificate of Training in Detoxification Acupuncture as an Acupuncture Detoxification Specialist (ADS) issued by NADA and is under the supervision of a person licensed to practice medicine in the state may use the NADA protocol for substance use disorder treatment. The supervising physician needs not be trained in acupuncture nor be present when the procedure is performed.

Disposable sterile needles must be used for all acupuncture treatments.

The following Michigan Compiled Laws, from the Public Health Code, pertain to acupuncture:

333.16215 Supervision of Acupuncture
333.16501 Definition of Acupuncturist
333.16511 Exemption from Registration

PROCEDURE:

The recommended procedure for the use of acupuncture as a substance use disorder treatment support is the protocol developed by NADA. This five point auricular protocol, which includes the liver, kidney, lung, sympathetic nervous system and shen men points, is the only procedure allowed to be performed by a NADA trained and certified ADS. Registered Acupuncturists and physicians may use their professional judgment and expertise in determining the acupuncture points to be used.

Clinicians who wish to become proficient in the NADA protocols must study under a NADA Registered Trainer, usually by participating in a 30-hour classroom/didactic training course followed by 40 hours of hands-on work in a clinic. Upon completion of training, the trainee's documentation is submitted to NADA for final approval and issuance of a certificate of training completion as an ADS. Once certified and insured, the ADS is able to bill for services.

More information about the NADA Protocol, how to become an ADS, and training resources may be found at www.acudetox.com.

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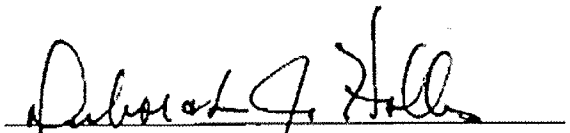

Deborah J. Hollis, Director
APPROVED BY: Bureau of Substance Abuse and Addiction Services

STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

RICK SNYDER
GOVERNOR

OLGA DAZZO
DIRECTOR

MEMORANDUM

DATE: April 26, 2012

TO: Substance Abuse Coordinating Agency Directors

FROM: Deborah J. Hollis, Director
Bureau of Substance Abuse and Addiction Services

SUBJECT: Treatment Policy #6: *Individualized Treatment and Recovery Planning*

Attached is the final version of Treatment Policy #6: *Individualized Treatment and Recovery Planning*. This policy became effective April 2, 2012.

A draft of this policy was sent to all substance abuse coordinating agencies for review in December 2011. Comments and feedback were received from the Detroit Bureau of Substance Abuse Prevention, Treatment and Recovery, Mid-South Substance Abuse Commission, and Genesee County Community Mental Health, which were utilized to finalize this policy. Some of the feedback received indicated that there was a preference for separate treatment and recovery planning. BSAAS believes that it is important that these activities take place simultaneously to ensure client input and the viability of recovery planning. Concerns were expressed that treatment goals and objectives that completely reflect the client's words are not always measurable. Adjustments were made to the policy to correct this issue. The policy also provides clarification regarding required signatures on treatment plans and updates.

If you have any questions or need further clarification, please contact Angie Smith-Butterwick, at smitha8@michigan.gov or 517-373-7898.

DJH:ssb

Attachment

c: Felix Sharpe
Jeff Wieferich

TREATMENT POLICY # 06

SUBJECT: Individualized Treatment and Recovery Planning

ISSUED: September 22, 2006, revised February 29, 2012

EFFECTIVE: April 2, 2012

PURPOSE

The purpose of this policy is to establish the requirements for individualized treatment and recovery planning. 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. By participating in the development of their recovery plan, clients can identify resources they may already be familiar with in their community and begin to learn about additional available services. Treatment and recovery planning requires an understanding that each client is unique and each plan must be developed based on the individual needs, goals, desires and strengths of each client.

The planning process can be limited by the information that is gathered in the assessment or by actual planning forms. All planning forms should be reviewed on at least an annual basis to ensure that the information being gathered, or the manner in which it is recorded, continues to support the individualized treatment and recovery planning process.

SCOPE

This policy impacts the PIHP and its provider network of substance use disorder services.

BACKGROUND

Expectations for individualized treatment planning had been advisory requirements in the contract with the CAs from 2004 through 2006. This policy formalizes those expectations and introduces the need for recovery planning as an essential part of this process.

REQUIREMENTS

The Administrative Rules for Substance Abuse Programs in Michigan promulgated under PA 368 of 1978, as amended, state, "A recipient shall participate in the development of his or her treatment plan." [Recipient Rights Rules, Section 305(1)].

All PIHP providers must also be accredited by one of the approved national accreditation bodies. Accreditation standards also require evidence of client participation in the treatment planning

process. Evidence of client participation includes goals and objectives in the client's own words, goals and objectives based on needs the client identified in the assessment, and evidence the client was in attendance when the plan was developed.

PROCEDURE

Treatment and recovery planning begins at the time the client enters treatment – either directly or based on a referral from an access system – and ends when the client completes or leaves formal treatment services. Planning is a dynamic process that evolves beyond the first or second session when required documentation has been completed. Throughout the treatment process, as the client's needs change, the plan must be revised to meet the new needs of the client.

Recovery planning is undertaken as a component of the treatment plan and should progress as the client moves through the treatment process. It is important that the recovery plan be a viable and workable plan for the client and, upon the end of formal treatment services, he/she is able to continue along his/her recovery path with guidance from his/her plan. It is not acceptable that the recovery plan be developed the day before a client's planned completion of treatment services.

The treatment and recovery plans are not limited to just the client and the counselor. The client may request any family members, friends or significant others be involved in the process. Once each plan is developed, the client, counselor, and other involved individuals, such as significant others, family and mental health providers, must sign the form indicating understanding of the plan and the expectations.

Establishing Goals and Objectives

The initial step in developing an individualized treatment and recovery plan involves the completion of a biopsychosocial assessment. This is a comprehensive assessment that includes current and historical information about the client. From this assessment, the needs and strengths of the client are identified and it is this information that assists the counselor and client in establishing the goals and objectives that will be focused on in treatment. The identified strengths can be used to help meet treatment goals based on the client's individual needs. Examples of strengths might be a healthy support network, stable employment, stable housing, a willingness to participate in counseling, etc. After strengths are identified, the counselor assists the client in using these strengths to accomplish the identified goals and objectives. Identifying strengths of the client can provide motivation to participate in treatment, assist in identifying the most appropriate modality of treatment (individual, group, etc.), and may take the focus off any negative situations that surround the client getting involved in treatment, i.e., legal problems, work problems, relationship problems, etc.

Writing the Plan

Once the goals and objectives are jointly decided on, they are recorded in the planning document utilized by the provider. Goals must be stated in the client's words or based on the client's reported concerns. Each goal that is written down should be directly tied to a need that was identified in the assessment. Once a goal has been identified, then the objectives – the activities the client needs to perform to achieve the goal – are recorded. The objectives must be developed with the client but do not have to be recorded in the client's exact words. The objectives need to be written in a manner in which they can be measured for progress toward completion along with a targeted completion date. The completion dates must be realistic to the client or the chances of compliance with treatment are greatly reduced.

Establishing Treatment Interventions

The next component of the plan is to determine the intervention(s) that will be used to assist the client in being able to accomplish the objectives. In other words – what action will the client take to achieve a goal, and what action will the counselor take to assist the client in achieving the goal. This should be specific, not just generalized statements of individual or group therapy. Again, these actions must be mutually agreed upon to provide the best chance of success for the client.

Framework for Treatment

The individualized treatment and recovery plan provides the framework by which services should be provided. Any individual or group sessions that the client participates in must address or be related to the goals and objectives in the plan. When progress notes are written, they reflect what goal(s)/objective(s) were addressed during a treatment session. The progress notes recorded by the clinician, should document progress or lack of progress and any adjustments/changes to the treatment and recovery plan. Once a change is decided on, it should then be added to the plan in the format described above and initialed by the client or with documentation of client approval.

Treatment and Recovery Plan Progress Reviews

Plans must be reviewed and documentation of such must be placed in the client record. The frequency of the reviews can be based on the time frame in treatment (60, 90, 120 days) or on the number of treatment episodes that have taken place since admission or since the last review (8, 10, 12 episodes). The reviews must include input from all clinicians/treatment/recovery providers involved in the care of the client, as well as any other individuals the client has involved in his/her plan. This review should reflect on the progress the client has made toward achieving each goal and/or objective, the need to keep specific goals/objectives or discontinue them, and the need to add any additional goals/objectives due to new needs of the client. As with the initial plan, the client, clinician, and other relevant individuals should sign this review. If individual signatures are unable to be obtained, documentation explaining why must be provided.

The plan and plan reviews not only serve as tools to provide care to the client, they help in the administrative function of service authorization. Decisions concerning, but not limited to, length of stay, transfer, discharge, continuing care, and authorizations by CAs must be based on individualized determinations of need and on progress toward treatment and recovery goals and objectives. Such decisions must not be based on arbitrary criteria, such as pre-determined time or payment limits.

Policy Monitoring and Review

The PIHP will monitor compliance with individualized treatment and recovery planning and these reviews will be made available to the Office of Recovery Oriented Systems of Care (OROSC) during site visits. OROSC will also review for individualized treatment and recovery planning during provider site visits. Reviews of plans will occur in the following manner:

- A review of the biopsychosocial assessment to determine where and how the needs and strengths were identified.

- A review of the plan to check for:

    1. Matching goals to needs – Needs from the assessment are reflected in the goals on the plan.
    2. Goals are in the client's words and are unique to the client – No standard or routine goals that are used by all clients.
    3. Measurable objectives – The ability to determine if and when an objective will be completed.
    4. Target dates for completion – The dates identified for completion of the goals and objectives are unique to the client and not just routine dates put in for completion of the plan.
    5. Intervention strategies – the specific types of strategies that will be used in treatment – group therapy, individual therapy, cognitive behavioral therapy, didactic groups, etc.
    6. Signatures – client, counselor, and involved individuals, or documentation as to why no signature.
    7. Recovery planning activities are taking place during the treatment episode.

- A review of progress notes to ensure documentation relates to goals and objectives, including client progress or lack of progress, changes, etc.

- An audit of the treatment and recovery plan progress review to check for:

    1. Progress note information matching what is in review.
    2. Rationale for continuation/discontinuation of goals/objectives.
    3. New goals and objectives developed with client input.
    4. Client participation/feedback present in the review.
    5. Signatures, i.e., client, counselor, and involved individuals, or documentation as to why no signature.

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APPROVED BY:

Deborah J. Hollis, Director
Bureau of Substance Abuse and Addiction Services

JENNIFER M. GRANHOLM
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

JANET OLSZEWSKI
DIRECTOR

DATE: December 12, 2007

TO: Coordinating Agency Executive Directors

FROM: Donald L. Allen, Director
Office of Drug Control Policy

SUBJECT: Treatment Policy #08: *Substance Abuse Case Management Program Requirements*

Attached is the final version of the Michigan Department of Community Health (MDCH), Office of Drug Control Policy (ODCP) Treatment Policy #08: *Substance Abuse Case Management Program Requirements.* This policy was sent to all coordinating agencies on September 7, 2007 with a review period of 30 days. Macomb County Community Mental Health submitted comments that were utilized in the finalization of the policy.

Attachment

TREATMENT POLICY # 08

SUBJECT: SUBSTANCE ABUSE CASE MANAGEMENT PROGRAM REQUIREMENTS

ISSUED: January 1, 2008

EFFECTIVE DATE: January 1, 2008

PURPOSE:

The purpose of this policy is to establish requirements for Case Management (CSM) programs.

SCOPE:

PIHP substance abuse provider network.

BACKGROUND:

The substance abuse administrative rules were changed July 5, 2006. These changes resulted in case management becoming a licensable program category. In October 2006, Michigan Department of Health & Human Services, Office of Recovery Oriented Systems of Care (MDHHS/OROSC) provided the field with a technical advisory on the different types of case management models to assist programs in making a decision on the type of CSM programs that can be utilized based on the needs of the population within their region.

REQUIREMENTS:

The definition of case management contained in Administrative Rule 325.14101(g) is as follows:

> Case Management means 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 the individualized treatment planning process.

The action plan guideline (APG) has established the requirement of having a CSM program available in each PIHP region by September 30, 2009. To ensure that each PIHP and their providers develop an identifiable case management program and satisfy APG requirements, the following must be incorporated in the development of CSM services process:

1. The program must be identifiable and distinct within the agency's service configuration.

2. The agency must offer or purport to offer the case management services as a separate and distinct program among any other program services that may be offered.

Eligibility

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

1. Client has a documented need in at least one domain involving community living skills, health care, housing, employment/financial, education or another functional area in that person's life.
2. Client has a demonstrated history of recovery failure with or without recovery support services.
3. Client has a substance use disorder involving a primary drug of choice that will require longer-term involvement in treatment services to support recovery (such as methamphetamine, heroin/opiates, inhalants).
4. The chronicity and severity of the client's disorder is such that ongoing support is needed to increase the probability of recovery (such as years of use and first involvement with treatment, or a co-occurring mental health disorder is present with substance use disorder).

A client who is receiving CSM services from another CSM service or program (mental health, child welfare, justice system etc.) is not eligible for substance use disorder CSM services regardless of the criteria met above. Also, a client who has needs that could be met through another CSM service, for which the client qualifies, is not eligible for substance use disorder CSM services. In situations where it is determined that the client's needs cannot be met, authorization for concurrent enrollment can be provided by the PIHP on a case-by-case basis. In these situations, there must be coordination with the other program to ensure that specific services are not duplicated.

Clients can receive CSM services when they are involved in other levels of care if it is determined to be a necessary adjunct to the current services. CSM services can also be provided as a step-down from a more intensive level of treatment and can be provided as a stand-alone service if eligibility requirements are met. CSM services are designed to provide the client with support to maintain recovery during the transition from formal treatment services to self-sustained recovery, but are also designed to assist in providing additional support while the client is receiving services in the initial period of treatment.

Minimum Service Expectations

There are many functions and/or activities that a case management program can be engaged in to provide services to clients. Although many of the functions of case management programs will be established at the local level, the following functions for a case management program are being established as the minimum expectations:

1. The ability to link and/or refer clients to support services depending on the needs and functioning level of clients.
2. The provider must be able to serve as an advocate to assist and/or represent the client and his/her needs with other agencies or service providers. This may include but is not limited to serving as the "voice" of the client in situations where the client is unable to effectively represent himself/herself, accompanying clients to appointments, assisting with completion of forms or meeting other requirements the client may have to secure support/services, making appointments for clients, or ensuring follow-through of appointments. The level and intensity of involvement should be dependent on the individual client.
3. Ability to see clients in their community or the capability for face-to-face client interaction outside of the office setting.
4. The CSM provider must be able to monitor and continually assess the changing functional and social needs of clients as they progress through recovery and document this information as required.
5. The CSM programs must be able to work with a treatment team if needed.
6. Case management services must be based on an individualized treatment or recovery plan and have the ability to provide, or refer for, crisis intervention.

It is not permissible for CSM providers to incorporate both service provision and service authorization/re-authorization responsibility for their own clients. Authorizations must be distinct from CSM functions and should be completed through a separate process that is independent of providing case management services to the client.

CSM Program Categories

Treatment Technical Advisory (TA) #03: *Implementing Case Management Services* identified four types of case management models that have been shown to be effective in helping clients with recovery from substance use disorders. In the TA, licensing requirements were not established for each model. To further clarify the requirements and expectations for PIHPs and providers developing a case management program funded through the MDHHS PIHP contract agreement, the models are reviewed below and licensing requirements for the PIHP provider network CSM programs have been established for each model:

1. **The Broker/Generalist**: This model identifies clients' needs and assists clients to access resources. Service planning or areas of needed assistance may be limited to contacts with the case manager and would not require development of an intensive long-term relationship. Clients who receive this type of CSM service typically do not have multiple needs and are able to access and utilize other resources more independently than clients who receive case management services under the other models. The case manager advocacy role is less intensive than other CSM service models. Essentially, the case manager provides the client with the information and

provides assistance with access to other services and supports, and the client is responsible for follow through. The case manager assesses and monitors follow-through, but less intensive support is needed by the client.

The ability for the case manager to be able to work with the client outside the office and in the client's environment is required but interventions within the office are appropriate given the higher functioning level of the clients. Therapeutic services, beyond resource acquisition, are not provided under this model and, if needed, the client is referred to an appropriate source for the service or referred back to the primary treatment provider if these services are being provided as an adjunct to another level of care. Crisis intervention services are limited to providing assistance with acquiring resources. Any clinical or mental health crisis interventions are provided by previously identified providers in the community. The development of social support networks for the client, a function of the other models of CSM, is not a part of this model.

- Possession of a Screening, Assessment, Referral and Follow-up (SARF) only license is permitted for programs that will be strictly providing this model only. A treatment license is not required as long as services meet the CSM Administrative Rule definitions. A service category license for case management programs for persons with substance use disorders is required.

2. **Strengths-Based Perspective**: The two principles of this model are 1) providing clients support for asserting direct control over the search for resources; and 2) assisting clients in examining their own strengths and assets as the vehicle for resource acquisition. This model encourages the use of informal helping networks, promotes the importance of the client-case manager relationship, and provides an active, aggressive form of outreach. This model has been used with the substance abuse population because of 1) the usefulness of helping the client access resources for recovery; 2) the strong advocacy component; and 3) the emphasis on helping clients identify their strengths, assets, and abilities.

   Services in this model include therapeutic interventions like therapy or skills teaching for clients and/or their significant others, when these are needed to assist with the recovery process. Crisis intervention services are provided as a part of this model as well. In keeping with the concept of building the client-case manager relationship, services in this model generally take place in the community or the client's environment in contrast to an office based setting.

   - A treatment license is required in addition to the case management service category license to provide this type of program.

3. **Assertive Community Treatment**: Utilizes a team model to provide services to clients. This model also provides services in the community and clients are sought

out by the team for contact. The chronic nature of substance abuse is acknowledged with the purpose of modifying the course of the condition and alleviating suffering. Abstinence is not an expectation of participation. Typically, this model is set up for relatively long-term involvement with clients due to the chronic nature of the population served and maintains ongoing contact with the client to assist with recovery. This model is fundamentally similar to the mental health Assertive Community Treatment (ACT) program and services design except for the composition of the team and the type of credentialed staff providing the service. The team composition is at local discretion.

- A treatment license is required in addition to the case management service category license to provide this type of program.

4. **Clinical/Rehabilitation**: This model involves combining therapy and case management services. In this way, all of the client needs are addressed through a single program. This can be described as having a single clinician serve as a therapist and as the case manager. This model serves clients that have been identified as having many needs and functional impairments but are not so severe that an ACT program is required. These clients have the ability to make many decisions for themselves in regards to treatment issues as well as the level of CSM intervention and advocacy needed.

   Whereas in the previous models, getting the clients involved in services and programs to meet identified needs is the main focus, there is equal focus on the therapeutic interventions and activities that are provided in this model. Services are provided in the community in the client's environment and this is the distinguishing factor between this service and standard outpatient care that takes place in an office setting.

   The following conditions must be in place in order for this type of program to meet the established CSM requirements:
   1. The program must have a distinct component of integrated CSM and clinical services
   2. Distinct eligibility criteria must be in place regarding client qualifications for the program
   3. The program must meet the minimum service expectations of a CSM program
   4. Clients are able to continue in the program even after the therapeutic needs are addressed but functional needs remain.

   - A treatment license is required in addition to the case management service category license to provide this type of program.

Care Management/Care Coordination

This service is designed to support CA resource allocation as well as service utilization. Agencies engaged in care coordination monitor and/or assist with referrals and assess associated barriers to service utilization by the client. Care Management/Care Coordination is considered to represent treatment episode management. Care management or care coordination, an allowable administrative expenditure service under Medicaid, is an administrative function performed at the CA or through the access system. Care management recognizes that some clients represent such service or financial risk to the organization that closer monitoring of the individual case is warranted. Involvement in care management services does not preclude the client from being involved in CSM services as the two programs have separate and distinct functions. However, services must be coordinated, collaborative and unduplicated.

The PIHP or access system provider may implement care management at any time.

Women's Specialty Services

Women's specialty services, required as part of the Federal Substance Abuse Prevention and Treatment block grant, are commonly referred to as "case management" services. However, the requirements of 1) providing or arranging primary medical care for women, including prenatal care, and child care while women are receiving such services; 2) providing or arranging primary pediatric care and immunizations for the children of women in treatment; and 3) providing sufficient transportation to ensure that women and their dependent children have access to the previously mentioned services, do not meet the expectations that ODCP has established for case management services as defined in the administrative rules. The services under the women's specialty requirements are considered care coordination but can be provided as part of a case management program.

REQUIRED REPORTS:

None unless otherwise specified in the MDHHS-PIHP agreement.

PROCEDURE:

None specified for establishing a CSM program.

REFERENCES:

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APPROVED BY: __*SIGNED*_____
Donald L. Allen, Jr., Director
Office of Drug Control Policy

TREATMENT POLICY #09

SUBJECT: Outpatient Treatment Continuum of Services

ISSUED: February 20, 2008, December 1, 2016

EFFECTIVE: January 1, 2017

PURPOSE

The purpose of this policy is to establish the requirements for outpatient services that endorse use of American Society of Addiction Medicine (ASAM) Level of Care (LOC) criteria and to ensure that services are individualized and culturally, age and gender appropriate.

SCOPE

This policy impacts the PIHP and its outpatient LOC service provider network.

BACKGROUND

Outpatient treatment includes a wide variety of covered services with the expectation that authorizations for these services are individualized to the needs of the client. Throughout the outpatient LOC, assessment, treatment plan and recovery support preparations are required as they must be included in the authorized treatment services. As a client's needs change, the frequency and/or duration of services may be increased or decreased as medically necessary. The ASAM levels correspond with planned hours of services, in a group and/or individual setting during a week and as scheduled with the client.

Historically, services have been described as follows:

- Outpatient – treatment that may be offered in a variety of settings, but often takes place in an office-type setting. Can include group and/or individual therapy services.
- Intensive Outpatient – treatment that often takes place in an office-type setting, but can be offered in other settings, and consists of a minimum of nine hours, maximum of 19 hours of services per week. Services include individual, group and interactive education-(didactic) type services.
- Enhanced Outpatient – similar to intensive outpatient service because it also offers expanded hours per week, but with a greater emphasis on individualized treatment to meet the client's needs.

ASAM levels of care describe the need for treatment from the perspective of weekly service intensity based on the needs of the client. The identification of these needs is intended to drive

service selection and authorization for care. The determination of service intensity, within outpatient services, is based on the client's ASAM LOC determination; not the designation of the provider program as being early intervention, outpatient, intensive outpatient, or partial hospitalization. For purposes of treatment episode data set (TEDS) admission reporting, LOC may be established on the basis of the authorization for service rather than service participation.

Definitions

Bundled Services – Are an approach to treatment that ties multiple covered services together and provides them in a single treatment setting. Specific activities are not differentiated in billing or reimbursement.

Counseling – An interpersonal helping relationship that begins with the client exploring the way they think, how they feel and what they do, for the purpose of enhancing their life. The counselor helps the client to set the goals that pave the way for positive change to occur.

Individual Counseling - face-to-face intervention for the purpose of goal setting and achievement, and skill building. This is distinct from treatment planning, as this may be goals and achievements identified in case management or through peer based services.

Individual Treatment Planning - direct and active client involvement in establishing the goals and expectations for treatment to ensure the appropriateness of the current LOC, to ensure true and realistic needs are being addressed, and to increase the client's motivation to participate in treatment. Treatment planning requires an understanding that each client is unique and each treatment plan must be developed based on the individual needs, goals, desires, and strengths of each client and be specific to the diagnostic impression and assessment.

Interactive Education (didactic) – Refers to services that are designed or intended to teach information about addiction and/or recovery skills.

Medical Necessity – Treatment that is reasonable, necessary and appropriate based on individualized treatment planning and evidence-based clinical standards.

Psychotherapy - an advanced clinical practice that includes the assessment, diagnosis, or treatment of mental, emotional, or behavioral disorders, conditions, addictions, or other bio-psychosocial problems and may include the involvement of the intrapsychic, intrapersonal, or psychosocial dynamics of individuals (Michigan Administrative Code, Social Work General Rules).

Recovery – A highly individualized journey of healing and transformation where the person gains control over his/her life. It involves the development of new meaning and purpose, growing beyond the impact of addiction or a diagnosis. This journey may include the pursuit of spiritual, emotional, mental, and physical well-being.

(http://www.michigan.gov/documents/mdch/ROSC_Glossary_of_Terms_350345_7.pdf)

Recovery Planning - purpose is to highlight and organize a person's goals, strengths, and capacities and to determine what barriers need to be removed or problems resolved to help a person achieve their goals. This should include an asset and strength-based assessment of the client.

Recovery Support and Preparation - services designed to support and promote recovery through development of knowledge and skills necessary for an individual's recovery.

Substance Use Disorder – A term inclusive of substance abuse and dependence that also encompasses problematic use of substances that does not meet the criteria for substance abuse or dependence.

Unbundled Services – An approach to treatment that seeks to provide the appropriate service or combination of specific services to match the needs of a client. Billing and reimbursement is specific to the service provided.

REQUIREMENTS

PIHPs must have the capacity to provide an outpatient continuum that will meet the needs of clients at all ASAM levels of intensity. Outpatient care is defined as treatment services that are provided in a setting that does not require the client to have an overnight stay at a facility as part of the treatment service but involves regularly scheduled sessions. Outpatient treatment is an organized, non-residential treatment service or an office practice with clinicians educated/trained in providing professionally directed alcohol and other drug treatment. The treatment occurs in regularly scheduled sessions, usually totaling fewer than nine contact hours per week, but when medically necessary can total over 20 hours in a week. The combination of days and hours and nature of services is based on the client's needs. A program director is responsible for the overall management of the clinical program and appropriate, credentialed and certified staff members provide treatment.

Treatment must be individualized based on a biopsychosocial assessment, diagnostic impression and client characteristics that include age, gender, culture and development. Authorization decisions regarding length of stay (including continued stay), change in LOC and discharge, must be based on the ASAM patient placement criteria. Client participation in referral and continuing care planning must occur prior to transfer or discharge.

ASAM Level 0.5 Early Intervention – These services are not differentiated by the number of hours received during a week. The amount and type of services provided are based on individual needs including consideration of both the client's motivation to change and other risk factors that may be present. This level of care is typically mandated through an impaired driving program that requires completion before reinstating driving privileges.

Prior to admission, a diagnostic assessment should be performed in conjunction with a comprehensive multidimensional assessment to determine whether the person meets the admission criteria for Level 0.5, which requires that the person does not meet the requirements for a substance use disorder. If new information, through the reassessment process indicates substance use disorder, and the person needs treatment, there are three options. Transfer individual to a clinically appropriate level of care, facilitate treatment at required 0.5 Level of care, or transfer them to the appropriate level of care as soon as 0.5 Level is completed.

Length of service at this level depends on an individual's ability to comprehend the information they are provided and use the information to make behavior changes, if the person acquires new problems and needs additional treatment, or regulatory mandated service.

Staff Requirements
This level of care requires staff that are trained professionally and know about the biopsychosocial dimensions of substance use and addictive disorders. They should be able to recognize addictive and substance-related disorders, know about alcohol, tobacco and other drug education, as well as motivational counseling. In addition, these professionals should have knowledge of adolescent development, the legal and personal consequences of high risk substance use and addictive behavior. Physicians may be directly involved in Screening and Brief Intervention activities with a person with high-risk drinking, drugging, non-medical use of prescription drugs and high risk addictive behaviors. Addiction specialist physicians are not involved with this process, but are influential in clinical teams and design and oversee SBIRT activities carried out by other staff. Certified or licensed staff in addiction counseling may be involved with screening and especially brief intervention activities, but this will often fall on generalist health care professionals. Educational programs designed to reduce or eliminate at-risk substance use are generally staffed by certified and/or licensed addiction counselors, social workers, or health educators and not by physicians.

Interventions at this level may involve individual, group, or family counseling, SBIRT services as well as planned educational experiences focused on helping the individual recognize and avoid harmful or high-risk substance use and/or addictive behavior.

ASAM Level 1 Outpatient –This level encompasses organized outpatient treatment services that can be delivered in a wide variety of settings. Addiction, mental health treatment or general health care personnel, provide professionally directed screening, evaluation, treatment and ongoing recovery and disease management services. These services are less than nine hours during a week. These services are catered to each patient's level of clinical severity and function and are designed to help the patient achieve changes in drug/alcohol use. Treatment must address major lifestyle changes such as attitudinal and behavioral issues that have the potential to undermine the goals of treatment or to impair the individual's ability to cope with major life tasks with the use of addictive substances.

These services promote greater access to care for individual's not interested in recovery who are mandated into treatment or those who previously only had access to care if they agreed to intensive periods of primary treatment; patients with co-occurring substance use and physical and mental health conditions; individuals in early stages of readiness to change; patients in early recovery who need education about addiction and person-centered treatment; and patients in ongoing recovery who need monitoring and continuing disease management.

Support Systems
This level of care is appropriate for the initial level of care for a patient whose severity of illness and level of function warrants this intensity of treatment. This patient should be able to complete professionally directed addiction and/or mental health treatment at this level using only one level of care unless there is an unanticipated event that causes change in his/her level of functioning; there is recurring evidence of patient's inability to use this level of care; this level represents a "step down" from a more intensive level of care for a patient whose progress warrants transfer; this level can be used for a patient who is in the early stages of change and who is not yet ready to commit to a full recovery; may be used for patients as a direct admission if their co-occurring condition is stable and monitored whether or not they have responded to more intensive services; or for patients that have achieved stability in recovery so this level is used for ongoing monitoring and disease management.

Staff Requirements
This level programming should be staffed by staff that are trained professionally and know about the biopsychosocial dimensions of substance use and addictive disorders. They should be able to recognize addictive and substance-related disorders, know about alcohol, tobacco and other drug education. These staff should be capable of monitoring stabilized mental health problems and recognizing any instability of patients with co-occurring mental health conditions. This level of care is similar to Level 0.5, but staff are trained in medication management services and require the involvement of licensed independent practitioner with prescribing authority as granted by state-based professional licensing boards. Physicians and physician assistants are the common prescribers, but office-based nurses often are involved with medication management in support of physicians. When co-occurring mental health or general medical conditions are present, assessment services for both diagnostic and treatment planning purposes may require the most highly skilled clinician available or require collaboration from credentialed or licensed mental health or addiction professionals.

ASAM Level 2.1 Intensive Outpatient – Services 9-19 hours in a week consisting primarily of counseling and education about addiction-related and mental health problems. Patient's needs for psychiatric and medical services are addressed through consultation and referral arrangements if patient is stable and only requires maintenance monitoring. The services are provided at least three days a week to fulfill the minimum nine-hour

commitment. If a patient requires less than nine hours per week, use this as a transition step down in intensity to be considered as a continuation of the IOP program for one or two weeks. This program differs from partial hospitalization programs and the intensity of clinical services that are available. Most intensive outpatient programs have less capacity to treat patients who have substantial unstable medical and psychiatric problems than do partial hospitalization programs.

Support Systems
Necessary support systems in this level include medical psychological, laboratory, and toxicology services that are available through consultation or referral. Emergency services should also be available by telephone 24-hours a day, seven days a week when treatment program is not in session. These services should also have direct affiliation with more and less intensive levels of care and supportive housing services.

Staff Requirements
Co-occurring enhanced programs should be staffed by appropriately credentialed mental health professionals who assess and treat co-occurring mental disorders. Clinical leadership and oversight may be offered by an addiction specialist physician. If not, capacity to consult with addiction psychiatrist should be available. These programs are designed for people with co-occurring disorders to tolerate and benefit from the services offered.

Overall, these programs should be staffed by an interdisciplinary team of appropriately credentialed addiction treatment professionals, including counselors, psychologists, social workers, and addiction credentialed physicians who can assess and treat substance use and other disorders. Physicians should have specialty training and/or experience in in addiction medicine or addiction psychiatry. Staff should be able to obtain and interpret information regarding the patient's biopsychosocial needs. Generalist physicians may be involved in providing general medical evaluations and concurrent/integrated general medical care. Some, if not all program staff should have sufficient cross-training to understand the signs and symptoms of mental disorders and to understand and be able to explain the uses of psychotropic medications and their interactions with substance use and other addictive disorders.

ASAM Level 2.5 Partial Hospitalization – Services that are provided 20 or more hours in a week. (Hospitalization is used as a descriptor by ASAM. It is not meant to indicate that the service must take place in a hospital setting.) These partial hospitalization services typically have direct access to psychiatric, medical, and laboratory services and are better able to meet needs in Dimensions 1, 2, and 3, which warrant daily monitoring or management, but which can be appropriately addressed in a structured outpatient setting. Patients who would otherwise be placed in Level 2.1 program may be considered for placement in this level if the patient resides in a facility that provides 24-hour support and

structure and that limits access to alcohol and other drugs. (Such as a correctional facility or other licensed health care facility or supervised living situation.)

Support Systems

Necessary support systems include medical, psychological, psychiatric, laboratory, and toxicology services that are available within 8 hours by telephone and within 48 hours in person. They should also include emergency services, which are available by telephone 24 hours a day, 7 days a week when treatment program is not in session. They should also have direct affiliation with more and less intensive levels of care and supportive housing services. Co-occurring enhanced programs offer psychiatric services appropriate to the patient's mental health condition. Such services should be available by telephone and on site, or closely coordinated off site, within a shorter time than in a co-occurring capable program. Clinical leadership and oversight may be offered by a certified addiction medicine physician with at least the capacity to consult with an addiction psychiatrist.

Staff Requirements

These programs should be staffed by an interdisciplinary team of appropriately credentialed addiction treatment professionals, including counselors, psychologists, social workers, and addiction credentialed physicians who can assess and treat substance use and other disorders. Physicians should have specialty training and/or experience in in addiction medicine or addiction psychiatry. Staff should be able to obtain and interpret information regarding the patient's biopsychosocial needs. These staff should also have sufficient cross-training to understand the signs and symptoms of mental disorders and to understand and be able to explain the uses of psychotropic medications and their interactions with substance use disorders. In addition, clinical leadership and oversight may be offered by a certified and/or licensed addiction psychiatrist. These programs also provide ongoing intensive case management for highly crisis-prone patients with co-occurring disorders. Such case management is delivered by cross-trained, interdisciplinary staff through mobile outreach, and involves engagement-oriented addiction treatment and psychiatric programming.

Adult Dimensional Admission Criteria

Dimension 1: Acute intoxication and/or withdrawal potential	See separate withdrawal management for how to approach unbundled withdrawal management for adults
Dimension 2: Biomedical Conditions and Complications	Individual's biomedical conditions are stable or are being actively addressed and will not interfere with therapeutic interventions
Dimension 3: Emotional, behavioral, or cognitive conditions and complications	Individual's emotional, behavioral, or cognitive conditions and complications are being addressed through appropriate mental health services and will not interfere with interventions

Dimension 4: Readiness to change	Individual expresses willingness to gain understanding of current addictive behavior
Dimension 5: Continued Problem Potential	Individual does not understand the need to alter current behavior or needs to acquire specific skills needed to change current pattern of use/behavior
Dimension 6: Living Environment	Individual's social support system composed primarily of persons who substance use prevent them from meeting obligations, their family members are currently using, significant other expresses value of substances that counter individual's progress, or significant other encourages or condones addictive behavior

Covered Services

The following services can be provided in the outpatient setting:

Individual Assessment – A face-to-face service for the purpose of identifying functional and treatment needs; and, to formulate the basis for the Individualized Treatment/Recovery Plan to be implemented by the provider.

Individual Treatment Planning – Refers to the direct and active client involvement in establishing the goals and expectations for treatment to ensure the appropriateness of the current LOC, to ensure true and realistic needs are being addressed and to increase the client's motivation to participate in treatment. Treatment planning requires an understanding that each client is unique and each treatment plan must be developed based on the individual needs, goals, desires and strengths of each client and be specific to the diagnostic impression and assessment.

Individual Therapy – Face-to-face interventions with the client.

Group Therapy – Face-to-face interventions with three or more clients, which includes therapeutic interventions/counseling.

Counseling – Face-to-face intervention (by non-professional staff) with a client, for the purpose of goal setting and achievement and skill building.

Interactive Education (didactic) Groups – Activities that center on teaching skills to clients and are necessary to support recovery. These groups can be led by non-masters prepared staff.

Family Therapy – Face-to-face interventions with the client and significant other and/or traditional or non-traditional family members. *Note: In these situations, the identified client need not be present for the intervention.*

Crisis Intervention – A service for the purpose of addressing problems/issues that may arise during treatment, which could result in the client requiring a higher LOC if intervention is not provided.

Referral/Linking/Coordinating of Services – Office-based service activity performed by the primary clinician to address needs identified through the assessment, and/or ensuring follow through with access to outside services, and/or to establish the client with another substance use disorder provider.

Recovery Support and Preparation – Services designed to support and promote recovery through development of knowledge and skills necessary for an individual's recovery.

Compliance Monitoring – For the purpose of tracking ongoing use of substances when this has been established as a part of the treatment plan or an identified part of the treatment program (i.e., onsite testing such as PBT's or non-laboratory urinalysis).

Early Intervention – Treatment services for individuals with substance use disorders and/or individuals who may not meet the threshold of abuse or dependence but are experiencing functional/social impairment as a result of use. Services may be initiated at any stage of change but are expected to be stage-based.

Detoxification/Withdrawal Monitoring – For the purpose of preventing/alleviating medical complications related to no longer using or decreasing the use of a substance.

Substance Abuse Outpatient Program – Programs that are individualized and include assessment, treatment planning, stage-based interventions, referral linking and monitoring, recovery support preparation and treatment based on medical necessity. These may include individual, group and family treatment. These services are billed under the "H" code sequence.

Note: The Substance Abuse Outpatient Program is the 'bundled' outpatient category while the above are various optional services within outpatient programs.

PROCEDURE

Outpatient care may be provided only when the service meets all of the following criteria:

- Medical necessity;
- The current edition of the Diagnostic and Statistical Manual of Mental Disorders is used to determine an initial diagnostic impression of a substance use disorder, abuse or dependence

(also known as provisional diagnosis) – the diagnostic impression must include all five axes;

- Is based on individualized determination of need; and,
- ASAM Patient Placement Criteria are used to determine substance use disorder treatment placement/admission and/or continued stay needs and are based on a LOC determination using the six assessment dimensions of the current ASAM Patient Placement Criteria below:

1) Withdrawal potential.
2) Medical conditions and complications.
3) Emotional, behavioral or cognitive conditions and complications.
4) Readiness to change.
5) Relapse, continued use or continued problem potential.
6) Recovery/living environment.

Outpatient treatment services are appropriate for those clients with minimal or manageable medical conditions; minimal or manageable withdrawal risks; emotional, behavioral and cognitive conditions that will not prevent the client from benefiting from this level of care; services must address treatment readiness; minimal or manageable relapse potential; and, a minimally to fully supportive recovery environment. Clients who continue to demonstrate a lack of benefit from outpatient services, whether they are actively or sporadically involved in their treatment, may be referred to the Access Management System (AMS) for another level of care determination and discharged if the client is unwilling to accept other services appropriate to their level of care determination. Relapse alone is not sufficient justification to discharge a client from treatment but it does indicate that a change in treatment services may be needed.

Admission Criteria

Outpatient services must be authorized based on the number of hours and/or types of services that are medically necessary. Re-authorization or continued treatment must take place when it has been demonstrated that the client is benefiting from treatment but additional covered services are needed for the client to be able to sustain recovery independently.

The services provided in the outpatient setting can be provided through a bundled substance abuse outpatient program or in an unbundled manner. The PIHP may decide if services in their region will be bundled or unbundled. Regardless of how services are purchased by the PIHP, services must be based on the individual needs of the client and services must be individually tailored to the client's needs.

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APPROVED BY: Thomas J. Renwick

Thomas J. Renwick, Director
Bureau of Community Based Services

TREATMENT POLICY #10

SUBJECT: Residential Treatment Continuum of Services

ISSUED: May 3, 2013, December 1, 2016

EFFECTIVE: January 16, 2017

PURPOSE:

The purpose of this policy is to establish the requirements for residential services to the extent licensing allows based on the American Society of Addiction Medicine (ASAM) Level of Care (LOC) criteria, and to support individualized services that maintain cultural, age, and gender appropriateness.

SCOPE:

This policy impacts the Prepaid Inpatient Health Plan (PIHP) and its adult residential LOC service provider network.

BACKGROUND:

Residential treatment includes a wide variety of covered services with the provision of these services expected to be individualized to the needs of the client. The Administrative Rules for Substance Abuse Services, established in 1981, are very limited in indicating what activities or services must be provided to clients in a residential program. They do indicate, however, that ten hours of scheduled activities, with two of those hours being formalized counseling, must take place each week.

At the time of their creation, these standards adequately met the needs of clients being served. In the time since the rules were promulgated, there have been many changes in the treatment field. The emergence of evidence-based best practices, the ASAM Criteria Third Edition (ASAM Criteria), and the stages-of-change models that have been developed. These changes have essentially left the administrative rules obsolete in the area of recommended services. This policy seeks to establish residential treatment criteria that will result in services that are provided in accordance with those outlined by ASAM, and are more reflective of services that have been shown to be effective in providing care to individuals receiving residential care.

Throughout the current residential level of services assessment, treatment planning, and recovery support preparations are required, and must be included in the authorized treatment services. Historically, residential services have been defined by length-of-stay, not by the needs of the client. This has resulted in essentially two descriptors for residential services:

- Short-term residential: less than 30 days in a program
- Long-term residential: 30 days or more in a program

This view of residential treatment has contributed to the expectation that all clients will equally benefit from the services being offered and resulted in clients with varying needs being admitted into the same program. This makes it more difficult to assure and provide services that are focused on addressing the individual needs of each client.

Definitions

Core Services - are defined as Treatment Basics, Therapeutic Interventions, and Interactive Education/Counseling. See the chart in the "Covered Services" section for further information.

Counseling - an interpersonal helping relationship that begins with the client exploring the way they think, how they feel and what they do, for the purpose of enhancing their life. The counselor helps the client to set the goals that pave the way for positive change to occur.

Crisis Intervention - a service for the purpose of addressing problems/issues that may arise during treatment and could result in the client requiring a higher LOC if intervention is not provided.

Face-to-Face - this interaction not only includes in-person contact, it may also include real-time video and audio linkage between a client and provider, as long as this service is provided within the established confidentiality standards for substance use disorder services.

Facilitates Transportation - assist the client, potential client, or referral source in arranging transportation to and from treatment.

Family Counseling - face-to-face intervention with the client and their significant other and/or traditional or non-traditional family members for the purpose of goal setting and achievement, as well as skill building. Note: in these situations, the identified client need not be present for the intervention.

Family Psychotherapy - face-to-face, insight-oriented interventions with the client and their significant other and/or traditional or non-traditional family members. Note: in these situations, the identified client need not be present for the intervention.

Group Counseling - face-to-face intervention for the purpose of goal setting and achievement, as well as skill building.

Group Psychotherapy - face-to-face, insight-oriented interventions with three or more clients.

Individual Assessment - face-to-face service for the purpose of identifying functional and treatment needs, and to formulate the basis for the Individualized Treatment Plan to be implemented by the provider.

Individual Counseling - face-to-face intervention for the purpose of goal setting and achievement, and skill building.

Individual Psychotherapy - face-to-face, insight-oriented interventions with the client.

Individual Treatment Planning - direct and active client involvement in establishing the goals and expectations for treatment to ensure the appropriateness of the current LOC, to ensure true and realistic needs are being addressed, and to increase the client's motivation to participate in treatment. Treatment planning requires an understanding that each client is unique and each treatment plan must be developed based on the individual needs, goals, desires, and strengths of each client and be specific to the diagnostic impression and assessment.

Interactive Education - services that are designed or intended to teach information about addiction and/or recovery skills, often referred to as a "didactic" education.

Interactive Education Groups - activities that center on teaching skills to clients necessary to support recovery, including "didactic" education.

Medical Necessity - treatment that is reasonable, necessary, and appropriate based on individualized treatment planning and evidence-based clinical standards.

Peer Support - individuals who have shared experiences of addiction and recovery, and offer support and guidance to one another in a treatment setting.

Professional Staff – as identified in the Staff Qualifications for SUD Treatment Services portion of the PIHP/MDHHS Contract include Substance Abuse Treatment Specialists, Substance Abuse Treatment Practitioner, Specially Focused Staff and Treatment Supervisor.

Psychotherapy - an advanced clinical practice that includes the assessment, diagnosis, or treatment of mental, emotional, or behavioral disorders, conditions, addictions, or other bio-psychosocial problems and may include the involvement of the intrapsychic, intrapersonal, or psychosocial dynamics of individuals (Michigan Administrative Code, Social Work General Rules).

Recovery: A highly individualized journey of healing and transformation where the person gains control over his/her life. It involves the development of new meaning and purpose, growing beyond the impact of addiction or a diagnosis. This journey may include the pursuit of spiritual, emotional, mental, and physical well-being. (http://www.michigan.gov/documents/mdch/ROSC_Glossary_of_Terms_350345_7.pdf)

Recovery Planning - purpose is to highlight and organize a person's goals, strengths, and capacities and to determine what barriers need to be removed or problems resolved to help a person achieve their goals. This should include an asset and strength-based assessment of the client.

Recovery Support and Preparation - services designed to support and promote recovery through development of knowledge and skills necessary for an individual's recovery.

Referral/Linking/Coordination of Services - office-based service activity performed by a primary clinician, or other assigned staff, to address needs identified through the assessment, and/or to ensure follow through with access to outside services, and/or to establish the client with another substance use disorder service provider.

Substance Use Disorder - a term inclusive of substance abuse and dependence, which also encompasses problematic use of substances.

Toxicology Screening - screening used for the purpose of tracking ongoing use of substances when this has been established as a part of the treatment plan or an identified part of the treatment program. (This may include onsite testing such as portable breathalyzers or non-laboratory urinalysis).

Withdrawal Management - monitoring for the purpose of preventing/alleviating medical complications related to no longer using, or decreasing the use of, a substance.

REQUIREMENTS:

The residential levels of care from ASAM are established based on the needs of the client. As part of the purpose of this document, the short and long-term descriptors will no longer be used to describe residential services. PIHPs will need to have the capacity to provide a residential continuum that will meet the needs of clients at ASAM levels 3.1, 3.3, 3.5, and 3.7.The frequency and duration of residential treatment services are expected to be guided by the ASAM levels of care, and are described as follows:

ASAM Level 3.1 – Clinically Managed Low-Intensity Residential Services

These services are directed toward applying recovery skills, preventing relapse, improving emotional functioning, promoting personal responsibility, and reintegrating the individual in the worlds of work, education, and family life. Treatment services are similar to low-intensity outpatient services focused on improving the individual's functioning and coping skills in Dimension 5 and 6.

The functional deficits found in this population may include problems in applying recovery skills to their everyday lives, lack of personal responsibility, or lack of connection to employment, education, or family life. This setting allows clients the opportunity to develop and practice skills while reintegrating into the community.

This type of programming can be beneficial to individuals who do not acknowledge a substance use problem, and services would be focused on engagement and continuing treatment. Treatment at this level is sometimes necessary to due to deficits in the individual's recovery environment and length of stay in clinically managed Level 3.1 programs is generally

longer than that of the more intensive levels of residential care. This allows the individual to practice and master the application of recovery skills.

Support Systems

Necessary support systems include telephone or in-person consultation with a physician and emergency services, available 24 hours a day, and 7 days a week. There also must be direct affiliations with other levels of care, or close coordination through referral to more and less intensive levels of care and other services. Programs should have the ability to arrange for needed procedures as appropriate to the severity and urgency of the individual's condition. These programs should also have the ability to arrange for pharmacotherapy for psychiatric or anti-addiction medications. They should also have direct affiliations with other levels of care or close coordination through referral to more and less intensive levels of care and other services such as literacy training and adult education.

Staff Requirements

Level 3.1 programs are staffed by allied health professional staff such as counselor aides or group living workers who are available onsite 24-hours a day or as required by licensing regulations. Clinical staff must be knowledgeable about the biological and psychosocial dimensions of substance use disorders and their treatment. They must also be able to identify the signs and symptoms of acute psychiatric conditions including psychiatric decompensation. Staff at this level are not involved in direct service provision, however, addiction physicians should review admission decisions to confirm clinical necessity of services

Co-occurring Enhanced Programs

These should be staffed by credentialed mental health professionals that have the ability to treat co-occurring disorders with the capacity to involve addiction-trained psychiatrists. These professionals should also have sufficient cross-training in addiction and mental health to understand the signs and symptoms of mental disorders, be able to understand and explain to the individual the purposes of different psychotropic medications and how they interact with substance use.

ASAM Level 3.3 – Clinically Managed Medium-Intensity Residential Services

These programs provide a structured recovery environment in combination with medium-intensity clinical services to support recovery. Services may be provided in a deliberately repetitive fashion to address the special needs of individuals who are often elderly, cognitively impaired, or developmentally delayed. Typically, they need a slower pace of treatment because of mental health problems or reduced cognitive functioning.

The deficits for clients at this level are primarily cognitive, either temporary or permanent. The clients in this LOC have needs that are more intensive and therefore, to benefit effectively from services, they must be provided at a slower pace and over a longer period of time. The client's level of impairment is more severe at this level, requiring services be provided differently in order for maximum benefit to be received.

Support Systems
Necessary support systems within this level include telephone or in-person consultations with a physician, or a physician assistant or nurse practitioner in states where they are licensed as physician extenders and may perform the duties designated here for a physician; and emergency services, available 24 hours a day, 7 days a week. They should have direct affiliations with other easily accessible levels of care or close coordination through referral to more and less intensive levels of care and other services. They need medical, psychiatric, psychological, laboratory and toxicology services available through consultation and referral as appropriate to the severity and urgency of the individual's condition.

Staff Requirements
Level 3.3 programs are staffed by physician extenders, and appropriately credentialed mental health professionals as well as allied health professional staff. These staff should be on-site 24-hours a day or as required by licensing regulations. In addition, one or more clinicians with competence in the treatment of substance use disorders should be onsite 24-hours a day. These staff should also be knowledgeable about the biological and psychosocial dimensions of substance abuse and mental health disorders as well as their treatments. They should also be able to identify signs and symptoms of acute psychiatric conditions including psychiatric decompensation. Staff should also have specialized training in behavior management techniques.

Co-occurring Enhanced Programs
This type of program needs to be staffed by credentialed psychiatrists and mental health professionals. They should be able to assess and treat people with co-occurring mental disorders and they need to have specialized training in behavior management techniques. Most, if not all, treatment professionals should have sufficient cross-training to understand signs and symptoms of mental disorders and be able to understand and explain to the individual the purpose of psychotropic medication and its interactions with substance use.

ASAM Level 3.5 – Clinically Managed High-Intensity Residential Services

These programs are designed to treat clients who have significant social and psychological problems. Treatment is directed toward diminishing client deficits through targeted interventions. Effective treatment approaches are primarily habilitative in focus; addressing the client's educational and vocational deficits, as well as his or her socially dysfunctional behavior. Clients at this level may have extensive treatment or criminal justice histories, limited work and educational experiences, and antisocial value systems.

The length of treatment depends on an individual's progress. However, as impairment is considered to be significant at this level, services should be of a duration that will adequately address the many habilitation needs of this population. Very often, the level of impairment will limit the services that can actually be provided to the client resulting in the primary focus of treatment at this level being focused on habilitation and development, or re-development,

of life skills. Due to the increased need for habilitation in this client population, the program will have to provide the right mix of services to promote life skill mastery for each individual.

Support Systems
Programs in this level of care should have telephone or in-person consultation with a physician, or a physician assistant or nurse practitioner in state where they are licensed as physician extenders and may perform the duties designated here for a physician; emergency services, available 24 hours a day, 7 days a week. They must also have direct affiliations with other levels or close coordination through referral to more and less intensive levels of care and other services. They must also have arranged medical, psychiatric, psychological, laboratory, and toxicology services as appropriate to the severity and urgency of the individual's condition.

Staff Requirements
Level 3.5 programs staffed by licensed or credentialed clinical staff such as addiction counselors and other professional staff who work with the allied health staff in interdisciplinary approach. Professional staff should be onsite 24-hours a day or per licensing regulations. One or more clinicians with competence in treatment of substance use disorders must be available onsite or on-call 24-hours per day. These staff should also be knowledgeable about the biological and psychosocial dimensions of substance abuse and mental health disorders as well as their treatments. Clinicians should be able to identify the signs and symptoms of acute psychiatric conditions, and have specialized training in behavior management techniques.

Co-occurring Enhanced Programs
This type of program should offer psychiatric services, medication evaluation and laboratory services. These services should be available by telephone within 8 hours and on-site or closely coordinated off-site staff within 24 hours, as appropriate by severity and urgency of the individual's mental health condition. These programs should be staffed by credentialed mental health professionals, including addiction psychiatrists who are able to assess and treat the co-occurring mental health disorder and have specialized training in behavior management. They should also have cross-training to understand the signs and symptoms of co-occurring mental disorders and be able to explain to the individual, the purpose of psychotropic drugs and how they interact with substance use.

ASAM Level 3.7 – Medically Monitored High-Intensity Inpatient Services

These programs offer a structured regime of professional 24-hour directed evaluation, observation, medical monitoring and addiction treatment in an inpatient setting. These programs operate in permanent facilities with inpatient beds and function under a set of defined policies, procedures and clinical protocols. These programs are for patients with subacute biomedical and emotional, behavioral or severe cognitive problems that require individual treatment but do not require the full resources of an acute care general hospital or medically managed individual program.

These services are designed to meet needs of patients who have functional limitations in Dimensions 1, 2, and 3. The care provided in these programs is delivered by an interdisciplinary staff of appropriately credentialed staff, including addiction credentialed physicians. The main focus of treatment is specific to substance related disorders. The skills of this team and their availability can accommodate withdrawal management and/or intensive inpatient treatment of addiction, and/or integrated treatment of co-occuring subacute biomedical, and/or emotional, behavioral or cognitive conditions.

Support Systems
This level of care requires physician monitoring, nursing care, and observations are made available. The following staffing is required for this level of care: a physician must be available to assess the individual in person within 24 hours of admission and thereafter as medically necessary; a registered nurse to conduct alcohol and other drug-focused nursing assessment at time of admission; an appropriately credentialed nurse is responsible for monitoring the individual's progress and for medication administration. There must be additional medical specialty consultation, psychological, laboratory and toxicology services available on-site through consultation or referral. There also must be coordination of necessary services or other levels of care are available through direct affiliation or a referral process. Psychiatric services should be available on-site through consultation or referral when presenting an issue that could be attended to at a later time. These services should be available within 8 hours by telephone or 24 hours in person.

Staff Requirements
These programs are staffed by an interdisciplinary staff (including physicians, nurses, addiction counselors, and behavioral health specialists) who are able to assess and treat the individual and obtain and interpret information regarding the individuals psychiatric and substance use or addictive disorders. Staff should be knowledgeable about the biological and psychosocial dimensions of addictions and other behavioral health disorders. The staff should have training in behavior management techniques and evidence-based practices. The staff should be able to provide a planned regimen of 24-hour professionally directed evaluation, care and treatment services. A licensed physician should oversee the treatment process and assure quality of care. Physicians perform physical examinations for all admitted to this level of care. These staff should have specific training in addiction medicine or addiction psychiatry and experience with adolescent medicine. Individuals should receive pharmacotherapy integrated with psychosocial therapies.

Co-occurring Enhanced Programs
Programs at this level should offer appropriate psychiatric services, medication evaluation and laboratory services. A psychiatrist should assess the individual within four hours of admission by telephone and within 24 hours following admission in person, if not sooner, as appropriate by individual's behavioral health condition. A registered nurse or licensed mental health clinician should conduct a behavioral health-focused assessment at the time of admission. If not done by a registered nurse, a separate nursing assessment must be done. The nurse is responsible for monitoring the individual's progress and administering or monitoring the

individual's self-administration of psychotropic medications. These must also be staffed by addiction psychiatrists and credentialed behavioral health professionals who can assess and treat co-occurring psychiatric disorders and who have specialized training in behavior management. These programs are ideally staffed by a certified addiction specialist physician, or a physician certified as an addiction psychiatrist. Some, if not all, treatment professionals should have sufficient cross-training to understand signs and symptoms of psychiatric disorders and be able to explain to the individual the purpose of psychotropic medication and how they interact with substance use. The intensity and care should meet the individual's needs.

ASAM LOC describe the need for treatment from the perspective of the level of impairment of the client; with the higher the level of impairment requiring the longer duration, slower more repetitive services. The identification of these needs is intended to assist with service selection and authorization for care. The placement of the client is based on the ASAM LOC determination. Due to the unique and complex nature of each client, it is recognized that not every client will "fit" cleanly into one level over another by just looking at the level of impairment. There may be situations where a case could be made for a client to receive services in each of these levels and each would be appropriate. In these situations, documentation should be made as to the rationale for the decision. In addition, variations in treatment that do not follow these guidelines should also be documented in the client record.

The cost of the service should not be the driving force behind the decision; the decision should be made based on what is most likely to help the client be successful in treatment and achieve recovery.

The ASAM Assessment Dimensions must be used to assist in the determination of the LOC needed by a client:

Level of Care	**Level 3.1**	**Level 3.3**	**Level 3.5**	**Level 3.7**
Dimension 1 Withdrawal Potential	No withdrawal risk, or minimal/stable withdrawal; concurrently receiving Level 1-WM or Level 2-WM	Not at risk of severe withdrawal, or moderate withdrawal is manageable at Level 3.2-WM	At minimal risk of severe withdrawal at Levels 3.3 or 3.5. If withdrawal is present, it meets Level 3.2-WM criteria	Approach "unbundled" withdrawal management for adults.