LAKESHORE REGIONAL ENTITY

SUBSTANCE USE DISORDER SERVICES PROVIDER MANUAL

Allegan County Community Mental Health Services
Community Mental Health of Ottawa County
HealthWest
Network180
West Michigan CMH System

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SUD SERVICES PROVIDER MANUAL

SECTION 1

INTRODUCTION AND OVERVIEW

1.1 Introduction

The responsibility for managing substance abuse treatment services will transfer from the Regional Substance Abuse Coordinating Agencies (CAs) to the Prepaid Inpatient Health Plans (PIHPs) on October 1, 2014. The five (5) affiliate Community Mental Health Service Provider (CMHSP) members of the Lakeshore Regional Entity (LRE) have been delegated the responsibility to manage the responsibilities for their respective areas. The region is comprised of 5 CMPSP: Community Mental Health of Ottawa County, Community Mental Health of Muskegon County, Network 180, Allegan County Community Mental Health, and West Michigan Community Mental Health. Within this region, Ottawa, Muskegon, and West Michigan CMHs are partnering for specific tasks and services and Network 180 and Allegan CMH are partnering. This document is the Provider Manual for the network of Substance Use Disorder Treatment Providers contracted with directly with the CMHs of Muskegon, Ottawa, and West Michigan heretofore referred to in this document as "CMHSP", referring to the specific CMH system with which the provider is contracted. This Provider Manual includes guidelines for treatment service definitions, requirements and restrictions, and is a reference source for issues relating to treatment services funded through the CMHSP. The guidelines provided within this document address both Block Grant and PA2 funding requirements. In many instances, throughout the document, it will note that the section applies only to Medicaid and Healthy Michigan Plan funded services or providers.

Block Grant Guidelines provided within this document and incorporated into contracts between the CMHSP and sub-contractors are derived from the terms of the Federal Block Grant, Public Act 368 of Michigan, the Annual Action Planning Guidelines (AAP) issued by the Michigan Department of Health and Human Services (MDHHS), and actions taken by the CMHSP.

For special purpose funds, from other funding sources, the terms set by that funding source will be provided in separate guidance specific to services funded through those funds.

Annually, MDHHS publishes Action Plan Guidelines (APG) that specifies minimum requirements and terms for both the CMHSP and its sub-contractors. MDHHS grants the PIHP/CMHSP authority to add further requirements germane to its own regional system so long as those additional requirements do not contradict or circumvent the Federal or State requirements.

The CMHSP will incorporate the terms of the Annual Action Plan (AAP) into this provider manual and the MDHHS contract. It is the responsibility of all sub-contractors to abide by the terms of the APG as reflected in this manual and their contract with the CMHSP.

Given the wide variety of sources of requirements and changes, this operational reference manual is provided as a single point of reference and compilation of requirements. While it is our intent to make it as authoritative and accurate as possible on the date of its publication, users are cautioned that original source material takes precedence in all

instances.

Amendments per MDHHS, other funding sources, or the CMHSP may be made into requirements for subcontractors. Additional or new information and/or requirements may be distributed to subcontractors through a variety of methods. For Network180 subcontractors, please contact your contract manager with questions regarding contractual requirements.

1.2 Role of the CMHSP

The CMHSP serves as the coordinating agency and is responsible for comprehensive planning and reporting for substance use disorder services in the CMHSP region. Each CMHSP must ensure a continuum of substance abuse treatment services based on local determination of treatment service needs and on Federal and State requirements, as outlined in MDHHS Treatment Policy #09 Outpatient Treatment Continuum of Services (See Appendices). The CMHSP is also responsible for establishing performance criteria with funded providers for audit purposes.

The CMHSP is expected to work toward a continuum of care for SUD Treatment and Recovery Services which includes Outpatient, Residential, Detoxification, Methadone and other Medication Assisted Treatment, Case Management, Recovery Support, and Early Intervention.

1.3 CMHSP Priorities

1.3.1 Recovery Oriented System of Care (ROSC)

Michigan has defined ROSC in the following way:

> *Michigan's recovery-oriented system of care supports an individual's journey toward recovery and wellness by creating and sustaining networks of formal and informal services and supports. The opportunities established through collaboration, partnership and a broad array of services promote life enhancing recovery and wellness for individuals, families and communities.*
>
> Adopted by the ROSC Transformation Steering Committee, September 30, 2010.

A ROSC Integrates Strategies To:

- Prevent the development of new SUDs.
- 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.

The following priorities have been established by MDHHS for the initial implementation of a ROSC transformation.

- Behavioral health and primary healthcare integration

- Community health promotion
- Recovery support services that are peer-based
- Prevention services that are environmental and population-based
- Services and supports whose focus is expanded, including both the continuum of care (from pre-treatment services to post-treatment check-ups and support) and the content of care (beyond supporting abstinence to promoting community health and helping people build meaningful lives in the community).

Additional information pertaining to Michigan's ROSC transformation initiative can be found in the ROSC area at the website: MDHHS - Recovery (michigan.gov)

1.3.2 Individualized Treatment Planning and Integrated Care

The CMHSP acknowledges that the best client outcomes will be achieved when substance use disorder treatment services are based on the foundation of an individualized treatment/recovery plan. To achieve the best results, these plans must be a product of the client's active involvement in establishing the goals and expectations for treatment to ensure appropriate level of care determination, identify true and realistic needs, and increase the client's motivation to participate in treatment.

The CMHSP is of the philosophy that in order for a client's treatment plan to effectively address a client's needs, the plan must incorporate a holistic approach to services, including integrated care for physical and mental health needs and trauma-informed care.

1.3.3 Data Driven Quality Improvement

The CMHSP places great importance on the provider network and the coordinating agency being able to use data to inform data-driven decision making in both planning and implementation of services. The CMHSP will work to support the provider network in monitoring the provision of services to guide service improvement.

1.3.4 Community Input and Involvement

The communities served by the CMHSP are in a unique position to assist the CMHSP in the distribution and management of resources coordinated by the agency. The CMHSP will work to involve community input in decision making. The CMHSP also places great importance on the agency and provider network being actively involved in community initiatives so that resources may be coordinated effectively.

1.4 Policy and Procedure Development

Policies and supporting procedures governing the operation of the CMHSP, including its sub-contractual relationships with providers, are derived, in order of precedence, from Federal Block Grant requirements, State of Michigan requirements, and adopted policies of CMHSP Boards of Directors.

The CMHSP is charged with ensuring that funded services meet the needs, priorities, and requirements as mandated by the MDHHS and the U.S. Department of Health and Human Services.

Federal and State mandates are not negotiable and the CMHSP does not have the authority to waive such requirements or mandates in the contracting process. The CMHSP acceptance of such are pre-conditions of receiving resource allocations which are distributed to providers through sub-contracts.

The CMHSP Board of Directors may endorse, remain neutral with respect to, or recommend against sub-contractor-initiated requests for changes in Federal or State requirements. The CMHSP Board of Directors may also initiate its own requests for changes. In neither instance does the action of the Board constitute a waiver of requirements.

1.5 Provider Network

Providers with a history of administering quality behavioral care in a cost-effective manner and meeting the CMHSP Provider Selection Criteria are selected to participate in the CMHSP provider panel network.

The CMHSP classifies providers as network or non-network providers. For the remainder of this manual, Network providers will be referred to as Providers and non-network providers will be referred to as non-network providers.

Contracted network providers are in no way a party to any employer/employee relationship with MDHHS, the CMHSPs, the Medical Services Administration, or any other such organization by virtue of contracting as a provider in the CMHSP Medicaid/Healthy Michigan Plans program.

The CMHSP's service network will contain a continuum of substance abuse care, as required, and allowed by Michigan Medicaid/Healthy Michigan Plan rules. It will provide for a distribution of professionals and health service providers. The CMHSP will establish a range of services from facilities. Services will be proximal to enrollees and timely access to care available.

- Where available, public transportation will be considered in provider location. The geographic dispersal of members in urban/suburban and rural communities affects ease and time required to access treatment. Ease of access affects follow-through and follow up to treatment and, therefore, contributes significantly to positive treatment outcome.
- For these clinical reasons, a thirty (30) mile transportation radius is established from the home to be the outside parameter for outpatient treatment and ancillary services, whenever possible. No Medicaid/Healthy Michigan Plans client should have to travel more than sixty (60) miles for appropriate outpatient services. The travel radius to a qualified detoxification or other residential care facility, if provided, may be greater, because there are far fewer such facilities, and this is an allowable (optional) service under the CMHSP Medicaid/Healthy Michigan Plan.

1.6 CMHSP Contact Information

Inquiries regarding administrative functions of each CMHSP and the content covered within this document can be made by telephone, fax, or mail to the respective CMHSP:

Allegan Community Mental Health
3283 122nd Ave, Allegan Mi 49010
Access: 1-877-608-3568
Fax: 269-673-2738

CMH of Ottawa County
12265 James St.
Holland MI 49424
Access: 1-877-588-4357
Fax: 616-393-5653

HealthWest (Muskegon County)
376 E. Apple Avenue
Muskegon MI 49442
Access: 1-855-795-1771
Fax: 231-724-4545

Network180 (Kent County)
790 Fuller NE, Grand Rapids, Mi 49503
Access: 1-800-749-7720
Fax: 616) 336-3593

West Michigan CMH
(Lake, Mason, Oceana Counties)
920 Diana St.
Ludington, MI 49431
Access: 1-800-992-2061
Fax: 231-845-7095

Claims forms should not be sent to the CMHSP. Refer to Section 6 of this manual for billing and reimbursement instructions and claim inquiries. This phone number should be used for inquiries related to the following:

- This manual and provider requirements
- Claims processing
- Reporting procedures
- Service Planning and Development

Customer Service

Inquiries regarding client services may be directed to the Customer Service Department of the CMHSP. Customer service is available after hours and on weekends for client's seeking services.

Allegan County Community Mental Health Services
Customer Service
Phone: 1-877-608-3568 or 269-686-5124
(TTY 269-686-5313)
Email: customerservices@accmhs.org

CMH of Ottawa County
Customer Service:
Main: 1-866-710-7378
Fax: 616 393-5687
Email:

cmhcustomerservices@miottawa.org

HealthWest
Customer Service:
1-231-720-3201

Network180
Customer Service:
616.855.5206
1.800.411.0690
customerservices@network180.org

West Michigan CMH (Lake, Mason, Oceana Counties)
Toll Free: 1-800-992-2061

This number should be used for the following purposes:

- Assist persons seeking services in identifying the service provider(s) best able to meet their needs.
- Assist referring organizations in identifying the service provider(s) best able to meet the needs of the person they are referring.
- Assist SUD treatment providers in identifying available service providers when the program needs to refer a client to a level of care that they do not provide.
- Service Eligibility.
- Benefits and program information.
- Discuss authorization of client services with the provider requesting authorization.

1.7 Manual Maintenance

Periodically, the CMHSP publishes bulletins, notices, or administrative letters or memorandums to supplement and update the provider manuals. These publications provide information relating to policies, procedures and benefits. They are the official means of updating the manual between reprinting or full manual issues.

The administrative letter or memorandum is used to communicate major policy changes impacting the CMHSP, such as:

- A change in the reimbursement mechanism for a provider.
- A change in the system of communicating admission and/or claims information.
- An announcement by the Department of Health and Human Services that affects the overall Plan.

Bulletins or notices are used to convey changes in the day-to-day operational procedures that apply to providers, to communicate changes in Medicaid/Healthy Michigan Plan coverage and to announce new provider participation.

SECTION 2

ACCESS TO SUBSTANCE USE (SUD) DISORDER SERVICES

2.1 Consumer Entrance to Services:

Persons seeking outpatient treatment services can present directly at any outpatient provider in the CMHSP Provider Network. Persons seeking residential or sub-acute detox services can present at any CMHSP contracted Outpatient Provider.

It is not required that the consumer or provider contact the CMHSP Access Management Staff prior to delivery of an assessment and initial outpatient or intensive outpatient services that result in an individualized treatment plan.

A. Outpatient Providers:

Non-MAT Providers: Persons seeking outpatient treatment services can present directly at any outpatient provider in the CMHSP Provider Network, including medication assisted treatment. Persons seeking residential or sub-acute detox services can now present at any CMHSP designated Outpatient Provider. Anyone who would like assistance in identifying the provider best able to meet their needs should contact CMHSP Customer Service for assistance.

Designated Outpatient Providers will conduct pre-screening to determine eligibility for CMHSP funded services, a full assessment for eligible clients, inform the person of the providers available to meet their needs, and make referrals when appropriate.

To be a designated Outpatient Provider in the CMHSP network, a provider must accept Block Grant and Medicaid/Healthy Michigan Plans for the CMHSP Region Counties of Allegan, Kent, Lake, Mason, Oceana, Muskegon, and Ottawa. Refer to the Lakeshore Regional Entity Provider Directory (https://mirecovery.org/community-mental-health-providers/) for a complete list of Substance Use Disorder Providers in the region.

B. Central Phone Support by CMHSP:

Allegan County Community Mental Health Services	1-269-673-6617
CMH of Ottawa County	1-877-588-4357
HealthWest (Muskegon County)	1-855-795-1771
Network180 (Kent County)	1-616-336-3909
West Michigan CMH (Lake, Mason, Oceana Counties)	1-800-992-2061

The above designated phone numbers that ring directly to access management staff at each CMHSP is available 24/7 to promote access to services. This phone number will be available to:

- Assist persons seeking services in identifying the service provider(s) best able to meet their needs.

- Assist referring organizations in identifying the service provider(s) best able to meet the needs of the person they are referring.
- Assist SUD Outpatient Providers in identifying available service providers when the program needs to refer a client to a level of care that they do not provide.

During regular business hours consumers who contact the designated phone number will be provided with assistance identifying an appropriate service provider in their community. A full screening will not be completed during business hours.

When a client calls, a CMHSP Access Staff Member will briefly examine the client's condition and make a referral to an appropriate network provider.

If the referral is routine, the Access Staff Member makes a routine referral to a designated Provider. Referrals are made based on:

- Location of the client
- Benefits Available
- Service Availability
- Client Preference

Clients who meet "urgent" or "crisis" criteria will be referred to an appropriate crisis resource such as the emergency room or local 24-hour mental health crises Access Center.

Network Providers are encouraged to include a statement in their after-hours recording that directs people to call 911 if it is an emergency or to call the CMHSP designated phone number for immediate assistance if the situation is not an emergency:

- **Urgent Situation:** A situation in which an individual is determined to be at-risk of experiencing a substance use disorder or mental health crisis in the near future, without the intervention of care, treatment, or support services. **Note**: Any priority population clients seeking substance use disorder services that meet the level of care criteria for admission to detoxification or residential services are an urgent situation.
- **Crisis Situation:** A situation in which a client seeking access is experiencing a medical or psychiatric emergency or who is suicidal or homicidal, thereby requiring an immediate referral/intervention to a provider specializing in the service most appropriate to the client's situation and needs.

Clients in need of substance use disorder services but who are not in the CMHSP region will be referred to the access center for the appropriate PIHP. Clients who are not in need of substance use disorder services will be referred to other community resources as available.

C. Pre-Screening

The outpatient provider where the client presents will be responsible for pre-

screening the consumer to ensure they meet eligibility standards prior to service provision with CMHSP funds.

Pre-screening can be done by non-clinical staff and may be done over the phone or in person if the client presents at the agency as the first contact.

Pre-screening should collect enough information to ensure eligibility and determine priority status of the client.

A client should not have to schedule an appointment to complete the pre-screen. Instead, the pre-screen should occur at the initial point of contact with the client and result in an appointment for initial services. If the provider is unable to complete the pre-screening upon initial contact the provider must ensure that pregnant drug users, injecting drug users, and parents at risk of losing custody are screened within twenty-four (24) hours, and all others within two (2) business days.

The provider where the consumer presents must determine, and document, the client's admission priority status, as defined in Section 3.2.

Priority Status: Certain priority populations must be given admission preference over any other client accessing the system. These clients are identified as a priority population under Block Grant funding requirements. Admission preference must be applied in the following order:

- Pregnant injecting drug user
- Pregnant drug user
- Injecting drug user
- Parents at-risk of losing custody of their children
- Individuals under MDOC supervision

Because these populations must be given admission priority, it is necessary to determine priority status during the pre-screening process. If the client is referred to another provider, the referring provider must notify the receiving provider of the priority status with appropriate releases of information.

For more details regarding priority populations and access standards refer to Section 2.3.

D. Choice of Provider

The outpatient provider where the consumer presents must inform the client of all available service provider options consistent with the appropriate level of care and resources for payment.

Client preference and choice is given high value in the placement process, and a client will not be authorized for a level or place of care that they state a firm unwillingness to attend. Prospective clients may have legal incentive to participate in treatment, but a Court-based referral does not guarantee CMHSP funding. Authorization for these clients will be based on clinical eligibility/medical necessity.

If a client indicates a preference to receive services from another provider, the pre-screening provider shall refer the client. When referring clients to another provider, the initial provider should assist the client in accessing services at the other provider. If the pre-screening was done over the phone, a three-way call is encouraged. If the pre-screening was done in person, the initiation of a phone call to the new provider with the client is encouraged.

E. Initial Appointment Scheduling

If the client chooses to receive services at the pre-screening provider, an initial appointment with the client should be scheduled if it is not possible to provide services immediately.

A provider must maintain adequate facilities and sufficient personnel to provide consumers with timely access to covered services as are medically needed.

Providers must assure that preference for treatment admission is given to priority populations and meet the following Federal and/or State admission priorities.

- Pregnant and pregnant injecting drug users must be offered admission within two (2) business days. Pre-natal referral and communicable disease risk reduction information must be provided within forty-eight (48) hours.

  Pregnant Medicaid/Healthy Michigan Plans clients must receive an assessment within twenty-four (24) hours, and admission to services within twenty-four (24) hours after the assessment.

- Injecting drug user, parents at risk of losing children, and all others must be offered admission within **fourteen (14) days**.

If it is not possible to offer an appointment within the required timeframe, the provider must contact the CMHSP Access Center in the appropriate county to receive assistance in identifying an alternative provider of service and to place the client on the waiting list if appropriate.

Admission delays of more than fourteen (14) days for any level of care shall be monitored by the CMHSP, and providers must notify CMHSP if they do not have the capacity to meet service requests within this time allowance.

F. Initial Services

Once the provider has determined eligibility the CMHSP will allow up to five (5) initial hours of outpatient or two (2) days of intensive outpatient services, including the assessment, before the provider must submit an authorization request. The provider must ensure that the full bio-psychosocial assessment is conducted within a reasonable timeframe.

Recently completed assessments by Community Mental Health, a Court/corrections program, primary medical care provider, or other qualified source should be utilized to the extent possible. If the assessment is a different tool than the provider used, the content of their assessment should be used to complete the corresponding portions of the provider's assessment tool and any

additionally required information would be collected from the client.

The bio-psychosocial assessment and treatment or discharge plan must be in place by the end of these initial sessions in order for the initial sessions to be eligible for reimbursement and/or authorization of additional services.

- For clients who do not need additional services a discharge plan should be in place by the end of the initial sessions to be eligible for reimbursement.
- For clients who discontinue contact prior to completion of a plan, the provider must document efforts to re-engage the client for the initial services to be eligible for reimbursement.

It is not required that these initial sessions be completed before an authorization request can be submitted. A provider may submit an authorization request at any point after the assessment has been completed.

This approach to initial services is designed to allow flexibility in the structuring of initial sessions and to allow the clinician to establish a relationship with the client in the initial session(s) rather than spending the first session(s) completing paperwork which has been found to reduce client retention in services.

The authorization request must be submitted within fourteen (14) days of the first date of service. It is expected that the client's individual treatment plan will be completed within fourteen (14) days of admission and must be signed by the client within fourteen (14) days of completion.

2.2 Referring to Another Provider

A. When a Referral is Necessary

A. Level of care: The provider must refer clients who want and are appropriate for a higher level of care that the outpatient provider does not offer. This may occur either before or after initial outpatient services are offered. Interim services may be provided at the lower level of care until the client is admitted to the higher level of care.

B. Client Choice: If a client indicates a preference to receive services from another provider, the pre-screening provider shall refer the client.

Co-Occurring Disorders: *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions* provides the following guidance for determining the service needs of clients presenting with co-occurring conditions:

- Individuals whose co-occurring mental disorder best fits within the category of low/moderate severity disorder can be appropriately treated in programs designed to treat primary substance use disorders.
- Individuals with concurrent high severity mental disorders are generally best managed in dual diagnosis specialty programs that can offer integrated mental health and addiction treatment approaches.

If a provider is not able to provide these services they should refer clients to an appropriate provider if one is available who will provide the services to the client. If no appropriate provider is available the provider should contact the CMHSP for assistance.

- Some patients may require immediate stabilization for their psychiatric symptoms before they can be engaged in ongoing addiction treatment and recovery. Depending on the severity of their symptoms, such patients may require referral to medical and/or psychiatric services outside the scope of addiction treatment. Patients whose biomedical or psychiatric disorders are so severe that stabilizing them is the highest priority are most appropriately treated in a medical or psychiatric facility before addiction treatment is initiated or continued.

B. Transferring Between Levels of Care:

CMHSP Customer Service is available to assist in referring clients by identifying available service providers:

A. Assessment: The ASAM Continuum will be completed by the outpatient provider. In some cases the assessment will be completed by detox or residential services providers if treatment begins there.

When multiple providers are involved in providing services to an individual, every effort must be made to avoid unnecessary duplication of assessments. The initial provider shall obtain signed releases of information allowing information to be shared with the other providers who will be involved in the case, the authorizing CMH, and the LRE.

Once services are authorized, the provider who completed the assessment will share the assessment report (with the client's permission) with the secondary provider. A second assessment at the next level of care will not be an allowable expense if already billed by the previous provider.

If the assessment provided is a different tool than the provider uses, the content of the assessment completed by the initial provider should be used to complete the corresponding portions of the provider's assessment tool and any additionally required information would be collected from the client. An additional assessment would not be billed by the provider receiving an assessment already completed.

B. Authorization at Higher LOC

When the Outpatient Provider clinician determines that a referral to residential or residential sub-acute detox services at another provider is necessary, they will need to coordinate authorization of services with the Access Staff Member at the CMHSP.

The Outpatient Provider will need to submit the following so that the CMHSP can create the authorization for the client and release it to the selected

residential provider:

- Residential authorization request form.
- All information required to create the Demographic and Payor records in the CMHSP Electronic Medical Record (EMR) and a copy of the Declaration of Income if the Outpatient Provider has not yet created these records for the client.
- A copy of the client's full bio-psychosocial assessment- which is sent both to CMH and to the detox provider.
- A copy of the individualized treatment plan (if completed).

If approved, the CMHSP Access Staff Member will enter an initial authorization for services at the higher level of care. The Outpatient Provider should then assist the client in contacting the residential provider to schedule admission.

Once this has been done, the Outpatient Provider should notify the CMHSP of the selected provider and anticipated admission date. The CMHSP will also need:

- A signed Release of Information between the CMHSP and the receiving residential provider. Without this release, the CMHSP will not be able to release the client's information to the residential provider.

When admitting the client, the residential provider should identify 'Other SA Program' as the referral source rather than 'AAR" when entering the client's admission record.

C. Interim Services

If the client is unable to be admitted to the higher level of care services immediately, the Outpatient Provider shall provide OP or IOP services until admission takes place at the higher level of care.

When requesting authorization for provision of interim services, the provider should note that the client is waiting for admission to a higher level of care. Refer to Section 3.1.3E for more information.

Providers must ensure that priority populations receive the required interim services as defined in Section 2.3. If the client refuses interim services, the refusal should be documented in the client file.

D. Transfer Criteria for a Higher Level of Care

According to *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Condition*, each of the six dimensions should be reviewed to determine a patient's need for transfer to a higher level of care. It is appropriate to transfer the patient from the present level of care to a higher level of care if they meet the following criteria:

- Has been unable to resolve the problem(s) that justified admission to the present level of care, despite amendments to the treatment plan; or
- Has demonstrated a lack of capacity to resolve their problem(s); or

- Has experienced an intensification of problem(s), or has developed a new problem(s) that can be addressed effectively only at a more intensive level of care.

E. Transfers from Detoxification to Next Level of Care

Medicaid/Healthy Michigan Plan clients must be admitted to the next level of care within seven (7) days of discharge from detoxification. However, it is recommended for all clients that they be admitted as soon as possible following detox services. If residential services are required, but there is not capacity to admit the client, interim services should be provided at a lower level of care until admission to residential occurs.

F. Warm Transfer

A "warm" transfer will be required if initial outpatient services have been provided and is to be encouraged in all cases. The referring provider should establish the appropriate release of information so that the provider receiving the referral can be made aware that the client is coming and ensure that information collected from the client is not duplicative. When the client arrives at the second provider they should be treated as if the transition is a continuation of their care. A warm transfer should also be ensured when a consumer is transitioning to a lower level of care.

When a consumer is transitioning to a lower level of care and they had received interim services there should be an attempt to allow the client to return to the original provider.

If transportation is a challenge, the referring provider should assist the client in accessing community resources to assist. Some Medicaid/Healthy Michigan Plans cover transportation assistance for clients.

C. Information Sharing Between Providers

The assessment process is time consuming, stressful, and can be traumatic for some individuals. It is important to remember that assessment can be very painful and shaming for clients who have to share their history. If the process is not undertaken with an awareness of how traditional service approaches may trigger a trauma victim, more harm can be done to an already fragile individual.

Because of this, the appropriate releases of information must be collected so that any screening and/or assessment results can be shared with the CMHSP and/or another provider who will serve the client. If the client refuses to allow the release this refusal must be documented in the client's file. When the CMHSP authorizes residential services we will share the assessment results with the residential provider once the release of information from the Outpatient Provider is received.

Recently completed assessments by Community Mental Health, a Court/corrections program, primary medical care provider, or other qualified source should be utilized to the extent possible. If the assessment is a different tool than the provider used, the content of their assessment should be used to complete the corresponding portions of

the provider's assessment tool and any additionally required information would be collected from the client.

The provider where the consumer presents must also determine the client's admission priority status and advise the potential admitting program of the client's admission priority status and to receive, from the potential admitting program, information on if and when admission may be expected.

When a client transitions between levels of care, whether at the same or a different provider, appropriate releases of information must be established and information regarding the assessment and treatment plan must be shared. If the client refuses to provide the release the refusal must be documented in the client's file.

A sample *Release of Information* has been provided in the Attachments section.

2.2.4 Coordination of Care with the Court System

When the Court system refers a client, the Provider must use the substance use disorder screening information provided by the District Court Probation Officer assessments when the Probation Officer has the appropriate credentialing through the Michigan Certification Board for Addiction Professionals (MCBAP).

A release of information form must accompany the District Court Probation Officer referral. In situations where information is not adequate, the release of information should allow the Provider to contact the District Court Probation Officer for additional information.

If the Court system refers the client to the CMHSP Access Staff Member, they will use the provided information to pre-authorize services at the provider of choice based on medical necessity, *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Condition* and financial eligibility.

Drug Court clients must be shown to need the level of clinical care being requested, per ASAM standards. In situations where the client is "borderline" in regard to level of care, the Drug Court preference level should be honored if funding permits.

2.3 Priority Populations/Admission Standards

Providers must provide services to priority population clients before any other non-priority client is admitted for any other treatment services. Exceptions can be made when it is the client's choice to wait for a program that is at capacity.

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

	admission within 48 business hours.	2. Referral for pre-natal care. 3. Early intervention clinical services.
Pregnant Substance Use Disorders	1. Screened and referred within 24 hours. 2. Detoxification, Methadone, or Residential – Offer admission within 24 business hours. Other Levels or Care – Offer admission within 48 business hours.	*Begin within 48 hours:* 1. Counseling and education on: a. HIV and TB. b. Risks of transmission to sexual partners and infants. c. Effects of alcohol and drug use on the fetus. 2. Referral for pre-natal care. 3. Early intervention clinical services.
Injecting Drug User	Screened and referred within 24 hours. Offer admission within 14 days.	*Begin within 48 hours – maximum waiting time 120 days:* 1. Counseling and education on: a. HIV and TB. b. Risks of transmission to sexual partners and infants. c. Effects of alcohol and drug use on the fetus. 2. Early intervention clinical services.
Parent At-Risk of Losing Children	Screened and referred w/in 24 hours. Offer admission w/in 14 days.	*Begin within 48 business hours:* Early intervention clinical services.
Individuals under MDOC Supervision	Provide notice of admission decision to the Supervising Agent within one business day	
All Others	Screened and referred within seven calendar days. Capacity to offer admission w/in 14 days.	Not required.

2.4 Eligibility Criteria for CMHSP Funded Services

Medical Necessity: CMHSP funded treatment services, for all funding streams, must meet medical necessity criteria to be allowable. It should be noted that medical necessity does not require recent use.

Medically necessary services are supports, services, and treatment that meet at least one of the following criteria:

- Necessary for screening and assessing the presence of substance use disorder.
- Required to identify and evaluate a substance use disorder.
- Intended to treat, ameliorate, diminish or stabilize the symptoms of a SUD.
- Expected to arrest or delay the progression of a SUD.
- Designed to assist the individual to attain or maintain a sufficient level of

functioning to achieve his/her goals of community inclusion and participation, independence, recovery or productivity.

In addition, determination of medical necessity must be based on all the following:

- Based on information provided by the individual, individual's family, and/or other individuals (e.g., friends, personal assistants/aids, etc.) who know the individual.
- Based on clinical information from the individual's primary care physician or clinicians with relevant qualifications who have evaluated the individual.
- Based on individualized treatment planning.
- Made by appropriately trained SUD professionals with sufficient clinical experience.
- Sufficient in amount, scope and duration of the service(s) to reasonably achieve its/their purpose.

Residency

- Block Grant and Medicaid/Healthy Michigan Plans: Only residents of Lake, Mason, Oceana, Allegan, Kent, Muskegon, and Ottawa Counties are eligible for CMHSP Block Grant funding. Non-CMHSP residents may apply to the CMHSP for funding assistance following the procedures provided using the *Non-Resident Service Request Form* (for Block Grant only) and will be considered on a case-by-case basis.
- Residency is defined using the county of financial responsibility (COFR) guidelines. Key elements of the COFR guidelines include:
    - The financially responsible CMHSP is the one that managed the public benefit in the county where the client last lived independently.
    - Licensed AFC homes, nursing homes, and homes for the aged are not considered living independently.
    - Adults living in transient settings (motels, homeless shelters, "couch surfing", etc.), on the street, or in their vehicle are considered residents of that county if they express intent to remain in that county.
    - Children or adolescents in foster care are considered residents of the county whose court has jurisdiction of their case.
    - Children or adolescents not in foster care are considered residents of the county where their parent or legal guardian resides.

  Questions regarding county of residency should be directed to the CMH Access Center.

Financial Eligibility:

The client must be eligible for CMHSP administered funds prior to service delivery, including Block Grant, Medicaid/Healthy Michigan Plans, Healthy Michigan Plan, or MIChild for residents of all counties in the CMHSP region.

Block Grant Treatment funds administered by the CMHSP are primarily to provide

services for current residents of the LRE region (Lake, Mason, Oceana, Allegan, Kent, Muskegon, and Ottawa). Residency in the area shall be established by evidence of an address within the region with stated intent to remain.

Acceptable documentation may include a Michigan driver's license, State identification card, school identification, auto registration, voter registration, a bank document, or other dated/addressed document from an official governmental unit, school, or employer.

When a person moves out of the region, residency will be considered to have ended thirty (30) days after the move, and CMHSP coverage will be discontinued unless continuation is applied for and granted by the CMHSP using the process described for non-CMHSP residents below.

Residents of all other counties with Medicaid/Healthy Michigan Plans should be referred to the appropriate PIHP Access Center for services.

Residency is defined using the county of financial responsibility (COFR) guidelines. The COFR guidelines are complex, so if there is any question regarding county of residency, consult one of the CMH Access Centers.

Non-CMHSP Residents:

Non-CMHSP Block Grant eligible residents may apply to the CMHSP for funding assistance using the *Non-Resident Application for Payment of Treatment Service* and will be considered on a case-by-case basis. CMHSP funded treatment providers may admit non-residents to treatment but must collect payment for the client from other sources, unless pre-approved by the CMHSP.

It is expected that the majority of requests will be from residents of adjacent counties, who are unable to access appropriate services within their region due to capacity, location, language and/or schedule barriers.

The CMHSP will grant approval when financially possible for MDHHS Priority populations.

Ability to Pay

Providers are required to use the *Ability to Pay* to determine financial eligibility for Block Grant funding provided in the Attachments section. Block Grant funds administered by the CMHSP are the last source of payment (Payor of Last Resort). If a client has Medicare, Medicaid, Healthy Michigan, MIChild, PA2 funding, partial insurance, or Department of Corrections (DOC) funding, all of these sources would be primary and need to be billed first. CMHSP funds may not be used to subsidize insured clients if the insured client chooses to go to a provider outside their insurance network.

Ability to Pay is determined by the following :

- **Minor Children:** For purposes of determining CMHSP financial eligibility, a child under 18 years of age will be considered a dependent; and total family income must be used unless the minor has been declared an emancipated

minor, is married, or confidentiality has been formally requested by the minor for initial treatment services. During the course of treatment, once there is parental knowledge of a child's treatment, parental resources must be considered and applied.

- **Adult Dependent**: In the case of a single person 18 years of age and over who is living with his/her family and is being claimed as a dependent for income tax purposes (i.e. a student), family income should be considered in determining CMHSP financial eligibility. If the person is covered by family health insurance, the available health insurance benefits must be used prior to using CMHSP Block Grant funds.
- **Adult Independent**: Once a person turns 18, they may be legally considered an adult. Their 1040 income tax form or current payroll stub should be used to document income, and to determine financial eligibility. Parental income is not used if the 18-year-old is not claimed by a parent as a dependent. If the person is covered by family health insurance, the available health insurance benefits must be used prior to using CMHSP Block Grant funds.
- **Married**: If married, the income of the client's spouse must also be considered.
- **Child support**: Child support paid should be deducted from an adult's income. Child support received should not be counted toward income.

SECTION 3

UTILIZATION MANAGEMENT

The CMHSP utilization management consists of the authorization of treatment services, concurrent reviews of treatment, retrospective reviews of challenging cases, random sample client file reviews, special studies, grievance and appeals procedures, review of authorization requests and service provision trends, and monitoring and assessment of operations and system trends.

During the course of the fiscal year and based on funding utilization, there may be a need for the CMHSP to institute a waiting list for Block Grant consumers. If this becomes necessary, providers will be given specific instructions.

In addition to the CMHSP Utilization Review, all Providers are expected to have internal utilization management capability. This capability must be expressed in systematic procedures which include initial assessments, concurrent review and retrospective reviews or studies. Adequate provision for staff supervision and consultation, peer review, and in-service training must be demonstrated.

3.1 Authorization Requests

Providers submit service authorization requests to the specified CMH department via the CMHSP EMR to be reviewed by a CMHSP Access Staff Member. Providers will use the designated CMHSP Customer Service phone number regarding authorization issues.

Authorization of services shall not be limited to consumers who report use within the past thirty (30) days because a restriction of services to only clients who report recent use is not in keeping with a Recovery Oriented System of Care (ROSC).

Service authorization requests for initial services and continuation reviews must be based on the appropriate level of care as determined by medical necessity criteria, taking into consideration all six dimensions, not just recent use patterns and progress toward treatment goals. The initial authorization request must be submitted via the CMHSP EMR system within fourteen (14) calendar days of the initial admission date.

Client preference and choice is given high value in the placement process, and a client will not be authorized for a level or place of care that they state a firm unwillingness to attend.

3.1.1 Authorization Parameters

Section 5.2 details the benefits and authorization parameters by level of care. Services authorizations will be for the entire amount within the level of care as summarized in the Authorization Matrix which is provided in the Attachments section.

Providers must discharge clients when it is clinically appropriate even if all authorized units of service have not been used. According to *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Condition*, it is appropriate to discharge the client when they have achieved the goals articulated in their individualized treatment plan, thus resolving the problem(s) that justified admission to the current level of care.

3.1.2 Maximum Benefits and Exceptions

Within the Treatment Specifications some services under certain funding streams have established maximum service amounts for a client to receive within a twelve (12) month period. These maximum amounts are expected to meet the needs of most clients. However, when a client is in need of services beyond the maximum amount they may be authorized if clinically appropriate.

Maximum services received are determined based on the previous twelve (12) month period and within the entire CMHSP network. The CMHSP will review requests for clients who have already received the maximum amount of services within the CMHSP provider network on a case by case basis through the standard authorization request process.

Information reviewed will include: the client's treatment plan goals/objectives that have been achieved/not achieved, and an explanation of why this client requires and is expected to benefit from an extension of treatment at this level of care. If necessary, the CMHSP may request additional information.

When the provider is aware that the client has used the maximum benefit, this information should be provided within the re-authorization request. When the provider is unaware that the client has used the maximum benefit, the CMHSP will notify the provider and request the additional information if necessary.

3.1.3 Authorization Request Submission

All clients seeking CMHSP-managed public funding, in whole or part, for their treatment services, must be authorized for those services by the CMHSP. A request for authorizations must be entered into the CMHSP EMR within fourteen (14) days of the first date a client receives services.

A. **Retroactive Authorization**

Once the provider has determined eligibility, the CMHSP will allow up to five (5) initial hours of outpatient or two (2) days of intensive outpatient services, including the assessment, before the provider must submit an authorization request. The provider must ensure that the full bio-psychosocial assessment is conducted within the five (5) hours but not to exceed fourteen (14) calendar days.

The bio-psychosocial assessment and treatment or discharge plan must be in place by the end of these initial five (5) sessions in order for the initial sessions to be eligible for reimbursement and/or authorization of additional services.

It is not required that these initial sessions be completed before an authorization request can be submitted. A provider may submit an authorization request at any point after the assessment but within fourteen (14) days of the first date client received services.

If the client participated in IOP, the authorization request must demonstrate that the client was/is clinically appropriate for that level of care to be retroactively approved.

Any additional services must be pre-approved prior to delivery.

i. **Assessment Only**

If only an assessment is completed for a client, a SARF record must be entered along with an authorization request for reimbursement of the assessment. This request will be approved retroactively as long as all eligibility criteria have been validated. An admission record should not be entered.

There are two scenarios where this may occur:

- Clients who are referred immediately to a residential program and no interim services are provided.
- Clients who are found not to have a substance use disorder diagnosis and are therefore not eligible for additional services.

ii. **Initial Services Only**

- **Initial Services Adequate:**

  When a client is not in need of additional services beyond the assessment and initial outpatient or IOP services, an authorization request must be submitted for an assessment and any initial session(s) that were provided. These services will be approved retroactively as long as all eligibility criteria have been validated and discharge planning has been completed. If an assessment was not necessary because a recent assessment was available, the authorization request should only include the initial outpatient or IOP services.

- **Client Discontinues Services:**

  When a client has discontinued care during initial services, a request must be submitted for authorization of the services that were provided. At least one attempt to re-engage the client in services must be documented and detailed in the authorization request.

iii. **Initial Services plus Additional:**

When the client is in need of services beyond the initial services, an authorization request should be submitted for the assessment, initial services, and the additional services. The initial services will be approved retroactively and the additional services will be pre-approved.

B. **Prior Authorization**

- **Residential, methadone, and sub-acute detoxification services** must be pre-approved before admission to residential services, including State Disability Assistance (SDA) room and board, and medication

supported treatment services with the exception of pregnant clients presenting for methadone.

When pregnant clients present for methadone, an authorization request must be submitted within twenty-four (24) hours of admission to ensure eligibility and provide retroactive authorization for that first day and any subsequent days. Proof of pregnancy must be collected by the Provider prior to admission and documentation placed in the client's records. All requirements as specified in the MDHHS Treatment Policy #5 "Criteria for Using Methadone for Medication Assisted Treatment and Recovery" must be followed.

- **Outpatient and Intensive Outpatient:** All services in excess of the initial five (5) hours of Outpatient or two (2) days of Intensive Outpatient must have prior authorization.

C. Requesting a Lower Level of Care (LOC) than Client Qualifies to Receive

If OP or IOP is being requested instead of residential services because a client has indicated that they prefer to receive the lower level of care, documentation of client choice of this level of care instead of residential should be documented and noted in the authorization request.

When clients who are receiving OP or IOP services while waiting for admission to residential services the Provider should note the anticipated date of admission to residential and that the request for OP or IOP are being provided as interim services in the authorization request.

3.2 Authorization Review

Service authorization approval will be determined based on *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Condition*, medical necessity, and validation of eligibility. The CMHSP will review each request by the end of the business day following submission, barring unusual circumstances.

After the initial authorization, concurrent reviews will be based on the criteria as the initial review and also take into consideration the Service Continuation Criteria as detailed in Section 3.2.5.These reviews will occur at each subsequent point where re-authorizations, extensions of treatment or change in the level of care are requested.

Patient progress toward criteria for discharge shall be considered in the decision process as defined in the Service Continuation Criteria detailed in Section 3.2.5.

3.2.1 Approval Baseline Parameters

In order to improve consistency in authorizations the CMHSP has established parameters for service requests for each level of care. These parameters provide the anticipated ASAM criteria and standard authorization of service amounts. This guidance is summarized in the Authorization Parameters Matrix, provided in the Attachments section and detailed in Section 5.2.

The CMHSP understands that in order to provide individualized treatment and

respect client preference, not all requests will fall within established parameters. Providers must ensure that authorization requests are based on individualized treatment planning per MDHHS Treatment Policy #06 "Individualized Treatment Planning" available at http://www.michigan.gov/MDHHS/0,1607,7-132-2941_4871_4877-133156--,00.html

3.2.2 Automated Approval

Approval of initial, non-complex Outpatient requests that fall within the approval baseline parameters will be automated unless:

- The client has utilized more than forty (40) units of Outpatient across all providers in the CMHSP network in the past twelve (12) months.

3.2.3 Manual Review

For requests that do not meet the criteria for automated approval and for residential, methadone, and sub-acute detox service requests, the client record and/or assessment will be reviewed for approval determination. If additional information is needed to process the request, the Access Management Staff will contact the requesting provider. Refer to Section 2.2.2 for more information.

A copy of the full assessment must be submitted to the CMHSP Access Staff Member with authorization requests for methadone, and residential services, including detox. The CMHSP may also contact the clinician for more information.

3.2.4 Length of Authorization

Standard authorizations will be active for one hundred and eighty (180) days from date of approval. Authorization dates may be extended with justification that the level of care is still appropriate for the client. Providers should submit an extension of the authorization dates to the CMHSP through a secure communication method (secure email, fax, phone) and provide justification for the extension in a brief narrative summary explaining why the extension is clinically necessary. An authorization end date will not be extended beyond twelve (12) months from the begin date.

Authorizations for methadone will reflect the required timelines established by MDHHS and provided in the BSAAS policy #05, *Criteria for Using Methadone for Medication-Assisted Treatment and Recovery* available at http://www.michigan.gov/MDHHS/0,1607,7-132-2941_4871_4877-133156--,00.html

3.2.5 Concurrent Review (Re-Authorization)

A concurrent review shall occur at each subsequent point after the initial authorization where extensions of treatment or change in the level of care are requested.

Just as with initial requests, re-authorization requests for client continuation must be based on medical necessity, ASAM criteria, continuation indicators, and updated clinical indicators for the client. Treatment planning and level of

service/intensity of care shall be reviewed and adjusted as necessary with consideration to length of stay, use of appropriate resources, involvement and participation of significant others in the treatment process, etc.

- Length of stay shall be initially assigned based upon medical necessity and length of stay norms and reviewed for continued stay or extended stay based upon medical necessity.
- The use of appropriate resources in the treatment process and other medical considerations shall be reviewed.
- If the provider or client does not agree with the CMHSP Access determination he/she may initiate the Appeal and Grievance Procedure.
- Continued patient progress toward criteria for discharge shall be considered in the decision process.

Service Continuation Criteria: According to *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Condition*, it is appropriate to retain the patient at the present level of care if:

- The patient is making progress but has not yet achieved the goals articulated in the individualized treatment plan. Continued treatment at the present level of care is assessed as necessary to permit the patient to continue work toward his or her treatment goals; **or**
- The patient is not yet making progress but has the capacity to resolve his or her problems. He or she is actively working toward the goals articulated in the individualized treatment plan. Continued treatment at the present level is assessed as necessary to permit the patient to continue to work toward his or her treatment goals; **and/or**
- New problems have been identified that are appropriately treated at the present level of care. This level is the least intensive at which the new problems can be addressed effectively.

Medication Assisted Treatment Services: State-administered funds, except Medicaid/Healthy Michigan Plans as covered under the Addendum, are limited for methadone to two (2) years per eligible client. This may be extended if the client meets the continued stay criteria specified in the MDHHS Treatment Policy #05, *Criteria for Using Methadone for Medication Assisted Treatment and Recovery*" available at http://www.michigan.gov/MDHHS/0,1607,7-132-2941_4871_4877-133156--,00.html

3.2.6 Pended Authorizations

CMHSP funded treatment services, for all funding streams, must meet medical necessity criteria to be authorized. If additional information is needed to process the request, the CMHSP's Access Management Staff (AMS) will send the authorization request back to the provider indicating what documentation or information is required to process the authorization. The provider shall have five

(5) business days to respond to the request for information by resubmitting the authorization. The CMHSP's Access Staff Member will review the Request for Authorization with additional information within one (1) business day. If the information sent is insufficient or inadequate, the CMHSP's Access Staff Member shall contact the provider directly to indicate what information is still required. The requested information shall be sent to the CMHSP's Access Staff Member within one (1) business day. Failure to provide requested information in a timely manner may jeopardize approval of the requested authorization.

3.3 Grievance and Appeals Procedure

3.3.1 Notification of Rights

Providers must notify all clients of their rights, including the procedure for filing a grievance and appeal. Medicaid/Healthy Michigan Plan clients must receive an adequate notice prior to the submission of an authorization request for services. In addition, Medicaid/Healthy Michigan Plan recipients must be notified through advance notice prior to any action to reduce or terminate current authorized services. Medicaid/Healthy Michigan Plan clients must receive Adequate or Advance Notices of their services and rights in accordance with sections of Federal Law 42 CFR 440-230(d), 42 CFR Chapter IV, Subpart F, Sections 438.402 to 424, MDHHS/MSA Policy Bulletin: Medicaid/Healthy Michigan Plans Eligibility Manual – Beneficiary.

3.3.2 Filing a Grievance

Clients may file a grievance and request an appeal by contacting the CMHSP Recipient Rights Advisor. The Recipient Rights Advisor may be reached at the following:

Allegan County Community Mental Health Services
1-269-686-5313

Community Mental Health of Ottawa County
1-877-588-4357

HealthWest
231-720-3201

Network180
616-336-3909

West Michigan CMH (Lake, Mason, Oceana Counties)
1-800-992-2061

The Recipient Rights Advisor role will not be assigned to an Access Staff Member.

3.3.3 Advocacy on Behalf of Client

Provider agencies may advocate for services on behalf of a client by contacting a CMHSP Access Staff Member. If after speaking with Access staff they still feel that additional consideration is required, they may contact a CMHSP Access Supervisor for further discussion/consideration.

If the provider feels the matter has not been satisfactorily resolved after speaking with the CMHSP Access Supervisor, they may submit a *Request for Review of Authorization Decision* to initiate a peer review of the decision. The request form is provided in the Attachments section.

3.4 Capacity Management

The CMHSP is responsible for monitoring availability of services and adjusting the service array as necessary to meet needs and must ensure that services are available year-round.

3.4.1 IDU Providers

Upon reaching 90 percent of capacity to admit individuals to the program, a Provider that serves IDUs must notify the CMHSP immediately. The CMHSP is required to notify the State within twenty four (24) hours.

3.4.2 Waiting List

If it is not possible to offer an appointment within the required timeframe the provider must contact a CMHSP Access Staff Member. If an alternative provider that can admit the client within the required timeframe is available they may be admitted with that Provider. If the client wishes to wait for an opening with the original Provider, that Provider must notify the client when an opening becomes available.

The CMHSP will contact the client every thirty (30) days, at a minimum, to determine continued interest in services, continued necessity of services, and whether the client might be appropriate for services from another provider with capacity to provide the services. This does not prohibit the service provider from contacting the client directly.

3.4.3 Mid-Year Adjustment to Allowable Benefits

It may be necessary for the CMHSP to implement a waiting list for Block Grant clients in order to ensure service availability year-round. If this is necessary, the CMHSP will notify each provider in the network by email, fax, and will also post a notice on the established website.

SECTION 4

CLIENT RIGHTS AND REQUIRED NOTIFICATIONS

4.1 Choice of Provider

The outpatient provider, where the consumer presents, must inform the client of all available service provider options consistent with the appropriate level of care and resources for payment. Refer to Section 2.1.4 for more information.

4.2 Recipient Rights

A recipient may not be denied appropriate service on the basis of race, color, national origin, religion, gender, age, mental or physical handicap, marital status, sexual preference, sexual identity, or political beliefs. All clients must receive notification of these rights. The Know Your Rights brochure is available in both English and Spanish. Copies are available upon request from your local CMHSP.

Records of the identity, of any recipient of services which are maintained in connection with the performance of any drug abuse prevention function conducted shall be confidential and be disclosed only for the purposes and under the circumstances described below:

1. The content of any record referred to above may be disclosed in accordance with the prior written consent of the recipient.
2. Whether or not a recipient gives written consent the content of any record referred to above may be disclosed as follows:
   - To medical personnel to the extent necessary to meet a bona fide medical emergency.
   - To qualified personnel for the purpose of conducting scientific research, management audits, financial audits, or program evaluation, but such personnel may not identify, directly or indirectly, any individual recipient in any report of such research, audit or evaluation, or otherwise disclose recipient identities in any manner.
   - Upon application, a court of competent jurisdiction may order disclosure of whether a specific individual is under treatment by a program. In all other respects, the confidentiality shall be the same as the physician-patient relationship provided by law.
   - Upon application, a court may order disclosure of a record for the purpose of a hearing under section 330.266 or section 330.268 of the Michigan Mental Health Code, Act 258 of 1974, as amended.

When maintaining records that include both the recipient's name and information regarding his or her substance use or abuse, the recipient shall be provided with both a summary of recipient rights and written notification that states:

"Recipients of substance abuse services have rights protected by State and Federal law and promulgated rules. For information contact the Bureau of

Health Systems, Division of Licensing and Certification, Substance Abuse Licensing Section, Recipient Rights Coordinator, P.O. Box 30664, Lansing, Michigan 48909."

Any program announcement, brochure, or other written communication that describes the program's services shall also include this statement.

For more information and full details regarding recipient rights for substance abuse services refer to Section XV of the MDHHS Substance Abuse Licensing Rules, Recipients Rights and Licensing Applications available at http://www.michigan.gov/lara/0,1607,7-154-27417_30419---,00.html.

4.3 Grievance and Appeal

Medicaid/Healthy Michigan Plan clients will receive Adequate and Advance Notices of their services and rights in accordance with sections of Federal Law 42 CFR 440-230(d), 42 CFR Chapter IV, Subpart F, Sections 438.402 to 424, and MDHHS BHDDA Appeal and Grievance Resolution Processes Technical Requirement.

Providers must notify all clients of their rights to file a grievance and appeal in relation to the authorization request for their services. Notification must occur prior to submission of an authorization request or an action that would result in a reduction or termination of services. Refer to MDHHS BHDDA Appeal and Grievance Resolution Processes Technical Requirement for more information.

4.4 their services and rights in accordance with sections of Federal Law 42 CFR 440-230(d), Charitable Choice Procedures

In order for the CMHSP to comply with 42CFR Parts 54 and 54a, and 45 CFR Parts 96, 260, and 1050, pertaining to the final rules for the Charitable Choice Provisions and Regulations, Providers must also comply.

Providers must identify themselves as religious (or faith-based), if applicable, and ensure that clients are notified of their right to request alternative services.

Unless a written request to use an alternate, but equivalent notice is made and approved by the CMHSP, the language below is required.

> *"No provider of substance abuse services receiving Federal funds from the U.S. Substance Abuse and Mental Health Services Administration, including this organization, may discriminate against you on the basis of religion, a religious belief, a refusal to hold a religious belief, or a refusal to actively participate in a religious practice.*
>
> *If you object to the religious character of this organization, Federal law gives you the right to a referral to another provider of substance abuse services. The referral, and your receipt of alternative services, must occur within a reasonable period of time after you request them. The alternative provider must be accessible to you and have the capacity to provide substance abuse services. The services provided to you by the alternative provider must be of a value not less than the value of the services you would have received from this organization."*

If a client objects to the religious character of a program, the Provider and the CMHSP's customer services department must work to refer the client and ensure connection to

alternative services within the standards of timeliness, capacity, accessibility, and equivalency.

Documentation must be in each client's file that they were given this "charitable choice" notice.

4.5 HIPAA Notification

Providers must provide clients with formal notice of their rights regarding privacy of protected health information, as required by the Federal Health Insurance Portability and Accountability Act of 1996. This notice is in addition to the HIPAA compliant privacy notice required to be given by your agency itself, and will not meet your obligations, as a treatment provider.

The *CMHSPHIPAA Privacy Brochure*, provided in the Attachments section and available upon request from the local CMHSP, shall be given to all newly admitted or re-admitted clients using CMHSP funding, as they come into the program. Documentation of this provision must be documented. The notice should be given to all clients who are receiving services funded in whole or in part by any source of funds managed by the CMHSP. The CMHSP privacy notice does not need to be given to clients whose services are in no way covered by any funding source managed by the CMHSP.

The provider is not required to collect a separate acknowledgement from each client that they have received this notice.

4.6 Communicable Disease

Given the increased risk of contracting HIV/AIDS, hepatitis, and other communicable diseases for those with a substance use disorder, it is important to recognize the role of communicable disease in the development of substance abuse treatment plans for clients.

There are requirements that all substance abuse treatment agencies receiving MDHHS/OROSC funds must meet in regard to communicable disease screening, information provision and referrals. These requirements must be met regardless of whether the provider receives a communicable disease allocation.

All publicly funded substance abuse treatment providers must assure that the following services are provided:

- Treatment providers are required to screen **all** substance abuse clients entering treatment for risk of HIV/AIDS, STDs, TB, and hepatitis, and to provide basic information about risk.
- 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 the 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.
- All pregnant women presenting themselves for treatment must be informed of available STD and HIV-testing resources.

- All clients with a history of injecting drug use (IDU) must be referred for Hepatitis C testing, unless documentation is provided affirming and existing positive Hepatitis C diagnosis.
- All persons receiving substance abuse services who are determined to be infected by mycobacterium tuberculosis must be referred for appropriate medical evaluation and treatment. The CMHSPs responsibility extends to ensuring that the agency to which the client is referred has the capacity to provide these medical services or to make these services available, based on ability to pay. If no such agency can be identified locally (within reasonable distance), the CMHSP must notify MDHHS.
- Provide basic information on HIV/AIDS, Tuberculosis, Hepatitis, and STDs to all clients entering treatment.
- For those clients entering or already active in substance abuse treatment who are identified with high-risk behaviors:
  - Each treatment agency must provide additional information about the resources available and referral to testing and treatment (with follow-up).
  - Each treatment agency is required to assure that communicable disease related health education and risk reduction activities are available, and that appropriate medical referrals are made when indicated.

For full details on communicable disease requirements please refer to MDHHS - Communicable Disease Information and Resources (michigan.gov)

4.7 Adequate Notice to Medicaid/Healthy Michigan Plans Clients

Adequate Notice requires that all clients be made aware of their right to appeal authorization decisions related to their services. Adequate notice must be provided to all Medicaid/Healthy Michigan Plan clients at the beginning of a new service episode or service level by the Provider. A copy of the signed Adequate Notice form must be kept in the client's file for all Medicaid/Healthy Michigan Plan clients.

4.8 Advance Directives to Medicaid/Healthy Michigan Plan Clients

The rights of Medicaid/Healthy Michigan Plan clients to make choices and decisions about their future medical and/or behavioral health care are respected by the CMHSP. Medicaid/Healthy Michigan Plan clients may make their choices known by completing an Advance Directive, as defined in 42 CFR 489.100, for medical and/or mental health care, also known as a Durable Power of Attorney. This is a document in which a client appoints another individual to make future medical and/or mental health decisions should their ability to make decisions become impaired. An Advance Directive is voluntary and it is against the law for health care providers or insurance companies to require one as a condition of treatment coverage.

Providers must offer all adult Medicaid/Healthy Michigan Plans clients information on Advance Directive laws and record in the client record if a client provides the Provider with an Advance Directive.

- Comply with all provisions for advance directives, described in Federal Code 42CFR 422.128, as required under 42CFR 438.6,

- Must have in effect written policies and procedures for the use and handling of advance directives written for any adult individual receiving treatment services by or through the Provider.
- Provide adults information regarding their rights to have and exercise advance directives under the law of the State of Michigan: MCL 700.5506 – 700.5512 and MCL 333.1051 – 333.1064.
- Update policies within 90 days of any changes to State law.
- Describe Provider procedures for respecting patient advance directives rights, including any limitations if applicable.

LRE shall monitor compliance with this policy. External review will be conducted during site visit reviews.

References:

- MDHHS - Psychiatric Advance Directive (michigan.gov)
- 42 C.F.R. 422.128

4.9 Corporate Compliance Plan

The CMHSP is committed to conducting itself as a good organizational citizen by promoting an organizational culture that encourages a commitment to compliance with the law. For more information refer to the LRE Corporate Compliance Plan found at Documents and Forms — Lakeshore Regional Entity (lsre.org).

The Corporate Compliance Plan shall be provided to all Medicaid/Healthy Michigan Plans Covered Individuals, and the Providers must obtain and retain (subject to review by the CMHSP) signed certifications that each such individual has received, has read, and understands the Code of Ethics and agrees to abide by the requirements of the LRE Corporate Compliance Program.

4.10 Lakeshore Regional Entity Guide to Services

Providers must offer all Medicaid/Healthy Michigan Plans clients the Lakeshore Regional Entity Guide To Services upon admission and annually thereafter for treatment episodes that exceed one (1) year in length. Copies are available upon request from your CMHSP or on-line at the Lakeshore Regional Entity website: Documents and Forms — Lakeshore Regional Entity (lsre.org)

SECTION 5

BENEFIT INFORMATION

5.1 Public Funding Sources

5.1.1 Block Grant

The CMHSP sets service limits and authorization parameters for funds that they manage which are provided in the Authorization Parameters Matrix, provided in the Attachments section. Priority for use of these funds is assigned to selected populations as defined in Section 2.3. The CMHSP will consider extensions for service limits on a case-by-case basis.

Covered Services: See PIHP/CMHSP ENCOUNTER REPORTING HCPCS and REVENUE CODES (https://www.michigan.gov/documents/mdhhs/MHCodeChart_554443_7.pdf)

Additional Requirements

All clients seeking Block Grant fund coverage must also apply for Medicaid/Healthy Michigan Plan/MIChild programs unless they can show recent ineligibility. If needed, providers must assist clients in submitting the application.

Community Grant consumers are assessed a co-pay for services based on the most recent CMHSP Ability to Pay scale. The co-pay is a client's share of cost based on a sliding fee scale calculation or other agreement and must be applied to Block Grant funded clients.

5.1.2 Medicaid/Healthy Michigan Plans

Medicaid/Healthy Michigan Plan are MDHHS programs for medical assistance established under Section 105 of Act No. 280 of the Public Acts of 1939, as amended, MCLA 400.105, and Title XIX of the Federal Social Security Act, 42. U.S.C. 1396, et.seq.

The LRE administers Medicaid/Healthy Michigan Plan funding for Substance Use Treatment Services in Allegan, Kent, Lake, Mason, Ocean, Muskegon and Ottawa County enrollees.

Covered Services See PIHP/CMHSP ENCOUNTER REPORTING HCPCS and REVENUE CODES (https://www.michigan.gov/documents/mdhhs/MHCodeChart_554443_7.pdf)

Medicaid/Healthy Michigan Plans Benefits Not Managed by the LRE: Some Medicaid/Healthy Michigan Plan services are funded through the Medical Services Administration and are not managed by the CMHSP. Medicaid/Healthy Michigan Plan covered substance abuse services and ancillary services which are not the responsibility of the CMHSP, include:

- **Acute detoxification:** This is a hospital provided service, billed directly to Medical Services Administration and subject to MSA criteria for

reimbursement.

- **Laboratory services:** Laboratory services related to substance abuse (with the exception of lab services required for Methadone and LAAM) should be billed directly to Medical Services Administration by the laboratory.
- **Pharmacy services:** Medications prescribed as a support to substance abuse treatment are paid for either or a fee-for-service basis by Medical Service Administration (for recipients who are not in a capitated health plan) or through the recipient's health plan (with prior authorization from the plan).

Requirements

- Medicaid/Healthy Michigan Plan consumers may ***not*** be charged a co-pay for Medicaid/Healthy Michigan Plan covered services.
- Coverage continuation: It is the provider's responsibility to ensure consumers maintain their Medicaid/Healthy Michigan Plan coverage as long as they meet eligibility criteria. Clients who fail to complete periodic communications with MDHHS to maintain their coverage will not be eligible for continuing CMHSP Block Grant coverage as an alternative.
- Transfer to CMHSP Block Grant funding will require review by the CMHSP, and documentation from MDHHS that A client was no longer eligible for reasons other than failure to provide necessary information to MDHHS. Provider assistance to help the client maintain coverage may be appropriate.
- Medicaid/Healthy Michigan Plan enrolled clients who relocate out of the Region 3 PIHP area must transfer to the new region's Medicaid/Healthy Michigan Plans PIHP coverage within thirty (30) days of a permanent move.

5.1.3 PUBLIC ACT 2 (PA2)

PA2 funds are county-assigned liquor taxes which are distributed by the State to the counties. Fifty (50) percent of the county liquor tax funding must be used for substance abuse services. Use of PA2 is locally determined but services must be provided by a licensed substance abuse service provider to benefit the population of the county from which the tax was collected.

For counties that have assigned oversight of PA2 funds to the CMHSP, the Block Grant requirements and conditions shall be applied to PA2 funds through specific Provider Agreements.

5.1.4 MICHILD

MIChild is the low-cost health insurance provided through the State of Michigan for children whose families do not qualify for Medicaid/Healthy Michigan Plans/Healthy Kids. Families pay a premium to the State each month.

Covered Services: See PIHP/CMHSP ENCOUNTER REPORTING HCPCS and REVENUE CODES

(https://www.michigan.gov/documents/mdhhs/MHCodeChart_554443_7.pdf)

Additional Requirements
MIChild consumers may not be charged a co-pay for MIChild covered services.

5.1.5 STATE DISABILITY ASSISTANCE (SDA) SERVICES

The State Disability Assistance (SDA) program funds cover room and board expenses for clients eligible for public assistance benefits while in residential or domiciliary care. These funds are extremely limited for the CMHSP region so they are restricted to clients admitted to long-term residential treatment at OAR.

Covered Service: Residential Room and Board

Eligibility: To be eligible for SDA funding for room and board services in a substance use disorder treatment program, a person must be:

- Determined to meet Michigan Department of Human Services' (DHS) eligibility criteria;
- Determined to be in need of residential treatment services;
- Authorized for residential treatment when the CMHSP expects to reimburse the provider for the treatment;
- At least 18 years of age or an emancipated minor; and
- In residence in a residential treatment program each day that SDA payments are made.

5.1.6 MEDICARE

Medicare is a federally funded health insurance program, often held by elderly persons or those determined to be permanently disabled. Medicare is not managed by the CMHSP but Medicare and Medicaid/Healthy Michigan Plans benefits should be coordinated. Non-elderly clients who have Medicare are likely to be eligible for Medicaid/Healthy Michigan Plans.

Specific Conditions:

- Medicare benefits must be used prior to billing CMHSP for client's care.
- Other funding sources may be requested to cover substance abuse treatment services not covered by a Medicare plan.

5.2 Treatment Specifications by Level of Care

Client co-pays apply to some services and funding categories. Where CMHSP co-pays apply, providers may selectively waive the co-pay for a client but may not bill the CMHSP or the co-pay amount. No co-pays may be assessed for services covered, approved, and billed to Medicaid/Healthy Michigan Plan, unless specifically allowed in the State of Michigan Medicaid/Healthy Michigan Plan Manual policies.

Clients who have private insurance co-pays, and meet CMHSP block grant eligibility criteria, may be assisted with CMHSP funding for a portion of their care costs. All group insurance plans for employers with over fifty (50) employees must now offer parity

coverage of addiction and mental health services, comparable to coverage for other medical conditions. Clients with separate health insurance should be asked to bring in their benefits summary, so coverage can be verified.

Providers may charge clients a nominal "therapeutic fee" for expenses not covered by the CMHSP. They may also specifically charge clients for extra reporting functions if client progress reports are asked to be prepared for Court personnel, employers, or other non-clinical parties requesting information. Such fees may not be billed to the CMHSP if not paid by the client. Providers frequently providing such reports to outside parties should show how they are covering the costs of these services. Failure of a client to pay such fees cannot bar public-funding eligible clients from participating in medically necessary treatment services. However, the provider is not obligated to provide unpaid reports to outside sources.

5.2.1 Covered Services

Rules and procedures established for covered services are available on the MDHHS/OROSC website at MDHHS - Policies and Advisories (michigan.gov)

5.2.2 Specialty Services

The following Michigan licensed secondary service categories may be covered by some CMHSP funding sources when funding is available. Providers are expected to provide these adjunct services, as appropriate to the needs of their clients, or to refer clients to other sources of these services.

Some of these services are not billed as a fee-for-service.

5.2.2.1 Women and Families Specialty Services (WFSS)

The SAPT Block Grant requires states to spend a set minimum amount each year for treatment and ancillary services for pregnant women and women with dependent children, including women who are attempting to regain custody of their children.

To be eligible for WFSS funds a provider must be designated as a Women and Family Specialty Provider or as gender-competent. For more information regarding this specialty service please refer to the Women's Specialty Services Guidance Document, provided in the MDHHS **Substance Use Disorder Services Policies:** MDHHS - Policies and Advisories (michigan.gov)

SECTION 6

CMHSP FINANCIAL AND REPORTING PROCEDURES

6.1 Financial Policies and Procedures

A Fee Schedule indicating a payment profile, specified services, and rates for those services is part of the contract and will be attached to the CMHSP Provider Agreement. Providers are expected to utilize the payment rates for services rendered and to hold Medicaid/Healthy Michigan Plans and MIChild members harmless from additional charges for those services (in keeping with the agreements). Specific reimbursement and finance issues are addressed in the CMHSP Medicaid/Healthy Michigan Plan Provider Agreement and CMHSP Block Grant Agreement.

6.1.1 Authorization

All CMHSP area clients seeking CMHSP-managed public funding, in whole or part, for their treatment services, must be authorized for those services by the CMHSP. Requests for authorizations must be submitted within fourteen (14) days of first client contact. For more information refer to Section 3.1.

6.1.2 Clean Claim

Clean Claim means a claim which is properly completed and contains all data elements necessary for processing in accordance with Provider Agreement and policy including submissions on the CMHSP EMR system, as agreed and appropriate, with all required data fields completed.

6.1.3 Ability to Pay

Providers are required to use the Ability to Pay to determine financial eligibility. Calculate the Ability to Pay using the Excel file provided at contract initiation.

The sliding fee scale does *not* apply to Medicaid/Healthy Michigan Plan or MIChild clients.

Calculating Household Income

In order to apply the sliding fee scale it is necessary to establish the household income and number of persons in the household. The way that this is calculated is determined by which of the following categories the person would fall under:

- **Minor Children:** For purposes of determining CMHSP financial eligibility, a child under 18 years of age will be considered a dependent; and total family income must be used unless the minor has been declared an emancipated minor, is married, or confidentiality has been formally requested by the minor for initial treatment services. During the course of treatment, once there is parental knowledge of a child's treatment, parental resources must be considered and applied.
- **Adult Dependent**: In the case of a single person 18 years of age and over who is living with his/her family and is being claimed as a dependent for

income tax purposes (i.e., a student), family income should be considered in determining CMHSP financial eligibility. If the person is covered by family health insurance, the available health insurance benefits must be used prior to using CMHSP Block Grant funds.

- **Adult Independent**: Once a person turns 18, they may be legally considered an adult. Their 1040 income tax form or current payroll stub should be used to document income, and to determine financial eligibility. Parental income is not used if the 18-year-old is not claimed by a parent as a dependent. If the person is covered by family health insurance, the available health insurance benefits must be used prior to using CMHSP Block Grant funds.
- **Married**: If married, the income of the client's spouse must also be considered.
- **Child support**: Child support paid should be deducted from an adult's income. Child support received should not be counted toward income.

6.1.4 Fee Collection

It is recommended that programs use at least three distinct attempts to collect fees assessed. At that point, if the fee still is not paid, the debt may be turned over to a collection agency. This is not applicable to Medicaid/Healthy Michigan Plans, or MIChild clients.

6.1.5 Co-Pays

A co-pay is a client's share of cost based on Ability to Pay. A co-pay must be applied to block grant or PA-2 funded clients per the Ability to Pay.

Medicaid/Healthy Michigan Plan or MIChild clients may not be charged co-pays for therapy, counseling, or medications unless they are structured into the State plan.

Fees assessed based on application of Ability to Pay but not collected, cannot be billed to the CMHSP.

6.1.6 Insurance Coverage

If an individual has insurance, they must use the benefits provided, and they must use approved providers associated with that insurance.

If an individual has partial insurance, the CMHSP cannot be billed until the insurance payment has been received. After partial insurance payment has been received, public funds may be used to reimburse the portion of the CMHSP rate that the insurance does not cover per contract rate reimbursement or as determined by Ability to Pay. CMHSP funds may not be used to subsidize insured clients if the insured client chooses to go to a provider outside their insurance network.

6.1.7 Verification of Income

Medicaid/Healthy Michigan Plan eligibility and income verification shall be

verified at least every six months or at a significant financial event, and proof of verification kept in the client record.

All Other Funding: Client income must be substantiated either by a current payroll stub, a 1040 Federal or State income tax form, or an unemployment pay stub, whenever possible.

Any person determined to be qualified for full CMHSP Block Grant payment must show application for Medicaid/Healthy Michigan Plans or MIChild, as appropriate or recent documentation of ineligibility.

Income should be verified and/or updated at least every six months or at a significant financial event, and proof of verification kept in the client record.

The *CMHSP Declaration of Income Application for Benefits* form, provided in the Attachments section, or one that contains the same information must be in the case record and signed by the client.

6.1.8 Coordination of Benefits

It is the policy of the CMHSP to promote the utilization of all insurance and other benefit coverage a consumer may have in a systematic way, as well as to assure coordination between Substance Abuse services and CMH, for the benefit of their clients.

Providers shall notify the CMHSP of any known Coordination of Benefits information which applies to a claim when it is submitted.

6.1.9 Financial Audits

- All CMHSP Providers are subject to audit to determine the validity of claims paid.
- Charges for improperly documented or inappropriate services are disallowed.
- Disallowed charges are deducted from future payments to the provider from CMHSP.

6.1.10 Medicaid/Healthy Michigan Plans Specific Billing Procedures

A. **Time Limit for Filing Medicaid/Healthy Michigan Plan Claims:** Medicaid/Healthy Michigan Plan claims must be submitted into the CMHSP's EMR system within sixty (60) days of the date of service. If the Covered Person/Member is retrospectively enrolled, claims should be submitted no later than sixty (60) days of notice of Medicaid/Healthy Michigan Plan enrollment approval.

B. **Do Not Bill a Medicaid/Healthy Michigan Plan Enrollee:** A provider should not bill or otherwise collect payment for services from a Medicaid/Healthy Michigan Plan enrollee except for spend-down deductibles, the CMHSP-approved co-payments, and non-covered or non-authorized services.

C. **Billable and Maximum Payments:**

A schedule of the CMHSP-approved covered or allowable services and the maximum payments provided by CMHSP to the contracted provider are issued to each provider as an attachment to the Provider Agreement.

Assignment of payment to a participating Network Provider or Facility Provider must be done as part of the Provider contracting process and attached to the assignee's formal agreement.

Providers must not bill, charge, collect from, seek compensation from, or have any recourse against Medicaid/Healthy Michigan Plan enrollees/members for services covered under the Michigan Medicaid/Healthy Michigan Plan Program (as defined in the Medicaid/Healthy Michigan Plan Provider Agreement).

Services provided must be pre-authorized by the CMHSP.

D. Non-Network Provider Reimbursement: Non-network providers will be reimbursed for authorized services, provided that an authorization request is made as required supporting the rendered service.

Non-network providers shall coordinate with the CMHSP regarding payment and to ensure that any cost to the beneficiary is no greater than it would be if the services were furnished within the network.

E. Medicaid/Healthy Michigan Plan Reimbursement Requirements:

Providers are contracted to provide services on a fee-for-service basis. Direct payment is made for services provided by credentialed and contracted providers when the following conditions are met:

- Services are provided as a result of an authorization from the CMHSP.
- Services provided are a covered substance abuse Medicaid/Healthy Michigan Plan benefit, identified on the CMHSP-approved Medicaid/Healthy Michigan Plan fee schedule.
- Services provided are in compliance with the requirements of the utilization management program.
- Services provided are within the scope of the provider's license and credentials.
- Services are performed in an approved setting as indicated in the Provider Agreement.
- Services are provided on or after the effective date of the Member's eligibility for covered services by the Plan.
- Claim must be submitted within the filing guidelines and meet clean claim criteria.

F. Medicaid/Healthy Michigan Plan Spend-Down Deductible Procedures:

Medicaid/Healthy Michigan Plan clients who have a monthly spend down

deductible amount may be served with CMHSP Block Grant funds if it is known or likely that the monthly deductible amount will not be incurred by the planned treatment services or other medical care they are receiving.

Clients whose planned treatment will meet the spend-down deductible within the month should be assisted in documenting eligible expenditures (incurred, but not necessarily paid by client) to DHS, to obtain active Medicaid/Healthy Michigan Plan coverage going forward. For such clients, CMHSP BlockGrant may fund up to the deductible amount for the month.

There are cases when a client has medical need for behavioral coverage but DHS has determined that they have excess income for full Medicaid/Healthy Michigan Plan eligibility, and therefore have an ability to pay some of their own medical care costs. These clients are known as or enrolled in a spend-down program. Spend-down means that the client must incur medical expenses each month equal to, or in excess of, an amount determined by the local DHS office to qualify for Medicaid/Healthy Michigan Plans coverage. Once their spend-down amount has been met each month, they become eligible for Medicaid/Healthy Michigan Plan benefits for the remainder of the month

Bills for service rendered prior to the effective date of Medicaid/Healthy Michigan Plan eligibility are the client's responsibility. The Provider may bill CMHSP Medicaid/Healthy Michigan Plans for any covered services (in excess of the client's liability) rendered during the eligible period.

Because bills have to be incurred before the spend-down deductible amount is met, there will often be a period of retroactive eligibility. This may be several days or up to a period of three months from the current month.

There may be one service that is partly the client's responsibility and partly CMHSP Medicaid/Healthy Michigan Plans funded. If the provider of service chooses to bill for this service and the client has no other insurance, the information entered or submitted must indicate the correct shares for each party involved.

If the client has other insurance the information entered must indicate the appropriate shares or amounts for each responsible party, including the client, and correct dates of effective coverage.

The client may be held responsible for payment of expenses that were incurred to meet the spend-down amount. Payment by client does not have to be made before Medicaid/Healthy Michigan Plan eligibility is approved. Consult with the CMHSP if other public funds are being sought to assist client in meeting the financial obligations of the spend-down deductible or co-pay.

G. Medicaid/Healthy Michigan Plan Third Party Claims:

Enrollee coverage may not exceed 100 percent of the established CMHSP established Medicaid/Healthy Michigan Plan fee for covered service when other insurers including Medicare are also providing coverage for the service. Medicaid/Healthy Michigan Plan under this plan will always be considered secondary, except in relation to CMHSP Block Grant funds. When coordination of benefits occurs the maximum fee screen will not be exceeded in making secondary payment.

In the event a service is covered by Medicaid/Healthy Michigan Plan as well as another plan, CMHSP determines primary versus secondary coverage for the service and eligibility determination purposes. When an Enrollee is enrolled in Medicare, Medicare will be the primary payer ahead of Medicaid/Healthy Michigan Plan in this plan, (or any plan contracted by the State). Other health plans include, but are not limited to, any group or individual plan providing substance abuse care through insurance coverage, group practice or other prepaid coverage; Worker's Compensation; disability; or under a labor-management trustee plan, union welfare plan, employer organization plan, employee benefit organization plan, or employer self-insurance plan, Medicare, automobile insurance, or other commercial carrier. Enrollees for whom Medicaid/Healthy Michigan Plan (under this plan) is secondary coverage are required to follow pre certification processes (Section II, 2.13) identical to those for whom coverage is primary. Enrollees must follow standard pre certification guidelines in order for services to be eligible for reimbursement and benefit coordination.

Providers are required to complete the authorization procedures in instances of secondary coverage in precisely the same manner as for coverage deemed primary. This requirement applies to both pre authorization and continuation (concurrent) review activities. Providers are also required to hold enrollees financially harmless once combined primary coverage and secondary coverage reimbursements total the CMHSP contracted rates for Medicaid/Healthy Michigan Plans in effect at the time.

6.2 Submission of Billing

6.2.1 Billing through CMHSP Electronic Medical Record (EMR) System

CMHSP treatment providers must submit bills for Medicaid/Healthy Michigan Plans, Block Grant, PA2, and MIChild funded services through the CMHSPs electronic medical record system unless otherwise instructed. Instructions and details of this process are found within the CMHSP Operations Manual.

Billing is expected to be complete by the 10th of the month following the month of service via the CMHSP electronic medical record system. If claims cannot be submitted via electronic medical records system, HCFA 1500 form is to be completed and submitted to CMHSP by the 10th of the month following the month of service.

- **Bills are to be generated within sixty (60) days of the date of service**, unless there is pending insurance. In cases where other insurance is to be billed and CMHSP Block Grant payment needs are uncertain, client record, admissions, authorization requests, and treatment services can be entered; however, treatment services (billing) should not be entered into the CMHSP EMR system until the contractual agency is ready to bill.

6.2.2 Financial Status Report

A Financial Status Report (FSR) is required only for performance-based reimbursement contracts with CMHSP and is due by the 10th of the month following the month for which services are being billed.

All costs submitted on the FSR for performance-based reimbursement contracts must be pre-approved by the CMHSP through the submission of the CMHSP Budget Cost-Detail and Supporting Narrative. The *Financial Status Report* and *Budget Cost-Detail and Supporting Narrative* are provided in the Attachments section.

6.2.3 Billing Adjustments

If additional services are being billed, they should be entered into the CMHSP EMR system in accordance with the CMHSP Operations manual.

If a service was billed in error, the details of the service should be submitted via email so a credit for the over payment can be issued against a future payment.

If the amount billed/paid for a service was incorrect, the details of the difference in rates should be submitted via email so a credit for overpayment or additional payment can be made.

Contract information for submitting billing adjustments can be found in the CMHSP Operations manual.

6.3 Payments

Payment for approved services will be issued by check or Electronic Funds Transfer (EFT). in the name and to the address of the contracted Provider. Payments will be made for CMHSP covered services only.

Payments for covered services (in accordance with the Providers Agreement) will be made within thirty (30) days following the receipt of a clean claim.

Retrospective Medicaid/Healthy Michigan Plans Eligibility: Retrospective monthly adjustments of Medicaid/Healthy Michigan Plan eligible enrollees by the Department of Community Health and/or the Medical Services Administration may affect the status of a client's eligibility. CMHSP will reduce future payments if consumer is determined to have Ability to Pay.

SECTION 7

PROVIDER SELECTION, QUALIFICATIONS AND SERVICE REQUIREMENTS

The CMHSP develops and maintains a network of substance abuse health care service providers through a formal provider application review and provider selection process.

Provider applicants shall complete a formal credentialing process which determines participation based on the standards adopted by LRE. Providers within the CMHSP network must maintain these standards once accepted as a Provider.

The standards guide the selection of facilities and (individual providers) and achieve compliance with the administrative rules of the HMO Act as amended and filed on January 5, 1988 for Medicaid/Healthy Michigan Plans providers.

7.1 Selection Review Process: A Provider may apply for, and be granted permission to deliver more than one type of service. To help ensure demonstrated competence, applicants will be asked to share references with the CMHSP that speak to the applicant's relevant experience. Also, the applicant's professional staff must provide individual professional credentials to assist the CMHSP in the credentialing process. Refer to Section 7.9 for more information about the credentialing process.

A Provider is notified of the approval or denial of application and (if approved) is given a standard formal contract. The signed and returned contract is retained in a Provider file and by the CMHSP.

As part of the on-going credentialing and review process, the CMHSP will review information about the provider from internal and external sources including; admission/discharge information or studies, client complaints and grievances, Client Satisfaction Information, Utilization Management Reports, and Quality Improvement Reports. This data will be combined with the Facility Provider's reapplication materials and presented to the CMHSP Board and/or appointed credentialing committee.

Information provided to the CMHSP by a provider or a provider applicant must be accurate and complete. Any falsification of such information may result in termination from participation.

7.2 Provider Standards Required

7.2.1 Credentialing: It is the policy of the CMHSP that all contracted Providers meet the standards for practice and satisfy the requirements of the Credentialing Processes established by the LRE. All substance abuse service providers must be qualified to perform services consistent with CMHSP's goals and objectives and State and community standards.

Provider Credential Reviews: LRE will review the credentials of all facilities and professionals applying for affiliation with the CMHSP, and reexamine provider credentials every two (2) years. Specific criteria shall apply to all facilities seeking affiliation or are being re-credentialed for continued affiliation.

Criteria are evaluated in the following areas:

A. Licensure: Providers must possess State of Michigan Department of Licensing and Regulatory Affairs (LARA) licensure which reflects approved ASAM Level

B. of Care designation for each type of substance abuse service(s) being delivered by Provider.

C. Accreditation: Providers must maintain accreditation as an alcohol and/or drug abuse program or broader behavioral health program by one of five national accreditation bodies; The Joint Commission (TJC)*, Commission on Accreditation of Rehabilitation Facilities (CARF)*, American Osteopathic Association (AOA), Council on Accreditation of Services for Families and Children (COA), or National Committee on Quality Assurance (NCQA) or other approved accreditation body.

*Methadone providers must meet additional specific national accreditation standards from these accrediting organizations.

D. Practice Organization and History:

- Providers must maintain liability insurance in amounts specified by the CMHSP.
- Convictions of a crime other than a misdemeanor of traffic offense will be evaluated on an individual basis by the CMHSP.
- Providers must have a history of acceptable participation in Medicaid/Healthy Michigan Plans, Medicare, and substance abuse block grant funding programs, as applicable.
- Providers must have an 'acceptable' report, if available from the National Practitioners Data Bank.
- The Provider must not currently be involved in a disciplinary process or have pending disciplinary actions by a hospital, or other such facility, licensing board, third party payer, or peer review entity.
- Provider must have no significant history of malpractice claims or adverse malpractice experience.
- Providers must maintain acceptable levels of malpractice insurance as identified by LRE.

E. **Service Delivery**

- Providers must maintain a clinical services system that provides assessment, diagnosis (utilizing current DSM) patient placement (using current ASAM criteria), and referral.
- Providers must have the capability to integrate the ASAM Patient Placement Criteria for admission, continued stay and discharge/transfer.
- Providers must provide a welcoming environment for individuals with co-occurring disorders. Providers with appropriate integrated licensure must utilize a comprehensive, continuous, integrated system

of care in accordance with the MDHHS/OROSC Policy and Procedures found at

http://www.michigan.gov/MDHHS/0,1607,7-132-2941_4871_4877-133156--,00.html

- Providers must maintain accessible and adequate office hours and meets the provisions of Act 230 of the Public Acts of 1972 as amended to allow access by enrollees with handicaps.
- Providers must maintain services in a geographical location convenient to the CMHSP area eligible persons, appropriate to the levels of care offered.
- Providers must comply with CMHSP Medicaid/Healthy Michigan Plan Provider Agreement and/or Block Grant Provider Agreement as applicable.
- Providers' client satisfaction must meet Lakeshore Regional Partner's expectations for Medicaid/Healthy Michigan Plan clients and for clients funded under other CMHSP managed funds.
- Providers must ensure the rights of clients to privacy and dignity while waiting for and receiving care.
- Providers shall not engage in or conduct research which involves inconvenience or risk to clients.

F. **Quality Improvement**: Providers must have active quality improvement programs. These programs should adequately identify problems, establish plans for improvement, and show problems corrected or improved. Utilization review and quality improvement activities must produce data as a basis for ongoing service maintenance, development, refinement, and management.

G. **Quality of Care**

To continue as a CMHSP Provider, providers must achieve and maintain the following standards:

- Performance indicators must meet MDHHS standards
- Complaint/grievance activity is not excessive for the Lakeshore Regional Partner region.
- Outcome indicators, if applied, meet acceptable CMHSP levels and parameters.
- Cooperate with quality improvement programs.
- Meet acceptable facility review expectations.

H. Utilization

- Meet CMHSP expectations for utilization performance, per staff productivity.
- Cooperate with CMHSP Utilization Management requests.

- Meet CMHSP expectations for ancillary service referrals.

I. **Physical Location Requirements**

- Provider locations may not be moved without the approval of the CMHSP.
- Treatment and other services shall be provided in a facility which is appropriate for the services provided and which is comfortable, safe, convenient, handicap accessible, and private.
- Grounds have (or have made available) adequate parking, including specially designated handicapped spaces close to entrances.
- Regular and effective snow and ice removal must be provided.
- The facility building must comply with all local fire and safety codes and meets the facility standards of an appropriate national accrediting body.
- Handicap-equipped rest rooms must be available to clients and those accompanying them.

J. **Disclosure:** Providers must provide full disclosure of ownership, affiliations, and organizational structure.

K. **Reputation:** Maintain an acceptable professional reputation in the community.

7.2.2 Corporate Compliance

The CMHSP is committed to conducting itself as a good organizational citizen by promoting an organizational culture that encourages a commitment to compliance with the law. This commitment extends to every aspect of our business as well as every work-related activity of our employees, contractors, and individuals with responsibility pertaining to the ordering, provision, marketing, documentation, billing or services reimbursable by Federal Health Care Programs. The commitment further extends to the preparation of claims, reports or other requests for reimbursement for such items or services with the statutes, regulations, and written directives of Medicare, Medicaid/Healthy Michigan Plan, and all other Federal Health Care Programs (as defined in 42 U.S.C. ξ 13201-7b (f), hereinafter collectively referred to as the "Federal Health Care Programs." CMHSP is also committed to ensuring that it complies with the requirements of all Federal and State programs from which it receives funding above and beyond "Federal Health Care Programs."

The CMHSP Corporate Compliance Plan provides standards of conduct and internal control systems that are reasonably capable of reducing the likelihood of violations of law. The Corporate Compliance Program, which is an outgrowth of the Plan, seeks to prevent violations of any law, whether criminal or non-criminal for which CMHSP is, or would be, liable. Refer to the *Corporate Compliance Plan* available at Documents and Forms — Lakeshore Regional Entity (lsre.org)

Therefore, CMHSP requires that contracted providers:

- Acknowledge the CMHSP's Compliance Program and Code of Ethics.
- The Corporate Compliance Plan is provided to all Covered Individuals.
- The Providers obtain and retain (subject to review by the CMHSP) signed certifications that each such individual has received, has read, and understands the CMHSP Code of Ethics and agrees to abide by the requirements of the CMHSP Corporate Compliance Program.

7.2.3 Conflict of Interest

All Providers within the CMHSP network must ensure a conflict of interest as defined under Executive Order 12549, Title XVIII or XIX does not exist. Providers within the CMHSP network must ensure that their employees are not engaging in activities with other organizations which may result in personal benefit to them at the expense of CMHSP or its provider members or which may influence their decisions on matters involving the CMHSP.

A conflict of interest exists when a workforce member's personal, family, or financial activities adversely influence the judgment required to perform ones duties. If a conflict of interest exists, or even the appearance of a conflict exists, the workforce member must report the potential conflict to their local Compliance Officer and the CMHSP's Compliance Officer.

7.3 Provider Reporting Requirements

All Data Reporting requirements and due dates are found in the Provider Agreement. Continued failure of providers to submit required reports to CMHSP may result in a financial penalty being imposed and serve as cause for termination of the CMHSP's contractual relationship with the Provider.

7.3.1 User Permissions and Data Entry

Access to the CMHSP EMR system is restricted to individuals granted permission to access the system by the CMHSP. Provider should contact the CMHSP Contract Manager to understand the process for obtaining authorization for staff to access the CMHSP EMR.

7.3.2 Census Logs: 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 and/or LRE will review the daily client census logs in data auditing site visits.

7.3.3 Sentinel Event Reporting Requirement

All residential service providers must report, review, investigate, and act upon sentinel events for persons living in 24-hour specialized settings and those living in their own homes receiving ongoing and continued personal care services.

Providers must immediately contact the CMHSP located in the Provider's county as well the CMHSP in the county of the client's residence, if different using the Sentinel Events Incident Report provided in the Attachments section.

A Sentinel Event is defined as an "unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase, 'or risk thereof' includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome." (JCAHO, 1998)

Any of the following should be reviewed to determine whether it meets the criteria for sentinel event.

- Death of a recipient which is not by natural cause or does **not** occur as a natural outcome to a chronic condition (e.g., terminal illness) or old age.
- Serious illness requiring admission to hospital, n**ot** including planned surgeries, whether inpatient or outpatient. It also does **not** include admissions directly related to the natural course of the person's chronic illness, or underlying condition. For example, hospitalization of an individual who has a known terminal illness in order to treat the conditions associated with the terminal illness is not a sentinel event.
- Alleged cause of abuse or neglect.
- Accident resulting in injury to recipient requiring emergency room visit or hospital admission.
- Behavioral episode: Serious challenging behaviors are those not already addressed in a treatment plan and include significant (in excess of $ 100) property damage, attempts at self-inflicted harm or harm to others, or unauthorized leaves of absence that result in death or loss of limb or function to the individual or risk thereof. All unauthorized leaves from residential treatment are not sentinel events in every instance. Serious physical harm is defined by the Administrative Rules for Mental Health (330.7001) as "physical damage suffered by a recipient that a physician or registered nurse determines caused or could have caused the death of a recipient, caused the impairment of his or her bodily functions, or caused the permanent disfigurement of a recipient."
- Arrest and/or conviction.
- Medication error means a) wrong medication; b) wrong dosage; c) double dosage; or d) missed dosage which resulted in death or loss of limb or function or the risk thereof. It does not include instances in which consumers have refused medication.

The Provider and CMHSP shall review all incidents to determine if the incidents meet the criteria and definitions above and if they are related to practice of care. The CMHSP shall ensure that persons involved in the review of sentinel events have the appropriate credentials to review the scope of care. The outcome of this review is a classification of incidents as either a) sentinel events, or b) non-sentinel events.

An "appropriate response" to a sentinel event "includes a thorough and credible root cause analysis, implementation of improvements to reduce risk, and monitoring of the effectiveness of those improvements." (JCAHO, 1998) A root cause analysis (JCAHO) or investigation (per CMS approval and MDHHS contractual requirement) is "processes for identifying the basic or causal factors that underlie variation in performance, including the occurrence or possible occurrence of a sentinel event. A root cause analysis focuses primarily on systems and processes, not individual performance." (JCAHO, 1998)

Following completion of a root cause analysis or investigation, the CMHSP will develop and implement either.

- A plan of action (JCAHO) or an Intervention (per CMS approval and MDHHS contractual requirement) to prevent further occurrence of the sentinel event. A plan of action or intervention must identify who will implement and when and how implementation will be monitored or evaluated.

  Or

- Presentation of a rationale for not pursuing a plan of action or an intervention.

Reporting is **not required** for:

- Accidents treated at medi-centers and urgent care clinics/centers should be included in the accident reporting along with those treated in emergency rooms. In many communities in the state where hospitals do not exist, medi-centers and urgent care clinics/centers are used in place of emergency rooms.
- Planned surgeries, whether outpatient or inpatient, are not considered unexpected occurrences and therefore are not included in the reporting of illnesses requiring admissions to hospitals.
- Report arrests and convictions as separate incidents.

7.3.4 Consumer Satisfaction Survey Collection Procedures

A sample of clients receiving substance abuse services funded in whole or part by CMHSP managed funds shall be surveyed. The CMHSP will provide detailed instruction for the collection process for client satisfaction surveys.

7.3.5 Medication Supported Treatment Logs: Providers of pharmacologic support services (either methadone or suboxone-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 and/or LRE will review these logs

in data auditing site visits.

7.3.6 Communicable Disease: Proof of staff communicable disease training must be recorded on the staff training log. MDHHS and/or LRE will review these logs in data auditing site visits.

7.3.7 Annual Equipment Inventory Report: This form must be completed annually by all performance reimbursement providers and submitted to the CMHSP within thirty (30) days of the new contract. The required form is provided in the Attachments section.

Equipment is defined as a tangible, nonexpendable, personal property having a useful life of more than one (1) year and an acquisition cost of $5,000 or more per unit and purchased in whole or part with MDHHS funds under an expenditure reimbursement contract with the CMHSP.

7.4 Provider Site Visit Reviews and Billing Verification

Site visits will consist of clinical audits as well as a review of Provider policies, procedures, staff credentialing, and compliance with contractual requirements. Each treatment provider in the CMHSP network will receive one annual site visit where LRE will review case files.

For Designated Women's Providers and Gender-Competent providers an additional protocol, the W*FSS Site Visit Evaluation Protoco*l, will be reviewed during the annual visit.

7.4.1 Purpose: To ensure:

- Each Provider is qualified to provide offered services.
- A high level of performance throughout the CMHSP network.
- Delineation of specific service areas and to ensure that specific standards and access objectives are met.
- Periodic assessment of the performance of CMHSP contracted Providers.
- Each provider has met achieved and maintained appropriate Accreditation as defined in Section 7.2.3.
- Each provider has met achieved and maintained appropriate Staff Credentialing as defined in Section 7.9.2.
- Each Provider meets all other requirements established in this manual and not monitored another way.

7.4.2 Out-of-Region Providers: The CMHSP will make every attempt to establish reciprocal agreements with the governing coordinating agencies and/or PIHPs for the geographic location of out-of-region providers. The intention of establishing these agreements is to allow the CMHSP to rely on the site visit findings conducted by those organizations. For Medicaid/Healthy Michigan Plans providers, the CMHSP will continue to conduct billing verification and any other Medicaid/Healthy Michigan Plan specific review requirements during each six-month period.

7.4.3 Case File Selection: The CMHSP selects at least ten (10) cases for review from the current fiscal year. The selection shall include both active and closed cases, as well as both Medicaid/Healthy Michigan Plan and Block Grant funded clients (where applicable). Within these respective categories, the selection will be random. Providers will be provided with the list of case files that will be reviewed 24 hours prior to the site visit. Medicaid/Healthy Michigan Plans reviews will consist of verification of at least twenty five (25) treatment units semi-annually.

7.4.4 Corrective Action

Providers who are out-of-compliance with standards must take corrective action and re-establish compliance with standards or risk loss of provider status.

Depending on the nature and significance of errors or deficiencies noted, up to two (2) errors or deficiencies out of ten (10) records would result in a corrective action plan. More than two errors result in a recommendation. A recommendation could, in rare cases, be issued based on a single deficiency.

7.4.5 Report of Findings:

Providers will receive communication regarding the results of the site visit within 30 days of the site visit. The CMHSP will provide a summary of the findings for each visit that identifies any corrective action required. If any finding reaches the threshold of less than 75%, the corrective action plan will include a follow-up visit by CMHSP within ninety (90) days to assure that changes have been implemented to eliminate the problem.

For Medicaid/Healthy Michigan Plans providers, a summary report will be compiled for the LRE for their respective PIHP area. For more information refer to the LRE Medicaid/Healthy Michigan Plan Claims Verification Policy adopted by the CMHSP.

7.5 Individualized Treatment Planning

The Administrative Rules for Substance Abuse Programs in Michigan promulgated under PA368 of 1978, as amended, state, "A recipient shall participate in the development of his or her treatment plan." [Recipient Rights Rules, Section 305(1)].

MDHHS, as well as accreditation standards 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. Each treatment plan must also contain the amount, scope and duration of treatment and the date service is to commence within the plan or review.

All providers will develop an individualized treatment plan for eligible clients obtaining services, with client participation in the plan. The provider will maintain a documented procedure for treatment planning.

Full guidelines and requirements are provided in the Treatment Policy #06, *Individualized Treatment and Recovery Planning*, available at http://www.michigan.gov/MDHHS/0,1607,7-132-2941_4871_4877-133156--,00.html .

Monitoring of Compliance: The CMHSP will monitor compliance with individualized treatment and recovery planning requirements during Provider site visits. These review findings will be made available to the Bureau of Substance Abuse and Addiction Services during their site visit to the CMHSP. MDHHS will also review for individualized treatment and recovery planning requirements during selected provider site visits. Reviews of plans will occur in the following manner:

A. A review of the bio-psychosocial assessment to determine where and how the needs and strengths were identified.

B. A review of the plan to check for:
    - Matching goals to needs – Needs from the assessment are reflected in the goals on the plan.
    - Goals are in the client's words and are unique to the client – No standard or routine goals that are used by all clients.
    - Measurable objectives – The ability to determine if and when an objective will be completed.
    - 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.
    - Intervention strategies – the specific types of strategies that will be used in treatment – group therapy, individual therapy, cognitive behavioral therapy, didactic groups, etc.
    - The amount, scope and duration of treatment within the plan.
    - Signatures – client, counselor, and involved individuals, or documentation as to why no signature.
    - Recovery planning activities are taking place during the treatment episode.

C. A review of progress notes to ensure documentation relates to goals and objectives, including client progress or lack of progress, changes, etc.

D. An audit of the treatment and recovery plan progress review to check for:
    - Progress note information matching what is in review.
    - Rationale for continuation/discontinuation of goals/objectives.
    - New goals and objectives developed with client input.
    - Client participation/feedback present in the review.
    - Signatures, i.e., client, counselor, and involved individuals, or documentation as to why no signature.

7.6 Cultural Competency

Contracted providers are required to participate in programs and training to enhance sensitivity to cultural and ethnic diversity. Providers must have a written and implemented cultural competency plan that includes:

- Identification and assessment of the cultural needs of potential and active clients

based on population served.

- Identification of how access to services is facilitated for persons with diverse cultural backgrounds and limited English proficiency.
- Identification standards for the recruitment and hiring of culturally competent staff members.
- Identification of how ongoing staff training needs in cultural competency will be assessed and met and the evidence that staff members receive training.
- An annual assessment of compliance with its cultural competency plan.

7.7 Limited English Proficiency

The CMHSP and its contracted providers shall provide accurate and timely language assistance and effective communication to limited-English-proficient (LEP) persons at no cost to the client. Including current and prospective patients/clients, family, and other interested persons to ensure them equal access to services. The procedures outlined in the Limited-English-Proficient (LEP) Persons Policy ensures that information is communicated to LEP persons in a language that they understand and maintains standards that insure compliance with the Title VI Civil Rights Act of 1964.

For more information refer to the full LEP policy provided in the Attachments section.

7.8 Service Availability

A Provider must assure that service availability will be maintained regardless of a Consumer's ability to pay.

A Provider must provide notification in writing to the CMHSP within three (3) days of any action that would require or result in significant modification, reductions, or elimination of the provision of service availability.

7.8.1 Access Standards

If it is not possible to offer an appointment within the required timeframe the provider must contact the CMHSP utilization review specialists to receive assistance in identifying an alternative provider of service and to place the client on the waiting list if appropriate.

Admission delays of more than fourteen (14) days for any level of care shall be monitored by the CMHSP, and providers must notify the CMHSP if they do not have the capacity to meet service requests within this time allowance.

Providers must have the capacity to accept Medicaid/Healthy Michigan Plan clients without waiting periods beyond set standards as defined in the Michigan's Mission-Based Performance Indicator System manual. Network Providers must provide assessments within twenty-four (24) hours and treatment admissions following assessment within twenty-four (24) hours for urgent situations. Assessments for non-urgent situations must be within fourteen (14) days, and treatment admissions following Assessment for non-urgent situations within fourteen (14) days.

Providers shall maintain adequate provision for referral resources to address

other client needs identified.

Upon reaching 90 percent of capacity to admit individuals to the program, a Provider that serves IDUs must notify the CMHSP immediately. The CMHSP is required to notify the State within twenty-four (24) hours.

No individual may be denied treatment because of race, color, creed, national origin, gender, religion, age, ancestry, marital status, sexual preference, sexual orientation, gender identity, or physical or mental handicap.

7.9 Staff Requirements

7.9.1 Staff Composition: Providers' **s**taff composition should generally include a balance of disciplines appropriate to the institution and the treatment methods utilized. Staff levels and composition will be reviewed against the programmatic goals of the facility to determine adequacy and depth for the intended effort.

7.9.2 Treatment Staff Credentialing

Staff providing services within the CMHSP network must meet the current requirements stated in the MDHHS Michigan PIHP/CMHSP Provider Qualifications Per Medicaid Services & HCPCS/CPT Codes.

These standards apply to employee and contractual staff serving clientele whose care is funded through any categories of funding administered by or for which the CMHSP is otherwise responsible.

The State of Michigan currently uses credentialing services and standards managed through the Michigan Certification Board of Addiction Professionals (MCBAP) www.mcbap.org. MCBAP administers the Michigan Addictions Fundamentals Examination (MAFE) and IC & RC (International Certification and Reciprocity Consortium) tests as part of the credentialing-process. MCBAP also administers the approval of professional development plans for staff in the process of upgrading their qualifications to meet certification-level standards.

Provider must follow CMHSP procedures when onboarding new staff. Staff credentials will be reviewed during the annual site visit.

A. Requirements by Job Function: refer to the MDHHS Michigan PIHP/CMHSP Provider Qualifications Per Medicaid Services & HCPCS/CPT for specific job function requirements.

7.9.3 Staff Certification Recommendations

A. Staff possessing a "Michigan-only" level of certification is encouraged to work towards achieving the ICRC credential.

B. Personnel certified at the Substance Abuse Treatment Practitioner level are encouraged to work towards the Substance Abuse Treatment Specialist level.

7.9.4 Additional Staff Requirements

A. Providers must ensure that criminal background checks are conducted as a condition of potential employment for all employees hired after 10/1/2003.

This requirement is not intended to imply that a criminal record should necessarily bar employment.

B. Providers receiving Medicaid/Healthy Michigan Plans funds must review the Medicaid/Healthy Michigan Plans Sanctioned Provider List, http://exclusions.oig.hhs.gov/ annually to assure no staff in employment or contracting with the Provider is listed. Pursuant to Section 1128 and Section 1902(a)(39) of the Social Security Act, the Medicaid/Healthy Michigan Plans Program will not reimburse a provider for any services rendered or that were ordered/prescribed by a sanctioned (e.g. suspended, terminated, excluded, etc.) provider. The effect of the provider's exclusion precludes them from furnishing, ordering, or prescribing items or services to any Medicaid/Healthy Michigan Plans member.

C. For clinical staff with less than 2,000 hours of substance use disorder treatment experience, the CMHSP requests completion of the MAFE (Michigan Addictions Fundamentals Examination) within ninety (90) days of hire in addition to the minimal MDHHS credentialing requirements. Program may request a waiver by submitting information on the person's relevant experience and the type of clinical supervision that is being provided.

7.9.5 Clinical Billing Code Allowed Based on Qualifications

Clinical staffs are those individuals providing the following clinical services: individual counseling, group counseling and/or didactic services in an outpatient or residential setting.

7.9.5.1 Block Grant, PA2, or MIChild Funded Treatment Services

For Substance Abuse Treatment Specialist (SATS) and Substance Abuse Treatment Practitioner (SATP) allowable billing codes, refer to page 13 and 14 of the *MDHHS Credentialing and Staff Qualification Requirements for the CA Provider Network*.

7.9.5.2 Medicaid/Healthy Michigan Plans Funded Treatment Services

For Substance Abuse Treatment Specialist (SATS) and Substance Abuse Treatment Practitioner (SATP) allowable billing codes refer to page 15 through 18 of the *Michigan PIHP/CMHSP Provider Qualifications Per Medicaid/Healthy Michigan Plans Services & HCPCS/CPT Codes* and *MDHHS Medicaid/Healthy Michigan Plans Provider Manual*, Mental Health/Substance Abuse, Section 2.4, "Staff Provider Qualifications".

Providers are responsible for ensuring they comply with future updates to the Medicaid/Healthy Michigan Plans Manual.

7.9.6 Credential Files and Verification

Providers are required to establish and maintain a credentials file on all employees or contractual staff providing clinical services. Providers must conduct primary source verification of education and licensure, registration and/or certification prior to employment and maintain proof of the primary source verification in the

credentials file.

Providers must conduct primary source verification of licensure, registration and/or certification on all clinicians and maintain proof of verification in the credential file annually.

A. **Credential File**: The credentials file must include, at minimum:

- A written application that is completed, signed and dated by the clinician that attests to:
  - a lack of present illegal drug use,
  - any history of loss of license,
  - felony convictions,
  - any history of loss or limitation of privileges or disciplinary action,
  - five (5) year history of professional liability claims resulting in judgment or settlement, and,
  - attestation by the applicant of the correctness of and completeness of the application.
- Academic history with proof of completion.
- Employment experience in the form of a resume.
- Copies of professional licenses, certifications and registrations.
- Current list of "in-service" trainings completed, including other professional training experiences pertinent to clinical practice. The credentials file must also include an evaluation of the clinician's work history for the prior five (5) years.
- Proof of the criminal background check for all employees hired after 10/1/2003.
- Proof of annual review of the Medicaid/Healthy Michigan Plans Sanctioned Provider List, http://exclusions.oig.hhs.gov/ to assure no staff in employment or contracting with the Provider is listed.
- A list of clinical privileges practiced by date granted.
- Proof of annual primary source verification of licensure, registration and/or certification on all clinicians and maintain in the credential file.
- Intern files must also contain the practicum and clinical experience supervised, with the areas of clinical practice, age group, and/or special skills learned. See the CMHSP Student Intern Policy section for more information.

B. **Verification of Credentials**

The *Confirmation of Credentials Form*, provided in the attachment section, must be submitted annually upon request to the CMHSP. During the annual provider site visit, the CMHSP will review the credential files for accuracy and thoroughness. A sampling methodology may be used to verify the information

contained in these forms and that annual primary source verification has been completed and documented in the credential file.

Clinical services rendered by staffs who do not meet credentialing requirements as detailed in Section 7.9.2 shall not be reimbursed by the CMHSP.

The CMHSP reserves the right to recognize and accept the credentialing activities and application of another RE/PIHP. A provider may submit a written request for such consideration.

C. **Provider Responsibility**: Prior to the delivery of services, it is the Provider's responsibility to ensure that all staff slated to provide direct treatment service funded in whole or in part with CMHSP funds meet the qualifications and to maintain credential files on all clinical staff.

Within fourteen (14) days of hire, the Provider must submit the New Employee Verification Form to the CMHSP for all employees who provide direct substance use disorder treatment services to CMHSP funded clients.

Annually, Providers must conduct primary source re-verifications of licensure, registration and/or certification on all clinicians and maintain proof of verification in the credential file.

7.9.7 Clinical Staff Approval Process

A *New Hire Verification Form* must be submitted for each treatment service staff providing CMHSP funded services within fourteen (14) days of hire. This form is provided in the Attachments section.

Forms will be reviewed internally at CMHSP who will conduct a review to verify the licensure, credentials, and checks for Federal Exclusionary Listing. Primary source verification does not need to be submitted to the CMHSP.

Based on the staff person's individual experience and preparation, the CMHSP may request completion of the Michigan Addictions Fundamentals Examination (MAFE) in addition to the minimal credentialing requirements.

7.9.8 Staff Training Requirements

In addition to meeting staff credentialing requirements, the CMHSP requires the following training requirements for all employees, volunteers, student interns, and persons under contract providing services to CMHSP funded clients.

The Confirmation of Trainings form, provided in the Attachments section, documenting provider and staff compliance must be submitted annually, upon request, for all professional staff whose scope of services provided is impacted by the topic(s) listed

A. Communicable Disease

To ensure that treatment program staff meets contractual requirements for training and knowledge on HIV/AIDS, MDHHS 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.

MDHHS provides a web-based training that will cover minimal knowledge standards necessary to meet this **Level 1** requirement. However, if a Provider desires to provide this training through other mechanisms, the following information must be included:

- Basic orientation on HIV/AIDS
    - 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.
- Basic training on agency policies and procedures.

All new hires must receive the required communicable disease training on communicable diseases within six (6) months of hire by a certified MDHHS/HAPIS trainer or the online training provided by MDHHS at www.MI-PTE.org.

Proof of staff communicable disease training must be recorded on the staff training log. Providers will be required to submit the *HIV Policy and Procedure Questionnaire and Training Log* annually, within thirty (30) days of the new contract each year. This report is provided in the Attachments section.

B. Advance Directives Training

Medicaid/Healthy Michigan Plan providers must annually, and within the first thirty (30) days of hire, educate its staff by a professionally credentialed authority on Advance Directive regulations, new regulations, forms, and related issues. CMHSP providers must log attendance at the annual training. For more information refer to Section 4.8.

For guidance, providers may follow the questions and answers in the *Michigan Advance Directive for Mental Health Care; Planning for Mental Health Care in the Event of Loss of Decision-Making Ability* located at Advance Directives (nrc-pad.org) and/or the BCBS Advance Directive – FAQs located at: http://www.bcbsm.com/member/establishing_advance_directive/advance_directive_faq.html.

C. Limited English Proficiency (LEP) Training

All providers must educate their staff within the first six (6) months of hire to ensure that information is communicated to LEP persons in a language that they understand. Limited-English-Proficient Person (LEP) is a person whose primary language or dialect is one other than English, and who has difficulty speaking and/or comprehending the English language such that it limits his/her ability to participate in, and benefit from, services communicated in English.

Trainings shall ensure staff compliance with the laws under Title VI Civil Rights Act of 1964, which prohibits discrimination against persons with LEP, and the CMHSP's LEP Policy. Ongoing staff trainings must be provided in accordance to the provider policy.

D. Cultural Competency Training

All providers are required to participate in programs and training to enhance sensitivity to cultural and ethnic diversity. New hires must be trained in the areas of cultural competence within the first six (6) months of hire. Ongoing staff training needs in cultural competency must be assessed, met, and documented according to each provider's Cultural Competency Plan.

E. Corporate Compliance & Deficit Reduction Act (DRA) Training

Medicaid/Healthy Michigan Plan providers must educate its staff upon hire regarding its Corporate Compliance Plan and the requirements of the Deficit Reduction Act to ensure compliance with the statutes, regulations, and written directives of Medicare, Medicaid/Healthy Michigan Plan, and all other Federal Health Care Programs (as defined in 42 U.S.C. ξ 13201-7b (f). Detailed information about the False Claims Act, Whistleblower protections, and policies and procedures for detecting and preventing fraud, waste, and abuse must be covered. Ongoing staff training needs shall be provided as needed, in accordance to the provider policy.

F. Recipient Rights Training

All providers must ensure staff is trained within thirty (30) days of hire to protect client rights in accordance with the rules under PA 368 of 1978, as amended. Specifically, the Administrative Rules for Substance Abuse Service Programs in Michigan, Section 3 – Recipient Rights (effective January 9, 1982). Ongoing staff training needs shall be provided, in accordance to the provider policy.

G. Medicaid/Healthy Michigan Plans Fair Hearings Training

Medicaid/Healthy Michigan Plan providers must ensure staff possess current working knowledge, or know where in the organization detailed information can be obtained regarding the steps and actions to be taken when a Medicaid/Healthy Michigan Plan client does not agree with the scope, duration, or intensity of services authorized. Agency staff must receive training in this area within the first thirty (30) days of hire and thereafter according to provider policy.

H. Confidentiality & Health Insurance Portability and Accountability Act (HIPAA) Training

All providers must review their written policies and procedures addressing the use of protected health data and information that falls under the HIPAA requirements with new staff and ensure training on all applicable Federal and State requirements of the HIPAA 45 CFR and Confidentiality Rules of 42 CFR

Part 2 within the first fifteen (15) days of hire. Ongoing trainings shall be provided, as needed, in accordance to the provider policy.

7.9.9 Patient Advocacy

A health care professional, who is acting within their lawful scope of practice, is not prohibited or restricted from advising or advocating for his or her patients in any of the following areas:

- The beneficiary's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;
- Any information the beneficiary needs in order to decide among all relevant treatment options;
- The risks, benefits, and consequences of treatment or non-treatment; and
- The beneficiary's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

7.9.10 False Claims Act

Providers must establish written policies that address and comply with the False Claims Act and ensure their employees are made aware of their rights under the Whistleblowers Provisions of the False Claims Act. For more information visit http://www.whistleblowers.gov/

7.9.11 Use of Student Interns

The CMHSP encourages the provider network to provide opportunities to support prospective addiction professionals. However, it is important to ensure that interns are involved in ways consistent with accepted standards and compatible with patient rights and needs.

It should be assumed that a new intern is unqualified to independently deliver any service to a client. Depending on the intensity of the learning situation, four (4) to eight (8) weeks should elapse before an intern can begin to function on his/her own in such critical areas as assessment, treatment planning, treatment, or prevention education. Four to eight weeks is optimal and should be extended when appropriate for the individual intern.

Billable activity or direct service credit should not be submitted under an intern's staff number until his/her supervisor has reviewed the performance after four to eight weeks and has certified, in writing, that the intern is able to work quasi-independently in specific areas without jeopardizing patients and will contribute to patient progress.

An Internship form must be completed and approved by the CMHSP prior to submitting treatment activity provided by the intern. The *Internship Form* is provided in the Attachments section.

Criminal background checks must be completed for interns prior to interaction with clients or access to protected health information.

A. Roles and Responsibilities

1. Responsibilities of the Studentship/Practicum Agency

The agency agreeing to accept a student must:

- Provide assurance the student is covered by adequate liability insurance.
- Assign a supervisor who has:
  - Capacity to provide adequate supervision and instruction to meet the sending school's requirements, and
  - A Michigan Certification Board of Addiction Professionals treatment credential.
- Ensure compliance with all Federal labor laws if the internship is unpaid.
- Ensure the student has basic protections in the work setting consistent with Federal and State laws, ethical considerations, and sound business practices.
- Ensure the student abides by all Federal confidentiality and privacy laws.
- Submit a completed New Employee Verification form to CMHSP for the student prior to direct contact with clients who are receiving services funded in whole or part by CMHSP managed funds.
- Submit other contractual items as required by CMHSP contract.

2. Responsibilities of Studentship/Practicum Supervisor

- Provide a documented orientation to the student, which minimally addresses:

  a. Federal Confidentiality and Privacy Laws
  b. CMHSP Student Intern Policy
  c. Michigan Certification Board for Addiction Professional's *Code of Ethics*
  d. Sponsoring Agency Policy and Procedures
  e. ASAM Patient Placement Criteria
  f. DSM IVR
  g. CMHSP Authorization Process
- Provide one (1) hour of formal scheduled direction supervision on a weekly basis.
- Review and sign-off on all written documentation for independent clinical activity, including but not limited to progress notes, treatment plans, initial authorization requests, reauthorization requests and correspondence.
- Utilizing the privileging process outlined in the Clinical Practicum /Studentship Criteria listed in this policy, assure that

the student is prepared to engage in the level of clinical practice assigned.

- Assist student in preparing an educational plan based on the Clinical Practicum/Studentship Criteria appropriate for the length of the practicum placement, and in consideration of the education and prior experience of the student.
- Review all clinical assignments.

3. Responsibility of the Student

- Provide written assurance of understanding of and adherence to the Federal Confidentiality and Privacy Laws;
- Provide written assurance of understanding of and adherence to the Michigan Certification Board of Addiction Professionals *Code of Ethics;*
- Provide services only as approved and directed by supervisor;
- Develop an appropriate educational plan with assistance of the supervisor.

B. **Clinical Practicum/Studentship Criteria**

Documentation of all activities and progressions made toward providing clinical services must be tracked, kept in the student's file, and available for CMHSP review.

It is the responsibility of the supervisor to document compliance and, through his/her signature, verify competence prior to allowing the student to progress to another level of activity.

C. Reimbursement for clinical Services

1. A Provider may only invoice the CMHSP for independent clinical services provided by a student intern when services meet all contractual requirements as stated in the Michigan Medicaid/Healthy Michigan Plan Manual and the CMHSP Contract.

2. For services provided to Medicaid/Healthy Michigan Plan and MIChild clients, the student intern must meet the following requirements:

- New Employee Verification form submitted to the CMHSP.
- Meet credentialing requirements for a Substance Abuse Treatment Practitioner (SATP) or a Substance Abuse Treatment Specialist (SATS) as verified by the Provider.

For services provided to Block Grant and PA2 clients, the student intern must meet the following requirements:

- New Employee Verification form submitted to the CMHSP.

- Pass the Michigan Addictions Fundamentals Examination (MAFE) Test, as verified by the Provider.
- Have a certified MCBAP Addictions Counselor supervise, review and co-sign all progress notes, treatment plans, communication, authorization requests, and other clinical documentation of the student intern.

3. The Provider must assure compliance with the Federal Fair Labor Standards Act and have documentation that the intern has progressed to being able to provide the level of service and activity billed.

7.10 Service Standards and Guidelines

7.10.1 Mental Health Practice Guidelines

All Medicaid/Healthy Michigan Plans funded services through the CMHSP must comply with appropriate mental health requirements as established by the MDHHS.

- Self-Determination http://www.michigan.gov/MDHHS/0,4612,7-132-2941_4868_4900-264686--,00.html
- Person Centered Planning (In substance use disorder treatment the individualized treatment planning is used to ensure person-centered planning) http://www.michigan.gov/MDHHS/0,4612,7-132-2941_4868_4900-264670--,00.html
- Recovery Philosophy http://www.michigan.gov/documents/MDHHS/March12007MemofromPatrick_188884_7.pdf
- Mental Health Evidence-Based Practices:
  - Assertive Community Treatment: http://www.michigan.gov/MDHHS/0,4612,7-132-2941_4868_38495_38496_38504---,00.html
  - Family Psycho-education: http://www.michigan.gov/MDHHS/0,4612,7-132-2941_4868_38495_38496_38504---,00.html
  - Improving Practices: http://www.michigan.gov/documents/MDHHS/Practice_Improvement_Steering_Committee_Meeting_11_9_09_302903_7.pdf
  - Supported Employment: http://www.michigan.gov/MDHHS/0,4612,7-132-2941_4868_38495_38496_38505---,00.html

7.10.2 LRE Policies and Procedures

As an affiliated member of the Lakeshore Regional Entity, all Medicaid/Healthy Michigan Plans funded services through CMHSP must comply with appropriate

LRE policies and procedures that govern the Medicaid/Healthy Michigan Plans benefit. The LRE policies and procedures can be found at the website Policies — Lakeshore Regional Entity (lsre.org)

1.0 General Management and Administration
1.1 Conflict of Interest
1.2 Asset Protection
2.0 Financial Management
3.0 Information Systems Management
4.1 Procurement of Service
4.2 Contract Management
4.3 Network Policy Development
4.4 Credentialing and Privileging
5.0 Utilization Management
6.0 Customer Services
6.1 Grievance and Appeals
6.2 Consumer Empowerment and Involvement
6.3 Community Benefit
7.1 QAPIP
7.2 Quality Management Committee
7.3 Critical Incidents and Sentinel Events
7.4 External Review Process
7.5 Conducting Research
7.6 Corporate Compliance
7.7 CMHSP Member Monitoring

7.10.3 MDHHS Best Practice Guidelines

The CMHSP is committed to following all guidelines provided by the MDHHS as detailed in their Treatment Policies and Technical Advisories. All CMHSP funded services must comply with these guidelines. The CMHSP will communicate requirements as established by these policies and technical advisories through this manual, contract requirements, and supplemental communications.

The Michigan Department of Health and Human Services/Bureau of Substance Abuse and Addiction Services policies and technical advisories for substance use disorder services can be found at:

http://www.michigan.gov/MDHHS/0,1607,7-132-2941_4871_4877-133156--,00.html

7.10.4 CMHSP Policies and Procedures

The following CMHSP Policies govern the Medicaid/Healthy Michigan Plan benefit and can be found on the CMHSP website:

- Medicaid/Healthy Michigan Plans Mission, Vision, Values and Ethics Statement
- Completion of Competency Based Evaluation
- Hiring Process

- Screening, Orientation and Supervision of potential employees
- Screening, Orientation and Supervision of Staff
- Financial Tracking of Contract Payments
- Billing Audit
- Recipient Rights Policies
- Staff Development
- Substance Abuse Services: Admission, Assessment, Discharge,
- Confidentiality, Credentialing Standards, Agency Discontinuation
- Services and Program Direction and Oversight
- Documentation Standards
- CMHSP Anti-Harassment Policy
- Quality Assessment and Performance Improvement
- LRE Corporate Compliance Plan

SECTION 8

PROVIDER AGREEMENT & NEGOTIATIONS

Negotiation as herein used refers to sub-contractor initiated requests for changes in the terms of their contract with the CMHSP. Normally such requests are received and acted upon as part of the Annual Action Planning process, although the possibility of extenuating circumstances that make a mid-year request appropriate is recognized.

Issues between the Provider and CMH involving contractual terms will be addressed by their respective designated representatives. All decisions to authorize, continue, or discontinue CMH payments for services to consumers will be those of CMH's Executive Director or designee. If disputes as to essential terms of this contract are not resolved by the Executive Director for the CMH, these issues will be referred for dispute resolution to the Executive Board of CMH and the Provider's governing body.

SECTION 9

CASE RECORD CONFIDENTIALITY

The CMHSP is responsible for ensuring the maintenance of all clinical records for covered benefits in accordance with accepted and prevailing standards for professional substance abuse care practice.

Confidentiality is a major professional and administrative component of clinical records management. Confidentiality is protected by a system of record control that ensures security of written and computer-based information and prescribes specified managed protocols for release of privileged information in keeping with all of Michigan Managed Care Providers policies and procedures.

The CMHSP and providers shall comply with Federal law governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1990 (HIPAA), 45 C.F.R. Parts 160 and 164, effective April 2003.