NorthCare Network

Substance Use Disorder Services

Operations Manual

FY24

Website: www.northcarenetwork.org

10/1/2023 – 9/30/2024

Updated 2/2024

NorthCare Network

NorthCare Network is the regional Prepaid Inpatient Health Plan (PIHP) for the Upper Peninsula of Michigan. Under contract with the Michigan Department of Health and Human Services (MDHHS) NorthCare Network is responsible to manage the 1115 Behavioral Health Demonstration Waiver Program, the Healthy Michigan Plan, and relevant approved Waivers in a designated service area and to provide a comprehensive array of specialty mental health and substance abuse services and supports for adults with serious mental illnesses (SMI), children and adolescents with serious emotional disturbances (SED), persons with intellectual/developmental disabilities (I/DD), and persons with substance use disorders (SUD). In addition, NorthCare Network manages behavioral health services for individuals, age 21 and older, with both Medicare and Medicaid who are enrolled in the MI Health Link Program. This manual and NorthCare Network policies, and plans are available at: www.northcarenetwork.org under the Provider section. All Network Providers are required to review these at our website. Each Network Provider will be emailed a notice of any new or revised policy, procedure or plan and are responsible for informing appropriate staff within your organizations. We ask that you update your contact information with NorthCare Network's Provider Network Specialist as needed, to ensure proper timely notice is received by your organization.

Mission, Vision, and Values

Mission

NorthCare Network ensures that every eligible recipient receives quality specialty mental health and substance use disorder services and supports through the responsible management of regional resources.

Vision

NorthCare Network envisions a full range of accessible, efficient, effective, and integrated quality behavioral health services and community-based supports for residents of Michigan's Upper Peninsula.

Values

- We believe in respect, consumer empowerment, person centered care, self-determination, full community participation, recovery, and a culture of gentleness.
- We also endorse effective, efficient community-based systems of care based on the ready availability of competent workforce and evidence-based practices.
- We believe in services that are accessible, accountable, value-based, and trauma informed.
- We support full compliance with state, federal and contract requirements, and responsible stewardship.
- The right care, at the right time, for the right cost, and with the right outcome.

NorthCare Network Hours of Operation

Regular office hours are 8:00 a.m. until 5:00 p.m., EST, Monday through Friday (holidays excluded)

During non-business and Holiday hours, MiCal (Michigan Crisis and Access Line) trained staff will answer the NorthCare SUD line. Calls will be managed appropriately based on request and necessity.

Michigan Crisis and Access Line (MiCAL)

MiCAL is a centralized state-wide crisis line which supports individuals with behavioral health and substance use disorder needs. MiCAL also offers the Michigan Warmline, which provides individuals with emotional support from a Certified Peer Support Specialist or Peer Recovery Coach from 10:00 a.m. to 2:00 a.m., 7 days a week. The Michigan Warmline can be reached at 888-PEER-753 (888-733-7753).

List of NorthCare Network Contracted Providers

Refer to the NorthCare Network Customer Handbook for the current listing of Substance Use Disorder Providers.

NorthCare Network Organization

Refer to the NorthCare Network Organizational Chart for a complete list of staff.

Below is a list of NorthCare Network SUD direct contacts.

Megan Rooney, Chief Executive Officer – 906-936-6845

Sara Sircely, SUD Services Director – 906-936-6844

Robert Wedin, Senior Clinical Director – 906-936-6858

Tami LeBlanc, SUD Clinical Director – 906-936-6847

Karena Grasso, Provider Network Specialist – 906-205-2838

Joan Wallner, Systems Analyst – 906-936-6867

Stacey Coleman, Compliance-Privacy Officer – 906-936-6843

Kathy Lyman, SUD/Access Specialist – 888-333-8030 or 906-936-6850

Courtney Brusso, SUD Priority Population Care Manager – 906-936-6851

Kayleigh Babcock, SUD Managed Care Clinical Specialist – 906-936-6862

Nicky Barber, Opioid Health Home (OHH) Care Coordinator – 906-936-6860

Customer Service 1-888-333-8030 or 906-936-6865

SUD fax – 1-248-406-1286

NorthCare Network Governing Board Members

Chairperson: George Botbyl, Pathways

Vice-Chairperson: Margaret Rayner, Pathways

Secretary: Pat Rozich, Copper Country

Copper Country: Michael Koskinen, James Tervo, Richard Herrala (alternate)

Gogebic: Joe Bonovetz, Bill Malloy, Carrie Braspenick, Collen Kichak (alternate)

Hiawatha: George Ecclesine, Jim Moore, Dr. John Shoberg

Northpointe: Ann Martin, Mari Negro, Kevin Pirlot, Patricia Phillips (alternate)

Pathways: Glenn Wing

SUD Policy Board Members

Chairperson: James Moore, Chippewa County

Vice-Chairperson: Craig Reiter, Schoolcraft County

Stephen Adamini, Marquette County

Robert Barron, Delta County

Joe Bonovetz, Gogebic County

Roy Britz, Houghton County

Randy Eckloff, Keweenaw County

Connie Westrich, Menominee County

Corina Clark, Mackinac County

Michael Koskinen, Baraga County

Ann Martin, Dickinson County

Nancy Morrison, Lucy County

Robert Nousiainen, Ontonagon County

Patti Peretto, Iron County

Rick Capogrossa, Alger County

Further information about the NorthCare Network Governing Board and SUD Policy Board can be found on our website.

General Information

Purpose of the Operations Manual

The purpose of this Operations Manual is to outline the basic framework for NorthCare Network Substance Use Disorder (SUD) processes. While every attempt has been made to be as clear and accurate as possible, omissions, ambiguities, and other imperfections may exist. In the event an error is discovered or a policy/procedure changes, contracted Providers will be notified in writing via email. The NorthCare Network Substance Use Disorder Services Operations Manual is incorporated by reference as part of the Provider Contract. As updates, clarifications, and changes are made to the MDHHS/PIHP Contracts or the Medicaid Provider Manual, this Substance Use Disorder Operations Manual will also be updated.

Notice of Privacy Practice

Protecting client health information is particularly important. The Federal Government has issued a set of regulations to guide the medical community in this area. The notice of privacy practices is sent out by NorthCare Network Substance Use Disorder staff to all funded recipients. The notice of privacy will describe the rights a client has about their medical record. The client has a right to inspect and copy their records; the right to request an amendment to their record; the right to a list of the disclosures and the right to inspect the information used or disclosed; and the right to request confidential communication with their health Providers.

Cell Phone Usage

Mobile telephones present some challenges to programs as conversations about confidential matters can take place anywhere and be overheard by anyone. Although 42 CFR Part 2 does not specifically address the use of mobile telephones, common sense and restraint should prevail.

Telemedicine/Telehealth

The use of Telemedicine, as with mobile phones, presents challenges for maintaining confidentiality. Several Providers may be involved, at different sites, with people listening to or viewing the Telemedicine session unbeknownst to the patient. In addition, communications could be intercepted or re-disclosed to unauthorized persons.

The same confidentiality principles apply to Telemedicine as to in-person treatment. Moreover, if protected health information is being transmitted or stored electronically, then the HIPAA electronic security standards will need to be implemented. Particular care must be taken to ensure that records are available only to authorized personnel and those sessions (individual or group) with alcohol or drug patients are not witnessed by unauthorized persons. Most Telemedicine sessions that involve the disclosure of alcohol or drug information will require an MDHHS-5515 consent form to be in place. The consent must list all parties participating in the Telemedicine conference, including technical support individuals operating the video cameras or other equipment. Re-disclosures are prohibited without the appropriate authorization.

This is a service that must be included in the Provider Contract and can only be billed using the appropriate Telemedicine CPT code.

If Telemedicine/Telehealth services are being used, the SUD Provider is responsible for completing the NorthCare Informed Consent for Telehealth Services form with the client. The completed form must be available in the client's chart. The SUD Provider is also responsible for clearly documenting in the client chart/progress note that the service provided was conducted via Telehealth. If the form template is needed, the NorthCare Clinical Director may be contacted for assistance at 906-936-6847.

Americans with Disabilities Act

All contractors must comply with applicable provisions of the Americans with Disabilities Act (the ADA). Further information may be found at: *Nondiscrimination on the Basis of Disability in State and Local Government Services*: United States Code of Federal Regulations, Title 28, Part 35, Washington, D.C. (1991).

LEP – Limited English Proficient

Individuals who do not speak English as their primary language and who have a limited ability to read, speak, write, or understand English can be limited English proficient, or "LEP." These individuals may be entitled to language assistance with respect to a particular type or service, benefit, or encounter. The following website may be helpful: www.LanguageLine.com.

Sign Language Interpreter

Signing Pros, LLC - Michigan's Premier American Sign Language Interpreting Agency (signingprosllc.com)
To schedule a sign language interpreter services to Request Interpreters – Michigan-based Interpreting Agency | Signing Pros (signingprosllc.com). Appointments requested within 48 hours will be billed at the Emergency Rate. Try your best to schedule appointments well in advance. Since this is a new process, please email pnm@northcarenetwork.org with any questions or concerns.

Recipient Rights

Substance use disorder recipient rights complaints are handled at the Provider level by the Recipient Rights Officer at the agency (a list of current Provider Recipient Rights staff is available on NorthCare's website.)

Medicaid Administrative Hearing Process

Please see NorthCare Network's Customer Handbook located on NorthCare's website for information on the Medicaid Administrative Hearing Process.

Confidentiality/Consent

Confidentiality is expected to be maintained in accordance with Federal law and regulations (42 CFR Part 2). In keeping with this, appropriate written consent must be obtained from a client for NorthCare Network Substance Use Disorder Services and Providers to share information. Listed below are essential items in ensuring appropriate confidentiality standards are followed:

- Providers must use the Consent to Share Behavioral Health Information Form (MDHHS-5515) as the release submitted to NorthCare Network for the referral process to begin in ELMER and to further obtain authorization for SUD services. The MDHHS-5515 form must be properly completed and faxed to NorthCare at 248-406-1286.

The MDHHS-5515 consent is typically in effect, unless otherwise noted or revoked by the client, for up to one year from client's signature. Exceptions permitting limited disclosures without written consent are as follows:

  - Internal Communications
  - De-identified disclosures
  - Qualified Service Organization Agreements (QSOAs)
  - Medical Emergency
  - Research
  - Audit & Evaluation
  - Official Judge's Court Order
  - Patient Threat/Crime on program premises or against program personnel
  - Reporting Suspected Child Abuse and Neglect
- There is no age limit for consent. Children and adolescents receiving substance use disorder treatment services must sign any release they choose to give; parental signatures are NOT required. Public Health Code, MCL 333.61.21.
- Each disclosure for individuals receiving SUD services and made with the individual's consent must be accompanied by a re-disclosure statement that reads:

  "This record which has been disclosed to you is protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of this record unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed in this record or, is otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65."

Click here for the MDHHS-5515 form.

Certification of Eligibility

The Certification of Eligibility form must be completed for all NorthCare clients who will be receiving Substance Use Disorder Services. For individuals receiving SUD Residential Services, the form must be faxed to NorthCare at 248-406-1286, along with the Consent to Share Behavioral Health Information Form (MDHHS-5515) prior to an authorization request being

considered. Outpatient services must also have the form completed by the client and filed in the client chart.

Information Fact Sheets

Informational Fact Sheets can be obtained from the following website for such topics as: HIB/AIDS, TB, Hepatitis C, etc. at www.cdc.gov then click "health topic A-Z". Another helpful sight is: www.healthymichigan.com – telephone number: 1-800-353-8227 (clearing house).

Access Management

Access management consists of those responsibilities associated with determining administrative and clinical eligibility, managing resources (including demand, capacity, and access), ensuring compliance with various funding eligibility and service requirements, and assuring associated quality of care. Activities to carry out these responsibilities include appropriate referral and linkage to other community resources. Services shall be provided in the amount and for the duration and within the scope that is appropriate to reasonably achieve the desired treatment outcomes and is the least restrictive level of care. This determination will be made using the following tools/clinical information as appropriate: NorthCare Brief Screening Tool, ASAM placement criteria, DSM 5, current and historical substance use disorder history, mental illness history, and motivation for treatment. **Access requirements apply to all funding sources.**

Target Population

While this varies somewhat according to funding source and priority status; target population is generally comprised of low-income residents with a substance use disorder residing in the fifteen counties of the Upper Peninsula of Michigan.

Residency in Region

NorthCare Network will not limit access to programs and services only to residents of its region, because the funds provided by MDHHS under the State contract come from Federal and Statewide resources. Members of Federal and State identified priority populations will be given access to Treatment services, consistent with the requirements of the State contract, regardless of their residency. However, for non-priority populations, NorthCare Network will give its regional residents priority in obtaining services when the actual demand for services by those residents eligible for services exceeds the capacity of the programs. **Providers are required to determine and document client's county of residence**.

Funding/Eligibility Criteria/Clinical Need

12-month availability of services

Contract Providers must maintain service availability throughout the fiscal year for persons who do not have the ability to pay.

Treatment Services must be based on the following:

Medical Necessity Criteria for substance use disorder supports and services: NorthCare Network must assure that treatment service authorization and re-authorization decisions are consistent with the following Medical Necessity Criteria. These criteria are substantively the same as the applicable criteria for substance use disorder Medicaid services.

Medical Necessity Criteria:

Medically necessary substance use disorder services are supports, services, and treatment:

- Necessary for screening and assessing the presence of substance use disorder; and/or
- Required to identify and evaluate a substance use disorder; and/or
- Intended to treat, ameliorate, diminish, or stabilize the symptoms of a substance use disorder; and/or
- Expected to arrest or delay the progression of a substance use disorder; and/or
- 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.

Determination Criteria

The determination of a medically necessary support, service or treatment must be:

- Based on information provided by the individual, individual's family, and/or other individuals (e.g., friends, personal assistants/aide) who know the individual; and
- Based on clinical information from the individual's primary care physician or clinicians with relevant qualifications who have evaluated the individual; and
- Based on individualized treatment planning; and
- Made by appropriately trained substance use disorder professionals with sufficient clinical experience; and
- Made within federal and state standards for timeliness; and
- Sufficient in amount, scope, and duration of the service(s) to reasonably achieve its/their purpose; and
- Documented in the individual plan of service.

Supports, services and treatment authorized by NorthCare Network must be:

- Delivered in accordance with federal and state standards for timeliness in a location that is accessible to the individual.
- Responsive to needs of multi-cultural populations and furnished in a culturally relevant manner; and
- Provided in the least restrictive, most integrated setting. Residential or other segregated settings shall be used only when less restrictive levels of treatment, service or support have been, for that beneficiary, unsuccessful or cannot be safely provided; and
- Delivered consistent with, where they exist, available research findings, health care practice guidelines and standards of practice issued by professionally recognized organizations or government agencies.

NorthCare Network Decisions

Using criteria for medical necessity, NorthCare Network may:

- Deny services.
  - That are deemed ineffective for a given condition based upon professionally and scientifically recognized and accepted standards of care.
  - That are experimental or investigational in nature; or
  - For which there exists another appropriate, efficacious, less restrictive, and cost-effective service, setting or support, that otherwise satisfies the standards for medically necessary services; and/or
  - Employ various methods to determine amount, scope, and duration of services, including prior authorization for certain services, concurrent utilization reviews, centralized assessment and referral, gate-keeping arrangements, protocols, and guidelines.
- NorthCare Network may not deny payment for services solely based on preset limits of the cost, amount, scope, and duration of services; but instead, determination of the need for services shall be conducted on an individualized basis. This does not preclude the establishment of quantitative benefit limits that are based on individual clinical needs, and clinical progress.

(Medicaid Provider Manual Section 2.5.A., B., C., D.)

Clinical Eligibility: DSM 5 Diagnosis

To be eligible for treatment services purchased in whole or part by state-administered funds, an individual must be found to meet the criteria for one or more selected substance use disorders found in the Diagnostic and Statistical Manual of Mental Disorders (DSM-V). These disorders are listed below. This requirement is not intended to prohibit use of these funds for family therapy. It is recognized that persons receiving family therapy do not necessarily have substance use disorders.

Alcohol Related Disorders:

F10.10 – Alcohol Use Disorder – Mild

F10.20 – Alcohol use Disorder – Moderate/Severe

F10.99 – Unspecified Alcohol-Related Disorder

Opioid Related Disorders:

F11.10 – Opioid Use Disorder - Mild

F11.20 – Opioid use Disorder – Moderate/Severe

F11.99 – Unspecified Opioid Related Disorder

Cannabis Related Disorders:

F12.10 – Cannabis Use Disorder – Mild

F12.20 – Cannabis Use Disorder – Moderate/Severe

F12.99 – Unspecified Cannabis use Disorder

Sedative, Hypnotic, or Anxiolytic (SHA) Related Disorders:

F13.10 – SHA - Mild

F13.20 – SHA – Moderate/Severe

F13.99 – Unspecified SHA Related Disorder

Stimulant Related Disorders:

F14.10 – Cocaine Abuse - Mild

F14.20 – Cocaine Abuse – Moderate/Severe

F15.10 – Amphetamine, Other, or Unspecified Stimulant – Mild

F15.20 – Amphetamine, Other, or Unspecified Stimulant – Moderate/Severe

Other (unknown) Substance Related Disorders:

F19.10 – Other (unknown) Substance Use Disorder – Mild

F19.20 – Other (unknown) Substance Use Disorder – Moderate/Severe

F19.99 – Unspecified Other (unknown) Substance Use Disorder

Funding Sources

All intensive levels of service must be screened by NorthCare Network Access staff and determined appropriate for that level of care for funding to be considered. At the screening's conclusion, the screener will offer to make a 3-way call to a contracted Provider of the client's choice to set up an admission date to enter the determined Level of Care. The client must give the screener permission to make the 3-way call and to disclose the level of care that was determined by the screening to the Provider chosen by the client.

- It is always the responsibility of the SUD provider to verify a client's insurance and income. If the client has no insurance or is underinsured, it is always the responsibility of the SUD provider to verify income to determine eligibility for Block Grant funding as available. Insurance and income verification begins with the first contact a provider has with the client (this would generally be during the pre-screen process) and periodically throughout every episode of care, as outlined below.

SUD Residential and/or Withdrawal Management Screening and Referral by Insurance:

The insurance table below is not an exhaustive list of insurance scenarios that may occur. Unique situations may arise which will require case by case consideration, as appropriate, and only in so far as beneficiary meets income guidelines for Block Grant, Block Grant funding is available, and all other available funding sources have been exhausted.

TABLE: SUBSTANCE USE DISORDER RESIDENTIAL SCREENING and REFERRAL BY INSURANCE

Insurance Benefit	**NorthCare SUD Screening for Residential and/or Withdrawal Management Services**	**NorthCare SUD Referral to Provider for Residential and/or Withdrawal Management Services**
Medicare + Medicaid	Yes	Yes, NorthCare will offer choice of provider and refer to one of our NorthCare paneled providers based on appropriate ASAM LOC.
Medicare only	No. The client will be directed to contact Medicare for further assistance, using the # on the back of their Medicare card.	No. The client will be directed to contact Medicare for further assistance, using the # on the back of their Medicare card.
MiHealth Link	Yes	Yes, refer as NorthCare normally does for MiHealth clients.
Medicare + Private Insurance *with* SUD treatment benefit OR Private insurance only *with* SUD treatment benefit	No. Refer client back to their insurance carrier.	No. Refer client back to their insurance carrier.

Private insurance only *without* SUD treatment benefit	Yes, but only if written confirmation from the insurance carrier or other responsible party is received by NorthCare, verifying client does not have SUD treatment benefits and only if client meets the income guidelines for Block Grant coverage and Block Grant funding is available.	Yes, but only if written confirmation from the insurance carrier or other responsible party is received by NorthCare, verifying client does not have SUD treatment benefits and only if client meets the income guidelines for Block Grant coverage and Block Grant funding is available.
Private Insurance + Medicaid	The client will be directed to contact their insurance carrier for a provider that may accept their insurance. Once the client has been admitted for treatment, the provider will contact NorthCare to arrange for a brief-screening with the client so that the Medicaid benefit can be used as a secondary payor as appropriate.	No. The client will self-refer.
Incarcerated Medicaid	Yes.	Yes, following guidelines outlined in NorthCare SOP for Jail Screening for Substance Use Disorder (SUD) Services, under Procedure heading and "If client is not eligible for DOC or OCC funding."
Medicare + Medicaid Spenddown, Not Met	Yes, as long as the client meets income guidelines for the use of Block Grant funding and so long as Block Grant funding is available.	Yes, as long as the client meets income guidelines for the use of Block Grant funding and so long as Block Grant funding is available.

Block Grant

To be eligible for Block Grant Funding, a client must meet income, medical necessity criteria and residency requirements (per State Contract) in one of the fifteen counties in the Upper Peninsula of Michigan.

Income: financial eligibility is determined according to a sliding fee scale based on the national poverty index. Financial eligibility must be documented by the Provider. Acceptable sources of documentation include pay stubs, unemployment check stubs, most recent income tax return, or a letter from an employer attesting to an employee's income. Other reasonable forms of documentation will be considered; however, any other form must also be in the client chart. Annual site visits by NorthCare Network will check to ensure that copies of approved documentation are found in client charts and the documentation information supports the sliding fee scale. Under certain circumstances there may be conflicting income information. NorthCare reserves the right to request income documentation, prior to authorization consideration.

Generally, financial eligibility is determined by income over a 12-month period. Yearly income can be based on the following alternative method for a valid reason such as recent unemployment. The formula is: $ (Last 3 months of income) x 4 (quarters in a year) = $(Projected 12-month income). *Exception requests (for income consideration other than discussed above) must be put into writing and directed to NorthCare Network's CEO or designee.*

Sliding Fee Scale Effective 11/1/2023

Family Size	Income Level
1	$ 29,160.00
2	$ 39,440.00
3	$ 49,720.00
4	$ 60,000.00
5	$ 70,280.00
6	$ 80,560.00
7	$ 90,840.00
8*	$ 101,120.00

*For each additional family member, add $10,280

The sliding fee scale is based on the Federal Poverty Guidelines, which are revised annually. The sliding fee scale is subject to revision by NorthCare Network during the year. If the scale is updated, Providers will be notified in writing and given effective date applying the new revision. The sliding fee scale is current at the time of this update.

Clients who meet the sliding fee scale and other requirements but are also covered by other insurance may be eligible for Block Grant funding in coordination with the other insurance plan.

Block Grant funds must be the last source of funding either in conjunction with other insurance or funding, or after other funding sources available to the consumer have been exhausted.

Financial information needed to determine ability to pay (financial responsibility) must be reviewed every 90 days (to coincide with the required 90-day treatment plan reviews for the outpatient services), at a change in an individual's financial status, or at time of a new admission. NorthCare recommends monthly "check-ins" with the client to see if any changes have occurred.

- To assist NorthCare in monitoring Block Grant funding and availability, NorthCare has included on the SUD Provider Referral Form an insurance section providers must complete.

  Client Insurance: Primary _____ Secondary _____

  Is the Client Block Grant eligible? _____ Date income was verified: _____

- Additionally, on the Provider Authorization Request form located in the ELMER system, NorthCare has added a BG verification checkbox (shown below) the SUD provider must also complete, which indicates that BG eligibility has been verified.

- Providers may also refer to the document *"***WHEN TO USE THE BLOCK GRANT VERIFICATION CHECKBOX ON THE AUTHORIZATION REQUEST FORM", located under the Help tab in ELMER.**

Residency: Priority clients will be placed according to State guidelines. NorthCare will follow the State "Admission Priority Requirements" established for non-priority clients. NorthCare Network will exercise a priority admission system for non-priority regional residents as the first opportunity to fill available treatment placements. All others would be considered for placement dependent on the capacity of the programs funded.

Medical Necessity: Clients seeking intensive levels of care-other than sub-acute withdrawal management programming, must first complete a SUD Access screening. Funds can only be accessed for intensive services if the screening demonstrates a medical necessity for such services. Substance use Disorder Services will be provided in the least restrictive, most integrated setting.

***Covered Services*: Refer to your Provider contract.**

Medicaid

To receive substance use disorder treatment funding through this source, it is necessary to verify current Medicaid coverage that identifies the recipient as a resident within NorthCare Network's fifteen-county Medicaid catchment area and demonstrate "medical necessity" for the service provided. Refer to the Medicaid Provider Manual available online at www.michigan.gov/mdhhs for a complete definition of medical necessity. Refer to NorthCare Network's Enrollee Rights and Protections policy.

Income: Financial eligibility for Medicaid is determined by Michigan's Department of Human Services (DHS). Clients apply at their local DHS office. A valid Medicaid card is documentation of income. Medicaid eligibility must be checked. It is essential that Providers be vigilant about checking Medicaid eligibility, as clients may be eligible one month but not the next. Verification must continue monthly and/or before each service.

Residency: Medicaid recipients whose County Code is not in the Upper Peninsula will be referred to the appropriate Regional Entity. Issues regarding the county of financial responsibility should be referred to NorthCare Network.

Allowable Services: Medicaid covered services include Initial Assessment, diagnostic evaluation, referral, and patient placement; Withdrawal Management (ASAM Level 3.2 Clinically Managed Residential, and ASAM Level 3.7 Medically Monitored); Residential Treatment; Intensive Outpatient Treatment; Outpatient Treatment; and Methadone Treatment.

Deductible: Some consumers may have a monthly Medicaid Spend Down (deductible) requirement. Unless and until a consumer's Medicaid spenddown is met, they are not eligible for use of Medicaid funding. NorthCare Network is not responsible for the submission of an individual's bill to DHHS for determination of Medicaid eligibility for those who have a deductible.

Healthy Michigan Plan (HMP)

Health care coverage for individuals who; are age 19-64 years, have income at or below 133% of the federal poverty level under the modified adjusted gross income methodology, do not qualify for or are not enrolled in Medicare, do not qualify for, or are not enrolled in other Medicaid programs, are not pregnant at the time of application and are resident of the State of Michigan.

Income: Financial eligibility for HMP is determined by Michigan's Department of Human Services (DHS). Clients apply at their local DHS office. HMP eligibility must be checked in ELMER.

It is essential that Providers be vigilant about checking HMP eligibility, as clients may be eligible one month but not the next.

Residency: HMP recipients whose County Code is not in the Upper Peninsula will be referred to the appropriate regional entity. Issues regarding the county of financial responsibility should be referred to NorthCare Network.

Covered Services: Initial Assessment, diagnostic evaluation, referral, and patient placement. Withdrawal Management (ASAM Level 3.2 Clinically Managed Residential, ASAM Level 3.7 Medically Monitored); Residential Treatment; Intensive Outpatient Treatment; Outpatient Treatment.

Medical Necessity: Substance use disorder services must be medically necessary and provided in the least restrictive, most integrated setting. Inpatient, licensed residential, or other segregated settings shall be used only when clinically appropriate. Providers of Medicaid and Healthy Michigan Plan covered services must accept clients referred by NorthCare Access and render medically necessary services which Provider is qualified by law to render, customarily provides, and has the capacity to provide.

State Disability Assistance (SDA)

The SDA program provides cash assistance to Michigan's eligible disabled, adults. *Income*: Application is made through the Michigan Department of Health and Human Services (MDHHS). The cash asset limit is $3,000.

Residency: Residency in substance use disorders residential treatment, Michigan residency and not receiving case assistance from another state. U.S. citizenship or have an acceptable alien status.

Medical Necessity: To receive SDA benefits, a client must be screened by NorthCare Access as needing a residential level of care according to the current ASAM placement criteria.

MI Health Link

The MI Health Link (MHL) is a program that allows individuals who have both full Medicare and full Medicaid to receive coordinated care. This means an individual, who enrolls in the MHL Program, will have one plan and one card for primary health care, behavioral health care, home and community-based services, nursing home care and medications. Individuals who choose to be enrolled will be assigned a person called an Integrated Care Coordinator who will help coordinate services by linking and coordinating with all Providers involved in the individual's health care. For more information about MHL contact the Upper Peninsula Health Plan (UPHP) at 1-800-835-2556 (TTY 711) or 906-225-7500

Points of Entry for Funded Services

Welcoming/Customer Service – Training Component on Website

A welcoming philosophy is based on the core belief of dignity and respect for all people while in turn following good business practice. It is important for the system to understand and support the client in seeking treatment by providing an environment including actions/behavior that foster entry and engagement throughout the treatment process and supports recovery.

Welcoming is conceptualized as an accepting attitude and understanding of how people "present" for treatment and a capacity on the part of that location to address their needs in a manner that accepts and fosters a service and treatment relationship that meets the needs and interests of the service recipient. Welcoming is also considered a best practice for programs that serve persons with co-occurring mental health and substance use disorders. A comprehensive pre-screen should take place with the person calling so they can be directed to the appropriate next step.

General principles associated with Welcoming

- Welcoming is a continuous process throughout the agency/program and involves access, entry, and on-going services
- Welcoming applies to all "clients" of an agency. Beside the individual seeking services and their family, a client also includes the public seeking services; other Providers seeking access for their clients; agency staff; and the community in which the service is located, and/or the community resides
- Welcoming is comprehensive and evidenced throughout all levels of care, all systems and service authorities
- A Welcoming system is "seamless." It enables service regardless of original entry point, Provider, and current services.
- In a Welcoming system, when resources are limited, or eligibility requirements are not met, the Provider ensures a connection is made to community supports
- A Welcoming system is culturally competent and able to provide access and services to all individuals seeking treatment

Welcoming – Service Recipient

- There is openness, acceptance and understanding of the presenting behaviors and characteristics of persons with substance use disorders
- And, for persons with co-occurring mental health problems, there is an openness, acceptance and understanding of their presenting behaviors and characteristics
- Welcoming is recipient based and incorporates meaningful client participation and "client satisfaction" that includes consideration to the family members/significant others
- Services are provided in a timely manner to meet the needs of the individual and/or their families
- Clients must be involved in the development of their treatment plans and goals.

Welcoming Organization

- The organization demonstrates an understanding and responsiveness to the variety of help-seeking behaviors related to various cultures and ages
- All staff within the organization incorporates and participates in the welcoming philosophy
- The program is efficient in sharing and gathering authorized information between involved agencies rather than having the client repeat it at each Provider
- The organization has an understanding of the local community, including community differences, local community involvement and opportunities for recovery support and inclusion by the service recipient
- Consideration is given to administrative details such as sharing paperwork across Providers, ongoing review to streamline paperwork to essential and necessary information
- A welcoming system can provide follow-up and assistance to an individual as they navigate the Provider and the community network(s)
- Welcoming is incorporated into continuous quality improvement initiatives.
- Hours of operation meet the needs of the population(s) being served.
- Personnel that provide the initial contact with a client receive training and develop skills that improve engagement in the treatment process
- All paperwork has purpose and represents added value. Ingredients to managing paperwork are the elimination of duplication, quality forms design and efficient process, transmission, and storage.

Welcoming – Environmental and Other Considerations

- The physical environment provides seating, space and consideration to privacy, and/or other “amenities” to foster an accepting, comfortable environment.
- The service location is considered regarding public transportation and accessibility.
- Waiting areas include consideration for family members or others accompanying the individual seeking services.

Mandated Admission Priorities

In accordance with SAPT Federal Block Grant regulations at CFR 96.131 and Sec 6232 of Public Act 368 of 1978, as amended, and per Medicaid Manual Bulletin (04-03) admission priorities are delivered in accordance with Federal and State standards.

Priority One – Pregnant, injecting drug user

Priority Two – Pregnant substance use disorders

Priority Three – Injecting drug user

Priority Four – Parent and risk of losing their child(ren) due to Substance Use (Open CPS case)

Priority Five – Individual under supervision of the Michigan Department of Corrections (MDOC) and referred by MDOC OR an individual being released directly from a MDOC facility without supervision and referred by MDOC. Excludes individuals referred by court and services through local community corrections (PA 511 funded) systems.

Priority Six – all others

Access Timeliness Standards

The following chart indicates the current admission priority standards for each population along with the current interim service requirements. Suggested additional interim services are *italics*. Screened and referred applies to intensive services and methadone. When a client calls an outpatient Provider for services, the Provider must follow the admission guidelines, not the screened and referred requirements. If a client calls an outpatient Provider and requests intensive services or methadone, they must then be referred to NorthCare for further services.

Population	Admission Requirement	Interim Service Requirement	Authority
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 admission within **48 business hours**.	*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. 2. Referral for prenatal care. 3. *Early intervention clinical services.*	CFR 96.121; CFR 96.131; Tx Policy #04 Recommended

Population	Admission Requirement	Interim Service Requirement	Authority
Pregnant Substance User	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 prenatal care. 3. *Early intervention clinical services.*	CFR 96.121; CFR 96.131; Recommended
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 needle sharing. c) Risks of transmission to sexual partners and infants. 2. *Early intervention clinical services.*	CFR 96.121; CFR 96.126; Recommended
Parent at Risk of Losing Children	Screened and referred within **24 hours**. Offer admission within **14 days**.	*Begin within **48 business hours**:* *Early intervention clinical services.*	MI Public Health Code Sec. 6232 Recommended
Population	**Admission Requirement**	**Interim Service Requirement**	**Authority**
Individual Under Supervision of MDOC and Referred by MDOC or Individual Being Released Directly from MDOC Without Super-vision and Referred by MDOC	Screened and referred **within 24 hours.** Offer admission within **14 days**.	*Begin within **48 business hours.*** Recovery Coach Services *Early intervention clinical services.*	MDHHS & PIHP Contract Recommended
All Others	Screened and referred within **7 calendar days**. Capacity to offer admission within **14 days**.	Not required.	CFR 96.131(a) – sets the order of priority. MDHHS & PIHP contract

ASAM Continuum

The Behavioral Health and Developmental Disabilities Administration (BHDDA) has approved the use of the American Society of Addiction Medicine (ASAM) Continuum as the standardized SUD assessment instrument to meet the criteria of the SUD 1115 Medicaid Waiver. The ASAM Continuum (AC) was fully implemented and operational on October 1, 2021.

- No more than four (4) Assessment (H0001) encounters, per individual, will be paid in a fiscal year.
- An annual AC (using the H0001 billing code) must be completed for outpatient clients who have been receiving continuous outpatient services for over 1 year (for example, if an AC was completed on 4/1/22 and the client is still in services on 4/1/23, a new AC must be completed by 4/1/23 or shortly thereafter).
- An AC may be updated anytime there is a change in condition. This may be accomplished one of two ways: using a progress note documenting the update and using the H0004 billing code; or completing a new AC, keeping in mind the MDHHS imposed limit of four (4) per fiscal year.
- All NorthCare clients approved for SUD treatment services or NorthCare clients who receive any SUD service that is reimbursed with Medicaid funds must be assessed using the AC. If the NorthCare client is *only* receiving MAT services accompanied by the H0050 Brief Intervention service, and no additional treatment services, an annual AC updated assessment would not have to be completed.
- Appropriate steps must first be taken by NorthCare staff to ensure that any ***non-contracted*** provider who is providing SUD services to a NorthCare referred client through Single Case Agreement (SCA) has or will have timely access to ELMER established to complete an AC. **(**Steps are outlined in the NorthCare SUD SCA Procedure under the ACCESS section. **This does not apply to non-contracted, Border-State SUD Providers, e.g., Willow Creek, Bellin Health who would only be providing sub-acute Withdrawal Management services not referred by NorthCare).**
- If an assessment tool, other than the AC is used for an episode of care, any service delivered within that episode will not be eligible for Medicaid funding.
- If clinically appropriate, an SUD outpatient provider may update an existing AC for a new or returning client using a progress note (H0004 code must be used for billing). For example, if a client completed an AC in January, left services in February, and then re-entered services in March, the AC completed in January could be used if clinically appropriate to do so. Reference must also be made to the previous AC in the progress note.
- The AC will be accessed from within the ELMER system. If technical issues are encountered and the AC is not able to be accessed due to circumstances beyond the control of Provider staff, depending on the nature of the problem, the NorthCare Clinical Director and/or NorthCare Systems Analyst should be notified immediately and

upon resolution, the AC should be completed as soon as possible thereafter. The Continuum User Manual for Michigan Providers also provides additional options for tech support depending on the nature of the issue.
(CONTINUUMSupport@FEIsystems.com.)

- Additionally, the AC must be completed by an appropriately licensed ***and*** MCBAP certified clinician. Acceptable credentials include, but are not limited to, LLMSW, LMSW, with CAADC, CADC. If the clinician completing the AC does not have the appropriate licensure ***and*** MCBAP credential (e.g., clinician completing the assessment only has a MCBAP Development plan) the AC must be reviewed, signed, and dated by a clinician that does have these credentials. The reviewed, signed, and dated document must be available in the client's chart within 5 days of completion of the assessment.
- NorthCare recommends that assessments be completed as soon as possible upon admission, but no later than three (3) days after admission (residential treatment).
- The use of the AC does not apply to the adolescent population. MDHHS requires that the GAIN-I assessment tool be used for the SUD youth population.
- Assessments are required for MAT and OHH clients **who will also be receiving NorthCare funded treatment services**
- If an AC assessment has been initiated in ELMER, it must be completed, signed and synchronized in ELMER before authorizations are approved.
- If an AC assessment is initiated, but not able to be completed, the SUD provider must delete the incomplete AC from the ELMER system. NorthCare technical assistance is available if help is needed.

Levels of Care/ASAM Criteria

Outpatient Treatment/Aftercare (Level 1.0) Block Grant, Healthy Michigan Plan, Medicaid

Eligibility criteria for Outpatient care are as follows:

- meets medical necessity criteria and
- the current edition of the DSM (as of this update, the DSM-5) is used to determine an initial diagnostic impression.
- is based on individualized determination of need and
- is cost effective and
- the American Society of Addiction Medicine (ASAM) Patient Placement Criteria is used to determine substance use disorder treatment placement/admission and/or continued stay needs and
- is based on a level of care determination using the six (6) assessment dimensions of the current ASAM Patient Placement Criteria:
    - Withdrawal potential
    - Medical conditions and complications
    - Emotional, behavioral, or cognitive conditions, and complications

- Readiness to change
- Relapse, continued use or continued problem potential
- Recover/living environment

When a client is specifically seeking outpatient services and does not indicate a desire for more intensive services, the appropriate point of entry is at the client's choice of contracted outpatient Providers. Provider clinical staff will administer an assessment to determine appropriate services. If a potential client contacts NorthCare first, they will be offered contact numbers to access outpatient services in their area. The only exception to this is for MDOC referred clients who are screened for all Levels of Care, including Outpatient.

Intensive Outpatient (Level 2.1), Block Grant, Healthy Michigan Plan, Medicaid

Intensive outpatient (IOP) treatment is a planned and organized non-residential treatment service in which SUD trained/educated clinicians provide several SUD treatment service components to beneficiaries. Treatment consists of regularly scheduled treatment, usually group therapy, within a structured program, for at least three days and at least nine hours per week. Examples include day or evening programs in which client attend a full spectrum of treatment programming but live at home or in special residences.

Services are provided over a period of weeks. Level 2.1 (IOP) programming provides essential education and treatment services while allowing the participant to apply their newly acquired skills in "real world environments". The service array would include individual, group, and family counseling as well as didactic elements regarding alcohol and drugs. Participants in this level of care would leave the treatment facility after completing their daily treatment. The focus is to allow participants to implement the skills they have gained in the program by returning to their home communities. Level of care is determined using the following tools/clinical information: NorthCare Brief Screening Tool, ASAM placement criteria, DSM V, substance use disorder history, mental illness history, and motivation.

Low-Intensity Residential (Level 3.1), Block Grant, Healthy Michigan Plan, Medicaid

- Low-intensity (3.1) treatment is a clinically managed, low-intensity residential 24-hour structure with available trained personnel. This setting must at least 5 hours of core clinical services per week, such as individual and/or group therapy, and at least 5 hours per week of Life Skills/Self-care (LS/SC), such as a social activities that promote healthy community integration/ reintegration; development of community supports, parenting, employment, job readiness, how to use public transportation, hygiene, nutrition, laundry, education. Services in a 3.1 setting must occur daily and must be documented in clients chart for Medicaid or block grant funding to be used. When documenting **Life Skills/Self Care**, time in/out does not have to be specified. Documentation must, however, include: **Date**: **Activity/Service with client response:** For example, *client was encouraged by staff to complete assigned chores; Client was observed completing chores*

without additional assistance from staff; client participated in a house meeting today which lasted 60 minutes and interacted appropriately with others, offered suggestions to the group, and displayed positive attitude; or client was observed in the milieu for two hours today, interacting appropriately with other residents. **Staff signature and date. Where possible the duration of the activity/service should be documented, such as the length of the house meeting or self-help meeting.**

One option for the daily documentation of LS/SC may be a summarization at the end of the day/shift, which combines all services provided to the client throughout the day, related to the required elements noted above.

If the client is attending a house meeting for the daily LS/SC service, a sign in/out sheet is not sufficient documentation and must be accompanied by a progress note in the client's chart.

Residential Treatment/Continued Care – (Level 3.3) Block Grant, Health Michigan, Medicaid

Residential treatment is defined as intensive therapeutic service which includes overnight stay and planned therapeutic, rehabilitative, or didactic counseling to address cognitive and behavioral impairments for the purpose of enabling the beneficiary to participate and benefit from less intensive treatment. A program director is responsible for the overall management of the clinical program, and treatment is provided by appropriate credentialed professional staff, including substance use disorder specialists. Residential treatment must be staffed 24-hours per day.

This intensive therapeutic service is limited to those beneficiaries who, because of specific cognitive and behavioral impairments, need a safe and stable environment in order to benefit from treatment. Level of care is determined using the following tools/clinical information: NorthCare Brief Screening Tool, ASAM placement criteria, DSM V, substance use disorder history, mental illness history, and motivation.

All admissions and continuing stay authorizations will be based on medical necessity, as outlined in the Michigan Medicaid Provider manual, and ASAM criteria.

Residential Treatment – (level 3.5) Block Grant, Healthy Michigan Plan, Medicaid

This is a 24/7 clinically monitored level of care. Clients stay at the facility while receiving services. Persons admitted to this level of care have significant social psychological problems but can benefit from high-intensity treatment services. Clients who begin at this level of care may step down to a lower level as medical necessity permits using ASAM placement criteria, DSM V, and motivation.

RESIDENTIAL SERVICE REQUIREMENTS

Level of Care	Minimum Weekly Core Services	Minimum Weekly Life Skills/Self Care
ASAM 3.1 Clients with lower impairment or lower complexity of needs	At least 5 hours of clinical services per week	At least 5 hours per week
ASAM 3.3 Clients with moderate to high impairment or moderate to high complexity of needs	Not less than 13 hours per week	Not less than 13 hours per week
ASAM 3.5 Clients with a significant level of impairment or very complex need	Not less than 20 hours per week	Not less than 20 hours per week
ASAM 3.7 Clients with significant level of impairment or very complex needs	Not less than 20 hours per week	Not less than 20 hours per week

RESIDENTIAL COVERED SERVICES

TYPE	RESIDENTIAL SERVICES DESCRIPTION
Basic Care	Room, board, supervision, self-administration of medications monitoring, toxicology screening, transportation facilitating to and from treatment; and treatment environment is structured, safe, and recovery-oriented.
Treatment Basics Core Service	Assessment; Episode of Care Plan (addressing treatment, recovery, discharge and transition across episode); coordination and referral; medical evaluation and attempt to link to services; connection to next provider and medical services; preparation for 'next step'.
Therapeutic Interventions Core Service	Individual, group, and family psychotherapy services appropriate for the individual's needs, and crisis intervention. Services provided by an appropriately licensed, credentialed, and supervised professional working within their scope of practice
Interactive Education /Counseling Core Service	Interaction and teaching with client(s) and staff to process skills and information adapted to the individual client needs. This

	includes alternative therapies, individual, group and family counseling, anger management, coping skills, recovery skills, relapse triggers, and crisis intervention. Examples: disease of addiction, mental health, and substance use disorder
Life Skills/Self-Care (building recovery capital)	Social activities that promote healthy community integration/ reintegration; development of community supports, parenting, employment, job readiness, how to use public transportation, hygiene, nutrition, laundry, education
Milieu/Environment (building recovery capital)	Peer support; recreation/exercise; leisure activities; family visits; treatment coordination; support groups; drug/alcohol free campus.
Medical Services <u>Core Service</u>	Physician monitoring, nursing care, and observation available. Medical specialty consultation, psychological, laboratory and toxicology services available. Psychiatric services available on-site

<u>Withdrawal Management – Residential Setting, Block Grant, Healthy Michigan Plan, Medicaid</u>
The need for withdrawal management is determined by qualified medical personnel. A qualification instrument such as the Clinical Institute Withdrawal Assessment (CIWA) may be used to rate the severity of symptoms related to withdrawal from alcohol and other physically addicting drugs.

<u>Clinically Managed Residential Withdrawal Management – Non-Medical or Social Detoxification Setting</u>
Emphasizes peer and social support for persons who warrant 24-hour support (ASAM Level 3.2-WM). These services must be provided under the supervision of a certified addictions counselor. Services must have arrangements for access to licensed medical personnel as needed.

<u>Medically Managed Residential Withdrawal Management – Freestanding Detoxification Center</u>
These services must be staffed 24-hours per day by a licensed physician (ASAM Level 3.7-WM). This service is limited to stabilization of the medical effects of the withdrawal, and referral to necessary ongoing treatment and/or support services. This service, when clinically indicated, is an alternative to acute medical care provided by licensed health care professional in a hospital setting. Appropriate program licensure program is required.

Authorization Requirements – Withdrawal Management (Detox Programming) Residential Setting

- Symptom alleviation is insufficient for purposes of admission, NorthCare will not pay for Residential detox programming for a person; who reports suicidal ideation and needs to become sober for a psychological evaluation to take place; in acute psychological distress; and/or needing a bed until sober.
- The client must be willing to participate in a planned sequence of addiction treatment and there must be documentation of current client status that provides evidence the admission is likely to directly assist the beneficiary in the adoption and pursuit of a plan for further appropriate treatment and recovery.
- The Provider must notify NorthCare of a client admission to a detox program by the next business day.
- Medical necessity and ASAM criteria for LOC will determine eligibility for admission to Withdrawal Management services.
- The Provider must coordinate, and document continued services with the client prior to discharge.
- For authorization purposes one unit = 24 hours. The timeline must:
  1. Clearly indicate the time of admission and discharge or transfer to another unit.
  2. If medical clearance is necessary, the "clock" does not start until a client has returned from the medical Provider and receives their initial withdrawal assessment.
  3. ASAM guidelines will be followed for "detox" scoring purposes and determining when a client is ready to transition from WM to another level of care.

Methadone Therapy: Block Grant, Healthy Michigan Plan, and Medicaid

This service may be funded through Block Grant, Healthy Michigan Plan, or Medicaid. NorthCare does not perform the eligibility screening for Methadone therapy, but rather funds an assessment performed by an addictionologist/physician, a behavioral health professional, and other medical staff. Clients may access the service by contacting NorthCare, which will then determine program availability. Clients who are determined to be appropriate for Methadone treatment by a qualified Provider will be assisted in gaining entry to a qualified Methadone Program which is mutually agreed to by NorthCare and the client.

Co-Occurring Referrals for Intensive Levels of Care

For co-occurring residential requests:

- CMHSP consumer contacts NorthCare SUD Access to request a screening and potential residential placement.
- Pre-screen will be completed, and the consumer will be offered a brief screen if appropriate.

- Once the brief screen has been completed and a clinical decision has been made, the NorthCare SUD screener will proceed with the referral process, as appropriate, and will also attempt a 3-way call with the client and their CMH worker, if the client is agreeable, for coordination of care purposes.

Co-occurring Providers

Screening/Assessments for co-occurring disorders should be completed on all NorthCare clients being admitted for services. This screening should be part of the routine intake or assessment process for new clients.

The co-occurring screening should include:

- A diagnostic interview to determine which, if any, DSM V mental disorder diagnoses is met by the client.
- A treatment history assessing the outcome of previous treatment experiences and barriers to effective treatment
- An assessment of the impact of mental disorders on the substance disorder from a longitudinal perspective
- An assessment of the consumer's awareness of the problem and stage of motivation to change

Coordination of Care for Co-occurring clients:

- The CMHSP and SUD Provider should collaborate throughout the course of treatment to provide efficient, medically necessary care. MDHHS 5515 Consent Form is required for the coordination between Providers. The SUD Provider will obtain this at the time admission and should encourage the individual to include the CMHSP, NorthCare Network, SUD Provider and any other Providers as appropriate. At a minimum, there must be a release obtained at the time of admission for NorthCare and the SUD Provider. All releases should be faxed to NorthCare (fax #: 248-406-1286).
- The CMHSP and the SUD Provider are responsible for appropriately coordinating services for co-occurring clients. **Please note, having two therapists is not recommended as a best practice and should be time limited if utilized.**
- To continue therapy with the CMHSP Provider while the client is in SUD residential treatment, for example, the following criteria must be met:
    - If a CMHSP client in residential SUD treatment has been receiving individual therapy at the CMHSP, and
    - their therapy needs exceed what the SUD provider is able to provide, and
    - the CMHSP therapy does not include SUD counseling, and

- if after care coordination between the CMHSP Provider and the SUD Provider takes place, and
- it is clinically appropriate for the therapy to continue with the CMHSP Provider, and
- the client is in agreement.

- For co-occurring clients.
  - Services must not be duplicated (example: the client may not receive Case Management services at both agencies at the same time; or both agencies providing SUD counseling at the same time)
  - The CMHSP services must take place at the CMHSP designated site, and the SUD services must take place at the SUD designated site
  - NorthCare Network Clinical Director should be notified by the agency requesting services outside of their scope that care coordination is taking place (example: if the SUD Provider is requesting that the client continue in individual therapy while in residential treatment)
  - In summary: in situations where it is determined that the client's needs cannot be met, authorization for concurrent enrollment can be provided by NorthCare Network on a case-by-case basis. In the situations, there must be coordination with the other program to ensure that specific services are not duplicated.
  - Further detail may be found in the NorthCare Coordinating Co-occurring Services Procedure. Please contact the NorthCare Clinical Director at 906-936-6847 to request a copy of this process.

Out-of-Network Services

If a medically necessary service covered under the contract is unavailable within the network, NorthCare Network adequately and timely covers the service out-of-network for as long as NorthCare is unable to provide it.

NorthCare Network requires out-of-network Providers to coordinate with NorthCare regarding payment and ensures that any cost to the beneficiary is no greater than it would be if the services were furnished within the network.

Treatment Planning

- T1007 (HCPCS - ALCOHOL AND/OR SUBSTANCE ABUSE SERVICES, TREATMENT PLAN DEVELOPMENT AND/OR MODIFICATION should be used under the following circumstances:

  a. Initial treatment plan development (1 encounter)

  b. A scheduled treatment plan review (for example, the required outpatient 90-day review).

c. When there is a significant change in condition for the client.

d. For co-occurring population and WSS (Women's Specialty Services) treatment planning and treatment planning modification, use the appropriate modifier as you normally would for those designated populations/programs.

e. Treatment plans

- As treatment plan goals/objectives are routinely reviewed during the course of a scheduled SUD counseling or SUD therapy session, T1007 would not be used and the encounter with the client would continue to be coded as a H0004 or 9083x, (as you normally would), as that is the primary service being provided.
- When requesting the T1007 for authorization, under amount, NorthCare recommends that SUD providers request two encounters for a six-month authorization period. This would be for the initial treatment plan and the 90-day review. After the first 6 months you would request reauthorization for two encounters to correspond with the number of treatment plan reviews scheduled.
- An additional "How To Guide" is available under the ELMER Help Guide tab.

<u>Documentation Standards and Supervision</u>

- Progress notes, which includes all individual and group notes, are required to be in client file within a maximum of two (2) business days.
- All documentation must have an in/out time, be signed and dated by clinician.
- Treatment plans must be signed and dated by the client and clinician.
- All service claims must be supported by progress note documentation, or in the case of an ASAM Continuum (H0001 claim), the assessment itself.
- Progress note documentation must identify the goal/objective being addressed and reflect individualized treatment.
- Discharge planning begins at admission and continues throughout the episode of care. This must be documented in the client chart and should include addressing social determinants and mental health needs. The lack, or absence of documented discharge planning, may result in denial of continued stay requests.
- Discharge summaries must also include after care plans/appointments. NorthCare recommends that discharge appointments include Primary Care Physician appointment. If there are no after-care plans/appointments, the reason why must be documented.
- Out of region SUD providers are required to notify NorthCare Clinical staff 1-2 weeks before a discharge so that discharge plans can be properly coordinated with the client prior to them returning to their home county. Those clients that may choose to remain in an area outside of their region must be fully informed of the options available to them for continuing care to avoid any interruption to care. NorthCare's SUD Managed

Care Clinical Specialist or SUD Clinical Director may be reached at 906-225-7222 for assistance with this.

- All out of region SUD providers must fax the client's discharge summary to NorthCare (fax # 248-406-1286) at time of discharge or no later than fourteen (14) days post discharge.
- All residential SUD providers are responsible for notifying NorthCare when any client leaves services. This can be accomplished through ELMER messaging or phone contact to the SUD Managed Care Access Clinician or SUD Clinical Director.
- Residential and OP providers are expected to coordinate discharges with MAT providers, for clients who are receiving MAT services. This would include ensuring that MAT aftercare appointments are made when the client leaves treatment and the discharge summary is sent to the MAT provider.
- Supervision of limited licensed staff should occur pursuant to the required standards set by LARA.
- Provider will provide at least monthly supervision for non-licensed staff (e.g., staff who have a MCBAP credential or Development Plan only). All clinical work including progress notes, treatment plans, use of the ASAM Placement Criteria, and assessments, must be reviewed by an appropriately licensed and credentialed supervisor with evidence available following agency protocol. (Example, supervision log or staff supervision records). Supervision records must be available upon request and will be reviewed during the annual site review process.

Authorization Process

A current release must be on file with NorthCare Network prior to the client being "referred" to a specific SUD Provider. A current release is one that covers the current authorization period being requested. An authorization becomes invalid once it is connected with an admission that has been or should be discharged. The release must be in the ELMER system.

Once the release is in the ELMER system the authorization request can be completed. It represents a snapshot of the client, so it is important to fully complete the form including an individualized treatment plan. NorthCare will approve units of service based on medical necessity, ASAM, DSM-V and treatment plan.

As stated at the bottom of the ELMER Authorization form; "This clinical authorization does not guarantee payment." The authorization is considered a part of the whole billing process. A final payment decision is made at the time of payment.

If you have questions on the authorization the preferred method of contact is using the ELMER messaging system. The second method would be to contact NorthCare SUD Managed Care Clinical Specialist at 906-936-6851. Finally, fax the SUD secure fax line: 248-406-1286.

Authorization Requirements:

- The requested treatment/service meets medical necessity criteria as established by the Michigan Medicaid Provider Manual
- The current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) is used to determine an initial diagnostic impression.
- The requested treatment/service is based on individualized determination of need.
- The treatment/service requested is the most appropriate, efficacious, least restrictive service, setting, or support that otherwise satisfies the standards for medically necessary services.
- The ASAM Patient Placement Criteria is used to determine substance use disorder treatment placement/admission and/or continued stay needs. The six ASAM assessment dimensions are:
    - Withdrawal potential
    - Medical conditions and complications
    - Emotional, behavioral, or cognitive conditions and complications
    - Readiness to change
    - Relapse, continued use or continued problem potential
    - Recovery/living environment

Returned Authorizations:

NorthCare Responsibilities:

- The reason the authorization request is being returned will be provided in the Authorizing Agent section of the Authorization Request form that was submitted in ELMER. For timely processing, response should be submitted within five business days, however, providers do have up to 14 calendar days.
- If no response is received from the provider, NorthCare will issue an ABD notice to the client with a copy to provider of delay due to provider non-response.
- If NorthCare does not receive a response from the provider within 28 calendar days from the initial submission, then a second notice will be issued to the client with copy to provider of denial due to medical necessity.

SUD Provider Responsibilities:

- Provide a response to NorthCare within five business days, but no later than fourteen days. Response is defined as: returning the authorization to NorthCare, accompanied by the requested information; or notifying NorthCare that additional time will be needed to collect the information requested.
- If denied due to medical necessity, the provider will need to submit a new authorization request if the service is still needed.
- If the provider determines that the initial request will not be re-submitted, the provider will be responsible for issuing an ABD to the client, including the reason for the action.

Process may be subject to change to improve workflow. Providers may also contact NorthCare if unique circumstances exist which will require individual consideration.

Source/ legal citation: § 438.404 Timely and adequate notice of adverse benefit determination; 42 CFR 438.210 (c)

Initial Authorization Requests:

- Residential: Initial authorization requests must be submitted within 10 calendar days of the client's date of admission.
- If an authorization request is not submitted within the required timeframe, a request may still be submitted. However, the authorization may only be approved for the request date forward. The provider is responsible for communicating to NorthCare if extenuating circumstances exist.

Re-Authorization Requirements:

Re-authorization requests may be approved when authorization requirements continue to be met. The request must:

- Document evidence of progress in achieving treatment plan goals
- Document continued medical necessity
- Document any cognitive and behavioral impairments which are impacting the clients progress towards achieving treatment plan goals
- Document discharge/aftercare/recovery plans, beginning at the time of admission and continuing throughout the entire treatment episode
- Have documentation that includes DSM V diagnoses; an updated ASAM Criteria LOC (all 6 dimensions)
- Be submitted 14 days prior to the begin date for **outpatient** services, to ensure an authorization is in place for continuation of care.
- Be submitted 48 business hours prior to the begin date for residential reauthorization requests, to ensure an authorization is in place for continuation of care.

Re-authorization requests will be approved when the documentation supports medical necessity/ASAM criteria for continued treatment.

Re-authorization of services can be denied in situations where the beneficiary has:

- Not been actively involved in their treatment despite active outreach efforts on the part of the Provider, as evidenced by repeatedly missing appointments (outpatient)
- Not been participating or refusing to participate in treatment activities
- Behaviors that are deemed to violate the rules and regulations of the program providing the services

Beneficiaries may also be terminated from treatment services by the Provider, based on the situations described above. In those cases where the Provider is early terminating a client's treatment, the Provider is responsible for giving the appropriate written notice to the client. (Please refer to the ABD section of this manual for further detail on the issuance of Notice of Adverse Benefit Determinations or ABD's).

- All cases may be subject to review by the NorthCare Utilization Management Team to determine medical necessity and appropriateness of continued stay.

Clients who transition from social detox into residential treatment at the same facility will be admitted into social detox and discharged from residential treatment. A separate referral from social detox into residential treatment is not necessary.

Provider Appeal

Once a case has been reviewed by the Utilization Management Team and a determination has been made that the client no longer meets medical necessity/ASAM criteria for continued stay, an Adverse Benefit Determination Notice will be sent to the client.

The Provider will also be given written notification of this determination which will outline the necessary steps to request rationale for the determination and/or the process for potential appeal.

The following steps must be taken by the Provider if they disagree with the UM decision:

- The Provider will contact NorthCare Clinical Director at 906-936-6847 or NorthCare's Senior Clinical Director at 906-936-6858 to discuss the case and/or request rationale for the decision. This discussion must occur within five business days of the disputed action.
- If Provider does not feel the situation has been satisfactorily resolved, they may submit a written appeal to NorthCare Network. The written request should clearly outline the specific issue to be reviewed, why it should be reviewed, and the desired outcome. The written request must be submitted within 14 days of the considered adverse determination. NorthCare Network staff will follow the procedures outlined in the NorthCare Network Service Authorization Policy.

  NorthCare Network
  Attn: Provider Network Management
  1230 Wilson Street
  Marquette, MI 49855
  Or by faxing to 906-232-1070
  Or by secure email to pnm@northcarenetwork.org In subject line state: Appeal

- The Provider, acting on behalf of the beneficiary, may request an Expedited Appeal by indicating that taking the time for a standard resolution could seriously jeopardize the beneficiary's life, physical or mental health, or ability to attain, maintain, or regain maximum function. (42 CFR 438.410(a)
- The beneficiary or Provider must file a request for an Expedited Appeal either orally or in writing.

- The beneficiary or Provider must file a request for an Expedited Appeal within 10 days of the Adverse Benefit Determination.
- NorthCare Network must make a decision on the Expedited Appeal within 72 hours of receipt of the Expedited Appeal.
- NorthCare Network must provide written notice of resolution to the Provider and beneficiary.

Adverse Benefit Determination Notice

Adverse Benefit Determinations (ABD's) are for Adverse (negative) service or payment decisions.

- Service decisions are based on consumers meeting medical necessity and ASAM criteria for SUD programs or services within a program.
- Payment decisions are based on consumers meeting medical necessity and ASAM criteria for eligibility for specific programs/services already provided. NorthCare, as the Medicaid payor, would create the ABD for any payment denials.
- A Notice for an ABD is required any time a new adverse service decision is made, or denial of payment decision is made.
- Decisions may include:
    1. Denying a request for a new service
    2. Denying an increase in service (e.g., amount, scope, or duration)
    3. Delaying the start of a particular service
    4. Reducing, suspending, or terminating existing services
    5. Denial of payment for a claim in whole or in part
- SUD providers must use the ABD form available in ELMER and provide this written notice to the client following the guidelines in the NorthCare Adverse Benefit Determinations for SUD Providers training (FY23). This is located in the ELMER Help guide, along with a guide for ABD SUD frequently asked questions (FAQ) available to all NorthCare paneled SUD providers.

Access

Provider agrees to:

- Secure prior payment authorization for all treatment rendered except for situations as described in this manual.
- Accept screening, concurrent reviews and retrospective review findings by NorthCare to determine Medical Necessity for payment of benefits subject to the applicable appeal procedures as described in this manual.
- Follow the procedures outlined for the filing of the appeal or grievance related to the determination of Medical Necessity for payment of benefits as described in this manual.

Provider acknowledges that the failure to follow the terms of NorthCare policies and procedures may result in a reduction in the amount of payment to the Provider.

Application Process

Screening Process

Individuals seeking outpatient services (with the exception of those individuals being referred by the MDOC) would contact the treatment Provider directly.

- The SUD provider will first complete the MDHHS 5515 Universal Consent form with the client and fax this to the NorthCare SUD Fax queue at 248-406-1286.
- A clinician from the SUD Provider agency conducts a comprehensive assessment using the standardized ASAM Continuum assessment tool and application of the ASAM criteria.
- Demographic data, financial information, and an Initial Authorization Request is entered into the appropriate online forms by the Provider and electronically transmitted to NorthCare Network
- In all cases, the Provider is responsible for entering demographic, financial, insurance, admission, and authorization data into the ELMER System

Individuals seeking Residential services must first complete a pre-screen with NorthCare where the following information will be obtained to determine client's priority status:

- Admission Priority
- Potential funding source
- Other insurance or benefit that may cover Substance Use Disorder treatment (Coordination of Benefits)
- Annual household income
- Current Community Mental Health Client
- Type of service requesting
- Treatment History (current and/or historical)
- Name, Phone number, Social Security Number, Date of Birth
- County of residence

After the pre-screen is completed, a brief-screening will be conducted with the client to determine the appropriate LOC applying ASAM criteria. Once NorthCare obtains an appropriate release of information, the brief-screening is available to the SUD Provider listed.

Choice of Provider

The client must be given a choice of Provider. On the Provider side, this choice must be documented on a "choice of Provider" form and kept in the client's file. The client must sign-off that they received the "choice of Provider" form – this is required for all levels of care.

Individual Assessment

A face-to-face service for the purpose of identifying functional, treatment, and recovery needs and a basis for formulating the individualized Treatment Plan. The initial service may also be delivered in a non-face-to-face manner using the currently approved tele-health communications guidelines (simultaneous audio/visual). This flexibility will be effective with timelines cited in applicable state and federal policy.

There is also an assessment-only option available, initiated by individuals seeking to determine if their substance use is a problem, and who are willing to participate in the recommended treatment based on the assessment findings. Outpatient Providers on the panel provide an appropriate access point for this service.

If the individual shares information that would indicate risk (impaired driving, positive drug screen, etc.) and reports their willingness to follow through with treatment recommendations based on the assessment, this service is reimbursable by NorthCare via ELMER.

Additionally, for payment to occur, the criteria must be clearly supported by the appropriate documentation.

It is the responsibility of the Provider to determine, at the time of scheduling, if the individual is being court ordered for assessment despite no evidence of a Substance Use Disorder, or if the individual is being court ordered for assessment but communicates, they are unwilling to consider treatment. NorthCare would not consider these for payment.

Documentation and Reporting Requirements

Refer to your Provider contract for documentation and reporting requirements.

Charitable Choice

Treatment clients and prevention service recipients are required to be notified of their right to request alternative services if the Provider is faith-based. The faith-based Provider must provide notice. Notification must be in the form of a model notice contained in the final regulations. The model notice contained in the federal regulations is.

> "No Provider of substance use disorder services receiving Federal funds from the U.S. Substance use disorder and Mental Health Services Administration, including this organization, may discriminate against you based on 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 referral to another Provider of substance use disorder 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 use disorder 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."

Providers and clients should contact NorthCare Network at 1-888-333-8030 with any questions, concerns or alternate referral related to Charitable Choice.

Primary Care Coordination

All appropriate steps must be taken to assure that substance use disorder treatment services are coordinated with other service Providers including primary health care.
Treatment case files must include, at a minimum, the primary care physician's name and address, a signed waiver release of information for purposes of coordination, or a statement that the client has refused to sign the waiver.

Care coordination agreements or joint referral agreements, by themselves, are not coordination of care. Client case file documentation is also necessary.

Non-Substance Use Referral

If a client is found to not need substance use disorder services, based on results of the Provider screening, Provider staff will make the appropriate community referrals based on client need. Providers are also responsible for issuing the Adverse Benefit Determination (ABD) notice to clients who do not meet the ASAM or medical necessity criteria for admission to services. ABDs are available to SUD Providers in the ELMER system. The ABD form in ELMER is required to be used by SUD Providers for all NorthCare Consumers (Medicaid and Block Grant recipients).

Outside Screenings

NorthCare will accept qualified screenings from Project Rehab Hispanic Program and Monroe Harbor Light Deaf/Hard of Hearing programs as part of determining an appropriate LOC.

Specialty Programs

All clients are screened for specialty programs and if they are applicable, clients are offered specialty programs based on client's choice and need. NorthCare will refer and coordinate services for clients based on specialty qualifications.

In cases where clients do not meet criteria for SUD treatment services, referrals to other types of services are offered, as appropriate.

Women's Specialty Services (WSS)

Providers must screen and/or assess pregnant women, women with dependent children, and women attempting to regain custody of their children, to determine whether these individuals or their children could benefit from the defined federal services listed below. If found appropriate, the individual should be referred to a program designated to deliver the specialty services listed below:

Designated treatment programs receiving funding for pregnant women and women with dependent children must *provide or arrange* for the following:

- Primary medical care for women, including referral for prenatal care if pregnant, and – while the women are receiving such treatment – childcare.
- Primary pediatric care for their children, including immunizations.
- Gender specific substance use disorder treatment and other therapeutic interventions for women, which may address issues of relationships, sexual and physical abuse, parenting, and childcare while the women are receiving these services.
- Therapeutic interventions for children in custody of women in treatment, which may, among other things, address their developmental needs, issues of sexual and physical abuse, and neglect.
- Sufficient case management and transportation to ensure that women and their dependent children have access to the above-mentioned services. Women with dependent children are defined to include women in treatment who are attempting to regain custody of their children.

The above five types of services, especially primary medical care, can only be covered when no other source of support is available and when no other source is financially responsible.

The same population must be screened by all Providers for ancillary services (childcare and transportation assistance) and pre-screened for Fetal Alcohol Syndrome Disorder (FASD). Ancillary services can be accessed through NorthCare Network, and children found to need further FAS services need to be referred to UP Health System Marquette Specialty clinic in Marquette 906-449-4424, located at 850 W Baraga Avenue Suite 31.

Training Requirements for designated Women's Specialty Programs

In addition to current credentialing standards, individuals working and providing direct service within a designated women's program (gender responsive) must have completed a minimum of 12 semester hours, or the equivalent, gender specific substance use disorder training or 2080 hours of supervision gender specific substance use disorder training/work experience within a designated women's program. Those not meeting the requirement must be supervised by another individual working within the program and be working towards meeting the requirement. Documentation is required to be kept in personnel files. Those working and providing direct service within a gender competent program must have completed a minimum of 8 semester hours, or the equivalent, of gender specific substance use disorder training or 1040 hours of supervised gender specific substance use disorder training. Those not meeting the requirements must be supervised by another individual working within the program and be working towards meeting the requirements. Documentation is required to be kept in personnel files. Other arrangements can be approved by the Bureau of Substance Abuse and Addiction Services (BSAAS) Women's Treatment Coordinator.
Pregnant women are given preference in admission to treatment facilities.

Philosophy

Women's services are developed around a relational model which recognized that the self is organized and developed in the context of important relationships. A model of empowerment and collaboration are essential treatment components. Treatment is specifically designed to be gender competent to address the specific needs of the family.

Access to WSS Treatment

Eligible women are defined as "pregnant women and women with dependent children, including women who are attempting to regain custody of their children. Michigan law extends priority population status to men whose children have been removed from the home or are in danger of being removed from the home under the child protection laws. Men who are shown to be the primary caregivers for their children are eligible to access ancillary services such as childcare, transportation, case management, therapeutic interventions for children, and primary medical and pediatric care." When completing an admission in ELMER, enroll the consumer in the Women's Specialty Program.

Assessment

Upon determining that an individual is eligible for WSS, the designated provider sites will complete a Women~~'s~~ and Family assessment that will be the basis for a collaborative treatment plan that includes the needs of children and family. The Referral Checklist for each child should be completed and a referral made and documented for each identified need; if FASD screening is indicated, the referral for this should be documented; the Women's Referral Checklist should be completed, and referrals documented for each identified need; and the Women's Specialty Assessment must be completed before the delivery of an ancillary HD service. Providers may

bill for the agency's assessment in addition to the WSS assessment. Both assessments can be completed at the same time and billed at the same time. Since there is an extensive amount of information required, continued assessment over time will lend more information as the family and clinician gain trust. It is the expectation that each child in the family system will be assessed, and appropriate referrals made. The clinician should be asking about each child's needs regardless of whether the child is physically present and addressing the health care needs of both the mother and child(ren). H0001 HD is the authorization code for a WSS assessment. When requesting authorization, you will be asked to enter the number of children's referrals made. For the initial authorization, put "zero" in the appropriate boxes and for each subsequent authorization, record the number of referrals made for children.

Fetal Alcohol Syndrome Disorder (FASD) Assessment

Substance use disorder treatment programs are in a unique position to have an impact on the FASD problem. It is required that all SUD programs include FASD prevention within the treatment regimen. All treatment programs that have contact with the children born to women who have used alcohol are required to screen these children for FASD and, if appropriate, refer for further diagnostic services. Additional Information regarding FASD may be found at www.cdc.gov/ncbddd.

Treatment Planning

Individual plans of service (IPOS) will be family centered, strength based, culturally competent and collaborative across systems with a culture of unconditional care. Plans should include an emphasis on safety, self-sufficiency and be outcome oriented. Consumers should be offered care coordination and access to a Recovery Coach where available. A well conducted assessment will also identify barriers and needs. Childcare, transportation and referrals for women and children's services will be addressed through an appropriate goal and objective in the IPOS. Women's health and reproductive needs should be explored and addressed. Parenting issues, employment, children's mental and physical health needs will be addressed with appropriate services and referrals provided. The intensity of service will vary according to the IPOS and needs of the client and family.

Services

Once it is determined that the individual qualifies for WSS, the HD modifier will be used for authorization of services. Non-gender specific services identified in the IPOS but not provided by a WSS Specialist, may be coded with the HD modifier. These services should be reviewed with the primary counselor to assure they are appropriate. For example, a woman may choose to attend a co-occurring, co-ed, non-gender specific group as part of her treatment plan.

Ancillary Services

Care Coordination

At times, the clinician can perform the function of both the care coordinator and counselor. Care coordination can be provided by paraprofessionals and interns. Care coordination contacts (15-minute units) should be scheduled to benefit the client and may vary in length depending

on the IPOS and needs of the client. Recovery Coaches can be used to support the plan. Care coordination conducted by phone may be billed but should not be used as a substitute for face-to-face. Authorization code: H0050HD Brief intervention/Care Coordination (15-minute unit). WSS Care Coordination claims must be supported by appropriate, corresponding documentation (progress note) which matches the authorized service.

Transportation

All Women's Specialty Services will provide access to transportation for women, children, and eligible men. This can be in the form of bus tickets, transport by a Recovery Coach, gas cards, etc. Use the T2003HD in the ELMER system when gas cards are being provided. When requesting authorization for transportation, request one unit per day for the date that transportation (most often gas card) will be used. For example, a client comes weekly for 3 months (12 sessions) and has a treatment plan that has the stated goal need for transportation. Request authorization for 12 (T2003HD) units. If a client is given $10 in gas cards per one counseling session, bill 1 unit of T2003 for that date, then bill the amount ($10). (T2003 can only be billed once per day.) Maximum of 1 unit/$40 per day. Use S0215 when requesting mileage – typically to reimburse a Provider for transporting a client out of region, etc.

Childcare

Funds are available to pay for licensed and kin care. All WSS programs are encouraged to provide on-site childcare whenever possible. When childcare is provided on-site, it is not necessary that the site be licensed as a day care Provider. Besides removing a significant barrier for the family, onsite childcare allows the clinician to evaluate the child(ren) for health and safety needs as well as mental health issues. To request reimbursement for childcare, complete the WSS Ancillary Services Request form and submit for payment as instructed on the form.

Discretionary Funds

As women and families work towards becoming self-sufficient, additional material needs may be identified. The clinician should first help the client identify community resources, when appropriate and in collaboration with the Women's Treatment Team, up to $200 of discretionary funds are available, without prior approval when other resources have been exhausted. For discretionary funds exceeding $200, complete the Ancillary Services Request form and submit it to NorthCare SUD fax, 248-406-1286, to the attention of the NorthCare Clinical Director. Authorization of ancillary services requires a goal that addresses the need in the IPOS. To request reimbursement for discretionary funds, complete the WSS Ancillary Services Request form and submit as instructed on the form.

Opioid Health Home (OHH) Programming

The OHH will provide comprehensive care management and coordination services to Medicaid beneficiaries with opioid use disorder. For enrolled beneficiaries, the OHH will function as the central point of contact for directing patient-centered care across the broader health care system. Beneficiaries will work with an interdisciplinary team of Providers to develop an

individualized recovery care plan to best manage their care. The model will also elevate the role and importance of peer recovery coaches and community health workers to foster direct empathy and connection to improve overall health and wellness. In doing so, this will attend to a beneficiary's complete health and social needs. Participation is voluntary, and enrolled beneficiaries may opt out at any time.
Opioid health home Providers receive reimbursement for providing the following federally mandated core services:

- Comprehensive care management
- Care coordination
- Health promotion
- Comprehensive transitional care
- Individual and family support
- Referral to community and social support services

Please refer to the OHH Appendix section of this manual beginning on page 81 for further information on OHH programming. For information about participating Upper Peninsula Opioid Health Home Partners, please contact the NorthCare Opioid Health Home Coordinator at (906) 936-6860.

Recovery Housing

The goal of providing recovery housing services is to provide a supportive recovery environment to help reduce the incidence of drug and alcohol abuse and dependency, prevent relapse, and support individuals in their recovery.

Substance Abuse Block Grant (SABG) and other grant funds may be used to fund room and board in conjunction with a treatment admission to the extent it is integral to the treatment process. Up to sixty (60) days may be funded for individuals participating in outpatient programming as evidenced by an appropriate admission.

Also refer to your Provider contract.

Recovery House Provider:

Procedures

- Eligibility Screening requirements
    - Individual meets the criteria for NorthCare funding (income, residency, and substance use disorder diagnosis)
    - Individual is actively engaged in NorthCare funded services.
    - Individual requires a highly structured and monitored living environment where recovery support is available

    - Individual has experienced a history of unsuccessful recovery attempts, which have resulted in a return to chronic use
    - Individual has significant negative factors in the areas of family, social, work, or environment that places him/her at-risk for relapse
- Admission Requirements
    - Individual has completed or does not need medical or sub-acute detoxification.
    - Individual has successfully completed long or short-term residential treatment, as applicable.
    - Individual does not present with a severe medical or psychiatric condition that would interfere in his/her ability to function in a supervised supportive living environment
    - Individual adheres to the requirement of attending an appropriate funded treatment service while residing in the recovery home which will be documented in the client's file
    - Individual demonstrates active motivation for recovery and a desire to work towards self-sufficiency
- Reporting Requirements
    - Provider will complete monthly report per contract requirement based on type of grant funds.
    - Provider will submit monthly invoice for individuals that meet eligibility requirements.

Training Peer Recovery Coaches

To be a peer recovery coach, individuals will need to complete the current designated training approved by MDHHS and meet all current requirements. To complete the entire scope of necessary elements, an average training would encompass approximately 40 hours.

Additional information can be found at this link:

- Peer Recovery Information (michigan.gov)
- MSA 17-45 (003) Recovery Coach Provider Description

Following certification, a minimum of 20 hours of continuing education, with at least 10 hours being SUD specific, and 6 hours in ethics is required over a two-year period.

For additional information on Recovery Coach certification, contact the NorthCare Network SUD Services Director 906-936-6844.

Recovery Coach Support Services (RCSS)

Within RCSS it is recognized that individuals in recovery, their families, and their community allies are critical resources that can effectively extend, enhance, and improve formal treatment

services. RCSS are designed to assist individuals in achieving personally identified goals for their recovery by selecting and focusing on specific services, resources, and supports. These services are available within most communities employing a peer-driven, strength-based, and wellness-oriented approach that is grounded in the culture(s) of recovery and utilizes existing community resources. RCSS emphasize strength, wellness, community-based delivery, and the provision of services by peers rather than SUD service professionals. As such, these services can be viewed as promoting self-efficacy, community connectedness, and quality of life, which are key factors to sustained recovery.

Type of Peer Recovery Support Services

The different kinds of activities have been divided into four service categories: emotional support, information support, instrumental support, and affiliation support (SAMHSA, 2009a).

County Jail Inmates

To ensure a timely screening for individuals who are at substantial risk for relapse and overdose, individuals requesting SUD services from a county jail, may be screened prior to release when assisted by a designated person from within the Criminal Justice system, such as a probation officer or the jail mental health professional (MHP) if one is available. The Consent to Share Behavioral Health Information form (MDHHS-5515) is required. Once received and it is verified that it is appropriately completed, a pre-screening phone interview will occur with either the client, if available, or the authorized person on the release of information. Insurance and income information will be requested. A phone screening will then be scheduled. The probation officer or MHP must be available to assure that the incarcerated individual is available for the phone screening with NorthCare. Additionally, the probation officer, or MHP will be responsible for communication with the treatment Provider and for assuring that the incarcerated individual has appropriate transportation to treatment when a treatment bed becomes available. Residential placement is not a guarantee and Providers do not hold beds. Client must be available for treatment when appropriate placement is determined.

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Credentialing

Any new or renewals to certifications or licenses will be requested along with the development plans for counselors and supervisors with MCBAP. Individual Credentialing paperwork can be obtained from NorthCare Network Provider Network Specialist, Karena Grasso, 906-205-2838, or via email kgrasso@northcarenetwork.org.

Staff qualifications and Professional Development

Refer to your Provider contract.

MCBAP Development Plan Requirements

Development Plan must be completed and submitted to MCBAP within 30 business days of beginning employment. It is the responsibility of the Provider/staff to meet requirement.

NorthCare Network Credentialing policy

Refer to NorthCare Network website: www.northcarenetwork.org for all policies. Information for credentialing will be found in NorthCare Network Credentialing Privileging Policy and NorthCare Network Credentialing Program Policy. More information can also be found in the Medicaid Manual and Provider contracts.

Providers must have a written system in place for credentialing and re-credentialing individual practitioners included in their Provider network. Appropriate and timely credentialing is the Provider's responsibility.

Clinician's Development Plan must be valid and on file at MCBAP prior to consideration to be added as a qualified clinician to the NorthCare Provider panel.

IC&RC Exam

Completion 6 months before applying for certification is highly recommended. If you fail the exam, you must wait 60 days before taking it again.

Expiration of Licenses

Any Provider who has not renewed their license or certification prior to its expiration will be immediately suspended/terminated from the Provider network. Services are not reimbursed during periods of lapsed license/certification. This can be monitored on the License And Regulatory Affairs (LARA) website.

Upper Midwest Indian Council on Addictive Disorders (UMICAD)

Tribal Providers get their certification from UMICAD, they have 3 levels of certification: ADC I, ADC II, ADC III. The IC&RC has a residency rule called "the 51% rule" on where a person can apply to take the ADC Written Exam and/or certification.

Credentialing Updates

Programs are required to notify NorthCare of any updates/changes to any existing clinician's credentials when the information is available to the clinician and/or program. All newly hired (or transferred between internal programs) clinician's credentialing information, along with hire date, must be submitted to NorthCare **within 2 weeks of hire** (or transfer). This notification will ensure the clinician is properly credentialed to provide substance use disorder service to NorthCare funded clients. *Termination dates* of all clinicians and ELMER users must be submitted *immediately* to NorthCare Network Provider Network Specialist, Karena Grasso via email kgrasso@northcarenetwork.org so that they can be removed from the ELMER system.

License Exclusion Check

The following website can be used to check any exclusions for licensed Providers. NorthCare Network will check all contracted Providers and clinicians through this website regularly:

- Department of Health & Human Services sanctioned Provider information is available on the following website: http://exclusions.oig.hhs.gov.
- MDHHS licensing sanctions for health facilities and professional are available at http://michigan.gov/healthlicense.

Provider Qualifications

Funded programs must be nationally accredited, and State licensed per contract. If a provider loses accreditation or licensure, the agency must notify NorthCare Network within two business days. Provider Credentialing paperwork can be obtained from NorthCare Network's Provider Network Specialist, Karena Grasso, 906-205-2838, or via email kgrasso@northcarenetwork.org.

Accessibility & Accommodation Policy

Substance use disorder Providers must have an accommodation policy - refer to "Accessibility & Accommodation Policy" on the NorthCare website.

- Access and accommodation of persons with the limited English proficiency
- Sensitivity and accommodation of diverse ethnic and cultural backgrounds (example, Native Americans)
- Accommodations for those with visual impairments (including persons who do not use verbal language to communicate or who use alternative forms of communicating)
- Staff education on the importance of each individual's diverse needs and the necessity to utilize person-centered thinking to create individual plans of service and actions to meet those needs. This training will recognize the disabilities affecting members may not be visible to the naked eye and may require accommodation in areas such as recognizing the effects of medications, adjusting meeting schedules and the length of meetings.

- A commitment to remove any barrier that may not be currently addressed. This may be accomplished by a variety of means: e.g., focus groups, consumer complaints, and consumer surveys.

Providers will be monitored for appropriate compliance during annual site reviews.

Background Check

It is the policy of NorthCare Network that appropriate background and exclusion checks be completed on all potential employees, students, interns, volunteers, contractors, and board members as part of their screening process. Criminal background checks are required prior to hire and every other year after the initial check. Refer to the NorthCare Network Background and Exclusion Check policy for complete details on the process that must be followed.

Compliance/Program Integrity

Providers that make or receive annual payments under the contract of at least $5,000,000, will have written policies that provide detailed information about the False Claims Act and other Federal and State laws described in section 1902(a)(68) of the Act, including information about rights of employees to be protected as whistleblowers. Providers meeting this threshold must also comply with Section 6032 of The Deficit Reduction Act (DRA) of 2005.

All Providers, including those not meeting the $5,000,000 threshold for a formal Compliance Program, are expected to have written policies and follow principles that promote ethical health care, and uphold the integrity of ethical business practice. Failure to do so will result in remediation efforts and/or contract action, if needed. NorthCare has the responsibility of regulating, overseeing, and monitoring the Medicaid processes of business conducted throughout its service area and to support business practices conducted with integrity and in compliance with the requirements of applicable laws and sound business practices. The NorthCare Compliance Plan, standards, and policies referenced herein are not exhaustive or all inclusive. All Network Providers are required to comply with all applicable laws, rules and regulations and policies including those that are not specifically addressed in the Compliance Plan. NorthCare will monitor compliance efforts of Network Providers during annual site reviews, at minimum.

The Provider must report to NorthCare Network within 30 calendar days when it has identified payments more than amounts specified in the contract. Recoveries of over payments due to fraud, waste, or abuse shall be reported by the Provider to NorthCare Network.

The Provider will provide prompt notification to NorthCare Network when it receives information about changes in an enrollee's circumstances that may affect the enrollee's eligibility including, changes in the enrollee's residence and the death of an enrollee.

Debarment and Suspension

Assurance is hereby given to NorthCare Network that the Network Provider will comply with Federal Regulation 45 CFR Part 76 and 42 CFR part 180, and certifies to the best of its knowledge and belief that it, including its employees and subcontractors:

- Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any federal department or PIHP.
- Have not within a three-year period preceding this agreement been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (federal, state, or local) transaction or contract under a public transaction; violation of federal or state antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

- Are not presently indicted or otherwise criminally or civilly charged by a government entity
- (federal, state or local) with commission of any of the offenses enumerated in section B, and
- Have not within a three-year period preceding this agreement had one or more public transactions (federal, state or local) terminated for cause or default.
- E) Provider agrees to immediately notify NorthCare if Provider or its employees are under investigation or if Provider receives notice of actions, claims or events regarding potential debarment or suspension.

Quality Management

Quality Improvement

NorthCare's Quality Assessment and Performance Improvement Program (QAPIP) is structured to facilitate and ensure an objective and systematic performance improvement program that monitors and evaluates the quality of care provided to clients identified to have any one or more of the following: mental illness, developmental disabilities, or substance use disorder. The QAPIP emphasizes the use of consumer and other stakeholder involvement to improve services. Quality management stresses the self-worth of employees; cooperation between employees; team building; and a partner relationship between NorthCare, CMHSPs, and advocacy groups and other human service agencies. Quality management is that it is less expensive overall to build quality into an organization's services (prevention) than it is to expend additional resources on rework and dissatisfied customers (remediation).

Each substance use disorder Provider is strongly encouraged to implement a Quality Assessment and Performance Improvement Program within their Provider organization that addresses:

- Structure and Accountability for the QI Program
- Active Participation by Stakeholders
- Components and Activities
- Process for Review and Follow-up of Sentinel Events
- Evaluation of Members' Experiences with Services
- Practice Guidelines
- Qualifications for Scope of Practice (Credentialing and Privileging)
- Verification of Service Delivery
- Utilization Management Activities
- Procedures for Adopting & Communicating Process & Outcome Improvements

Utilization Management

Utilization Management is a set of functions and activities focused on ensuring that clients receive services with the appropriate frequency and duration which are delivered according to practice guidelines for obtaining the best possible outcomes.

Please refer to the NorthCare website: www.northcarenetwork.org for the complete Utilization Management policy. Although NorthCare is responsible for authorizing services, Providers are required to review the effectiveness of interventions and adjust accordingly. This includes, but is not limited to, the following standards:

- To assure an accessible and appropriate set of services for plan members
- To maximize cost-effectiveness
- To assure Uniform Benefit-Customers with similar needs will receive similar services regardless of where they obtain services within catchment area
- Medicaid services must comply with the standards within the MDHHS current Medicaid Provider Manual
- Substance Use Disorder services must utilize DSM-V for diagnosis and ASAM criteria for level of care (placement/admission, continued stay, and discharge/transfer).
- Performance measures are expected to meet or exceed industry standards

Site Visits

Annual Site reviews will be conducted using an overall quality management plan. The site review protocol areas of review will include, but are not limited to, organizational policies and contractual requirements; claims management; client chart review; data collection; performance indicator timeliness, reporting; licensing and accreditation; staff credentials and professional training; clinical practices and recipient rights.

All requirements along with the site visit date will be sent to the Providers in advance of the proposed date. Portions of the annual site visits will be conducted via desk audit. This is meant to reduce the time spent at each Provider site and allows Provider staff flexible time to submit contractual requirements.

Desk Audit

Desk audits are considered part of the annual site review for each Provider. An email will be sent out to the Program Directors/Supervisors requesting various contractual agency information, along with a due date for when the information must be returned to NorthCare Network. Desk Audit data must be submitted to NorthCare prior to the on-site review.

State of Emergencies/Pandemics and Audits

NorthCare Network will follow the Center for Disease Control and Prevention (CDC) guidelines closely during the audit period. Alternate options will be discussed individually with each organization and NorthCare's Provider Network Specialist.

NorthCare Training

NorthCare Network Substance Use Disorder Providers can utilize Improving MI Practices for contractual training requirements listed below to be completed within 30 days of hire and annually thereafter.

- Communicable Diseases
- Confidentiality/Consent
- Corporate Compliance/Deficit Reduction Act (DRA)
- Cultural Competency
- HIPAA/Security
- Recipient Rights
- Trauma Informed/Responsive Systems of Care

The training site will provide a certificate of completion for the training and NorthCare will monitor this at time of site review in the employee human resources files. NorthCare strongly encourages Providers to have a tracking system in place to ensure that all staff have the required training.

Risk Assessment for Communicable Disease

The Risk Assessment for Communicable Disease must be completed on each client.

Communicable Disease

- Provider policy for referral process for testing – TB, Hepatitis, STD, and HIV when appropriate
- Provider policy assuring all pregnant women presenting for treatment are offered referral for or provided STD and HIV testing.
- HIV/Health education for all clients
- Detox and Residential Only – all clients must have a TB test at admission. If a client does not have a valid test result available or a test has not yet been administered at time of admission, the test will be done on the 1st day of admission. Documentation that a TB test was administered along with the subsequent results, must be in client's chart.
- Protocol for residents and staff if suspicion of contagious diseases is evidenced upon client admission and prior to actual test being conducted.

- Provider policy/protocol for making clients aware of available resources if already infected with TB, Hepatitis, STD, or HIV
- Utilization of state funds is prohibited for the distribution of sterile needles for injection of any illegal drugs.
- Provider policy – ALL staff (including clerical, janitorial, etc.) must have minimal knowledge of HIV/AIDS, TB – training logs documentation.
- All new hires into the system must receive a minimum of 3 hours of training on communicable disease within 6 months of hire.
- Clinicians receive an expanded level of training relevant to their positions within 6 months of hire.
- Updates are provided at least every two years.
- Screening tool to identify high risk clients.

Definition for Communicable Disease Training

Level 1 – Minimal standards for ALL employees:

- HIV/AIDS, TB, Hepatitis (especially A, B, and C) and STDs as they relate to the agency target population.
- Modes of transmission (risk factors, myths, and facts, etc.)
- Linkage between substance use disorder and these communicable diseases.
- Overview of treatment possibilities
- Local resources available for further information/screening
- Universal precaution procedures—basic knowledge of universal precautions for blood borne and body fluids transmission of pathogens.

It is anticipated that the above could be adequately covered in a two-hour session, with update trainings every year, and may be provided by agency staff that have completed Level 2 training.

Deficit Reduction Act (DRA)

The provider must educate all staff on the DRA and provide up-to-date information to staff on a regular basis.

Cultural Competence

All Providers must have a written cultural competency plan implemented at their agency. The plan must include:

- Identification on assessment of the cultural needs of potential and active clients based on population served.
- Identification of how ongoing staff training needs in Cultural Competency will be assessed and met and the evidence that staff members receive training

- Process for ensuring the panel Providers comply with all applicable requirements concerning the provision of culturally competent services
- Process for annually assessing compliance with the cultural competence plan

Using the ELMER System

System Authentication/Data Encryption

The ELMER system requires user authentication. Base credentials are a username and password. All user passwords must be changed at least every 90 days and are required to be at least 6 characters and should contain a combination of letters and numbers. All data transmitted over the internet is SSL encrypted. To access the ELMER system username and passwords must be assigned. To request access to ELMER contact NorthCare's Provider Network Specialist, Karena Grasso at 906-205-2838 or kgrasso@northcarenetwork.org.

Usernames/passwords will be given to the employee via confidential email or over the telephone **only.** Employees are strictly prohibited from sharing their username and/or passwords. Off-site access of the ELMER system is also strictly **prohibited**. Access to Electronic Health Systems (including ELMER) is permitted only from NorthCare Network managed equipment or Business Associate managed equipment. No personal equipment shall be used to gain access to Electronic Health Systems. Notify NorthCare Network immediately to have a username disabled when an employee leaves your agency. This should be done without delay, so that continued access is not possible. Any issues with the ELMER system should be reported to NorthCare's Provider Network Specialist at 906-205-2838.

Program Discharge Policy

All programs must have a policy that details their Client Discharge policy. Clients must be given this information upon admission and must sign a document showing they received and understand the Discharge Policy. The use of behavioral contracts related to client relapse and continued use during treatment is not clinically appropriate. This practice is not supported by research and fails to comply with the Substance Abuse and Mental Health Services Administration (SAMSHA) guidelines.

The program Discharge policy must include the following components:

- A recipient shall be informed if a program has a policy for discharging recipients who fail to comply with program rules and shall receive, at admission and thereafter upon request, a notification form that includes written procedures which explain all the following:
    - The types of infractions that can lead to discharge.
    - Who has the authority to discharge recipients

- How and in what situations prior notification is to be given to the recipient who is being considered for discharge.
- The mechanism for review or appeal of a discharge decision
- A copy of the notification form signed by the recipient shall be maintained in the recipient's case file.
- If the client is being discharged prior to the expiration of their current authorization for a program violation, the Provider is responsible for giving the client appropriate written notice (ABD)

Data Entry

Refer to the "Help" section of ELMER to view referral guides.

Outpatient Treatment Discharge

Discharge Date Extensions: Discharge data must be submitted when no treatment services have been provided to the client in the last *60 days*. Discharge date is the date of the last billable treatment service.

Residential Treatment "Reason for Discharge"

Do **not** use "Completed Treatment" for Residential Treatment Discharge reason when additional treatment is planned or expected as part of the current treatment episode. In the Episode of Care model Residential SUD Treatment is not considered to be the ideal "end" of treatment. While a client at discharge from residential treatment may have "successfully completed that *level of care*," it is generally expected the client will be stepped down, or referred to a lower level of care, i.e., outpatient SUD treatment, for follow-up care. Therefore, the guideline is to reserve "Completed Treatment" for an Outpatient SUD Discharge reason.

Importance of Discharge Data and Keeping Discharges "up to date"

SUD Treatment discharge data is used to measure outcomes of Treatment, from each admission to the corresponding discharge. Outcomes, in turn, help determine State and Federal funding. NOMS (National Outcome Measures) specifically look at changes in frequency of use, employment status and housing status, as well as "how many days did it take client to access treatment" and "how long did client engage in outpatient treatment."

If a client in outpatient treatment needs to enter detox for example, the outpatient Provider must discharge the clint before the detox Provider can admit him/her. Although the client may

be returning to the outpatient program following a two-day detox stay, a courtesy discharge, followed by a new admission is required.

A discharge, from ANY level of care, may be requested of the appropriate Provider staff by NorthCare for administrative purposes. This will be done in writing via secure email, or ELMER messaging. The format used will be client initials and MCO#. This discharge is expected to be completed within *2 business days*.

BH-TEDS Admission Update & Discharge Coding Structure

Needing particular attention on ELMER system

Includes State Behavioral Health Treatment Episode Data Set (BH-TEDS) Coding Instructions.

Note: Some information is collected at the time of Admission, Update and at time of Discharge and should reflect current status.

New for FY24 ~~All~~ Reference the BH-TEDS Coding Instruction in the ELMER Help Section – SUD How-To-Guides

Corrections / Legal Status

- Legal Related Status
  - Categorized by Adults, Children/Youth, Adults and Children/Youth
  - New section for Juvenile Justice Involvement at Update or Discharge
  - Youth Prior Law Enforcement History
  - Youth Prior Juvenile Justice History

Employment / Financial

- When selecting Employment Status of 04 - "Not in Competitive, Integrated, Labor Force "
    - There are new detailed responses. The new values for Detailed "Not in Competitive, Integrated Labor Force' provide greater detail about individuals in this Employment Status

Juvenile Justice Involvement at Update or Discharge

- Specifies if the child/youth's juvenile justice status at update or discharge

If an individual gets a new Medicaid ID # during the course of treatment, like in the case of adoption, submit an update record with an Update date of the date the Medicaid ID changes.

MBI (Medicare Beneficiary Identification #)

Medicare beneficiaries should have received their new randomly generated MBI number by April/2019. If an individual obtains Medicare during an episode of treatment, a separate S

record is not required to be submitted. Simply Enter the new Medicare ID # on all records submitted after the number has been received.

The Medicare MBI is made up of 11 randomly generated numbers and upper-case letters all in a specific format and no special characters are used.

BH-TEDs validates against the Medicare ID# format. If this field is not blank and any field position contains an invalid value, the record will generate an error.

Arrests in the Past 30 Days

Specifies the number of separate arrests in the past 30 days or since Service Start/Most recent Update, whichever is sooner.

Validation Edits:

a) must be less than 25 or zero if the Service Start, Update or End Date is after 09/30/2022

b) If this field is blank or contains an invalid value, the record will be rejected

Date of Request/First Contact with Treatment Provider (Performance Indicator Reporting)

Date client, or, NorthCare SUD Services, Screener and Client, contacted *Admitting Treatment Provider* to request this Treatment admission. The ELMER system uses Date of First Contact to calculate time to treatment.

Gender Identity

Gender identity is a person's internal understanding and experience of their gender. It is a separate from sex assigned at birth.

Type of Treatment Service Setting at Admission, Update and Discharge:

02 – Residential Detox – SU services in 24-hour, free-standing residential setting that provides for safe withdrawal and transition to ongoing SU treatment. Includes ASAM Levels WM-3.2 and WM 3.7

04 – Residential Rehab – SU services in non-acute 24-hour settings that typically provide 30 or less days of SU treatment. Typically includes ASAM Levels 3.3, 3.5 and 3.7.

05 – Residential Rehab – SU services in non-acute residential settings that typically provide more than 30 days of SU treatment. Typically includes ASAM Levels 3.3 and 3.1. and may include transitional living arrangements such as half-way houses.

06 – Ambulatory Intensive OP – (IOP Treatment) SU ambulatory intensive outpatient services in a non-acute care setting. Similar to ASAM Level 2.1 with nine (9) or more hours per week and Level 2.5 with 20 or more hours per week.

07 – Ambulatory Outpatient – SU ambulatory non-intensive services in outpatient settings which include individual, family, group, case management, and/or pharmacological therapies. Similar to ASAM Level 1.0, outpatient treatment, non-intensive with less than nine (9) hours per week.

Prior Treatment Episodes

Indicates an attempt to answer the question: "How many times have you tried to address this problem at any treatment Provider?"

0 – 0 previous episodes

1 – 1 previous episode

2 – 2 previous episodes

3 – 3 previous episodes

4 – 4 previous episodes

5 – 5 or more previous episodes

7 – Unknown

Codependent/Collateral Person Served

A Codependent/Collateral Individual is a person with no alcohol or drug problem but is formally receiving substance use treatment to address problems arising from his/her relationship with an alcohol or drug user.

Designations

I/DD Designation

Intellectual/Developmental Disability

1 – Yes

2 – No

3 – Not Evaluated (Is not allowed on the Update or Discharge records. When it is unclear if the individual meets the Michigan Mental Health Code Definition of I/DD, select No)

SMI or SED Designation

Serious Mental illness or Severe Emotional Disturbance

1 – Yes

2 – No

3 – Not Evaluated (Is not allowed on the Update or Discharge records. When it is unclear if the individual meets the Michigan Mental Health Code Definition of I/DD, select No)

Detailed SMI or SED Status

Serious Mental Illness or Severe Emotional Disturbance

1 – SMI

2 – SED

3 – Neither SMI nor SED

4 – Not Evaluated or N/A (Is not allowed on the Update or Discharge records. When it is unclear if the individual meets the Michigan Mental Health Code Definition of I/DD, select No)

Co-occurring Disorder/Integrated Substance Use and Mental Health Treatment

1 – Integrated Treatment - Yes, client with co-occurring SUD and MH problems is being treated with an integrated treatment plan by an integrated team

2 – No, client does NOT have a co-occurring SUD and MH problem

3 – Co-occurring, Not Integrated - Client with co-occurring SUD and MH problems is NOT currently receiving integrated treatment

Currently in Mainstream Special Education

Identifies whether the individual is currently in mainstream education with Special Education Status

1 – Yes

2 – No

6 – Not Applicable – Individual is not school age

School Attendance Status

Only applies to school-age (3-17 years old) or, individuals in Special Education (0-26 years old). *Always choose 6 – Not applicable for a person who is older than 26 years old.*

1 – Yes

2 – No

6 – Not applicable

Living Arrangements

Identifies whether an individual is homeless or describes the individual's current residential situation or arrangement.

1 – Homeless – Individual having no fixed address and includes homeless shelters

2 – Dependent Living – Individual living in a supervised setting such as a residential institution, halfway house, transitional housing, recovery housing, a group home, OR children (under age 18) living with parents, relatives or guardians, OR SUD individuals in foster care

3 – Independent Living – Individual with a fixed address living alone or with others in a private residence independently. Includes adult children (18 and older) living with parents and adolescents living independently. Also includes individuals living independently with case management or supported housing support.

Employment Financial

Employment status – Describes the individual's current employment status.

1 – Individual working 35 hours or more per week, with or without supports, in a typical workplace setting, where the majority of persons employed are not persons with disabilities, earning wages consistent with those paid workers without disabilities in the community performing the same or similar work. The individual earns at least minimum wage. May include self-employment and active-duty members of the uniformed services.

2 – Individual working less than 35 hours per week, with or without supports, in a typical workplace setting, where the majority of persons employed are not persons with disabilities, earning wages consistent with those paid workers without disabilities in the community performing the same or similar work. The individual earns at least minimum wage. May include self-employment.

3 – Unemployed – Individual who has actively looked for work during the past 30 days or on a layoff from a job

4 – Not in competitive, Integrated Labor Force An individual: a.) who has not looked for work in the past 30 days; b.) whose current disability symptoms prevent him/her from competitively or non-competitively working; c.) who is primarily a student, homemaker, retired, inmate of an institution; or d.) who works in a non-competitive or non-integrated environment. Individuals in this category are further described in "Detailed Not in Labor Force.

98 – Not applicable – Individual is under 16 years of age; always use 98

4a – *FY24 New selections*

Total Annual Income – Specifies the individuals' current annualized income utilized in calculating his/her ability to pay.

Number of Dependents – Number of dependents utilized in calculating ATP.

Enrolled in State Disability Income (SDA,) Supplemental Security Income (SSI,) or Social Security Disability Income (SSDI) – Identifies whether the individual is enrolled in SDA, SSI, and/or SSDI or if an individual who *otherwise qualifies for SDA is having his/her room and board at a substance use facility being paid by SDA funds*.

Veteran Military Information – Fields must be completed to sign document. When Veteran Status is Veteran, the following question – Would you like to be referred to the Veteran Navigator? Is required to be answered. All Veterans wishing to speak to the Veteran Navigator will be contacted by the Veteran Navigator directly.

<u>Substance Use Problem</u>

The following coding applies to Primary, Secondary and Tertiary Substances. The same drug cannot be used for more than one category. If Primary Substance – 00 at Admission, client must have Co-Dependent – "Yes" and/or 2, 3, or 9 must be coded in other factors.

01 – None – If none, all related fields (route of administering, frequency of use, and age of first use) must be N/A

02 – Alcohol

03 – Cocaine/Crack

04 – Marijuana/Hashish – Includes THC and any other cannabis sativa preparations

05 – Heroin

06 – Non-prescription Methadone (illicit use)

07 – Synthetic Opiates & Other Opiates – includes buprenorphine, butorphanol, codeine, hydrocodone, hydromorphone, meperidine, morphine, opium, oxycodone, pentazocine, propoxyphene, tramadol, and other narcotic analgesics, opiates, or synthetics

08 – PCP – phencyclidine

09 – Hallucinogens – Includes LSD, DMT, mescaline, peyote, psilocybin, STD, and other hallucinogens

10 – Methamphetamine/Speed

11 – Other Amphetamines – Includes amphetamines, MDMA, 'bath salts', phenmetrazine, and other amines and related drugs

12 – Other Stimulants – Includes methylphenidate and any other stimulants

13 – Benzodiazepines – Includes alprazolam, chlordiazepoxide, clonazepam, clorazepate, diazepam, flunitrazepam, flurazepam, halazepam, lorazepam, oxazepam, prazepam, temazepam, triazolam, and other benzodiazepines

14 – Other Tranquilizers – Includes meprobamate, and other non-benzodiazepine tranquilizers

15 – Barbiturates – Includes amobarbital, pentobarbital, phenobarbital, secobarbital, etc.

16 – Other Sedatives or Hypnotics – Includes chloral hydrate, ethchlorvynol, glutethimide, methaqualone, and other non-barbiturate sedatives and hypnotics

17 - Inhalants – Includes aerosols, chloroform, ether, nitrous oxide and other anesthetics, gasoline, glue, nitrites, paint thinner and other solvents, and other inappropriately inhaled products

18 – Over-the-counter medications – includes aspirin, dextromethorphan and other cough syrups, diphenhydramine, and other antihistamines, ephedrine, sleep aids, and any other legally obtained, non-prescription medication

20 – Other drugs – includes diphenylhydantoin/phenytoin, GHB/GBL, ketamine, "spice," carisoprodol, and other drugs

Medication-Assisted Opioid Therapy

Identifies whether the use of opioid medications such as methadone, buprenorphine, vivitrol, suboxone, or naltrexone will be part of the individual's treatment plan.

1 – Yes

2 – No

6 – N/A used if the individual is not in treatment for an opioid problem.

Attendance at Substance Use or Co-dependent Self-help Groups in the Past 30 days

Indicates the frequency of attendance at a self-help group in the past 30 days or since Service Start/Most recent Update, whichever is sooner.

01 – No Attendance

02 – less than once a week (1-3 times in the past 30 days)

03 – About once a week (4-7 times in the past 30 days)

04 – 2 to 3 times per week (8-15 times in the past 30 days)

05 – At least 4 times per week (16-30 or more times in the past 30 days)

Discharge Date

Date of *last treatment service* client received and usually matches last billable treatment. Unless Service End is due to death, then Date of Death is the Discharge (service end date)

Reason for Service Update/End

Identifies the records as Update/End or indicates the outcome of a treatment episode or reason for transfer/discontinuance. Most significant reason for client's discharge:

01 – Treatment completed – Substantially all parts of the Treatment plan or program are completed and the individual is not transferring on to another LOC or treatment provider

02 – Dropped Out of Treatment – Individual chose not to complete treatment program. Includes individuals who drop out of treatment for unknown reasons, individuals with whom contact has been lost, individuals who fail to return from leave (i.e., AWOL), and individuals who have not attended for some time as identified by state guidelines.

03 – Terminated by Facility – Generally because of non-compliance with treatment or violation of rules, laws, policies, or procedures

04 – Transferring to another program or Facility/Completed Level of Care – Individual will transfer to another level of care, program, Provider, or facility

05 – Incarcerated or Released by Courts – Individual's treatment is terminated because s/he has been subject to jail, prison, or house confinement or s/he has been released by or to the courts

06 – Death – the death of the individual receiving SUD services

07 – Other – Individual transferred or discontinued treatment because of change in life circumstances, like extended illness, hospitalization, or change or residence out of NorthCare Network's SUD treatment region.

Diagnosis – Must have at least one SUD Diagnosis, if co-occurring treatment is provided must also have a secondary diagnosis for the Mental Health Problem

Note – Outpatient Discharges

Discharge must be submitted when no treatment services have been provided to client in last *60 days* and/or Previous authorization has expired. Discharge Date is the date of the last billable service.

Note – Detox Discharges

Document the Treatment referral plan to follow detox discharge. In the discharge notes box include the name of follow-up treatment Provider client is being referred to after Detox and the date planned for follow-up treatment admission. If client will not make the *7-day* timeliness standard (from detox discharge to follow-up treatment), list appointment dates offered, refused, accepted and check reason for delay following detox discharge.

Provider Billing

General Information

Treatment Providers will bill for services via the NorthCare ELMER system. To accomplish billing, all services must be prior-authorized.

Treatment services should be billed to NorthCare Network on a monthly basis. Providers are encouraged to bill for services by the 10th of the month following the month treatment was provided.

ALL services must be billed within 60 days of treatment. An exception will be automatic for those clients with 3rd party insurance. This will allow the treatment Provider the opportunity to bill the 3rd party insurance prior to billing NorthCare. Once third-party payment has been received, the amount paid can be included when the treatment is entered into the ELMER system.

DO NOT combine fiscal years in a batch.

Example: September 2021 dates of service should not be processed in the same batch as November 2021 dates of service. Create and submit a separate batch.

Providers can expect reimbursement from NorthCare Network within 45 days for clean claims submitted for payment. Processed claims can be viewed and printed at the provider level.

Claims Processing

Refer to the How to Guides in ELMER – click on “Help” at the top of the ELMER Provider page.

- SUD Provider Claims Entry Quick Reference
- SUD Provider Claims Submission User Manual

State-Required Reporting

The Michigan Department of Health and Human Services (MDHHS) requires periodic reporting by NorthCare Network SUD Services of information specific to the regional panel of Treatment Providers and clients they serve. For NorthCare Network SUD Services to compile accurate regional data, it is essential that reliable information from individual Providers be submitted on a timely basis. In addition to the data entered in ELMER, Providers are required to submit the following report forms.

Monthly Provider Report – 90% Capacity Management report

The purpose of this report is to show which SUD Treatment Providers reach 90% capacity during the reported month. It provides another way to look at our region's capacity to serve Federal Priority Populations: IV Drug Users and Pregnant Women. Whereas many Residential SUD Treatment Providers reach 90% capacity in a specific month, Outpatient SUD Treatment Providers, according to the State, seldom hit 90% full capacity on any given day. Please refer to "How to Complete Monthly Capacity Management Report" for Outpatient and Residential Methods for calculating 90% capacity. Submit this report by the 15th of the month following the reported month.

Monthly Provider Report – Federal Priority Populations Waiting List Exception Report

This monthly report is used for NorthCare Network SUD Services certification that federal block grant priority clients (pregnant drug users and/or IV drug users) are served according to Timeliness guidelines specified in Public Law 102-321. Monthly Federal Priority Populations Waiting List Exception Report form was designed for electronic submission via email or faxing of this information to the NorthCare SUD Services 1-248-406-1286. Information required on this monthly report:

- Name of reporting SUD Treatment Program
- Reporting Month, Year
- "Yes" or "No"? Did SUD Treatment Program have the capacity to serve all clients with Federal Priority Codes 1, 2, or 3 within the specified number of days?
- If "NO" to above; Provide date deficiency occurred, date NorthCare SUD Services was notified by telephone, and complete the additional report, *Documentation when Federal Priority Populations Waiting List Exception Occurs*
- Person Submitting Report
- Date of Certification

Report is due within 15 days of the end of every report month. Electronic submission (email completed form) is preferred. The following are definitions and timeliness guidelines to be used for this report:

Federal Priority Codes

1 – Pregnant injecting drug user

2 – Pregnant non-injecting drug user

3 – Injecting drug user

Timeliness Guidelines

1923(a)(2) Treat Within Specified Number of Days – Each individual who requests and is in need of treatment for intravenous drug abuse must be admitted to a program of such treatment not later than (A) 14 days after making the request for admission to such a program; or (B) 120 days after the date of such request, if no such program has the capacity to admit the individual on the date of such request and if interim services are made available to the individual not later than 48 hours after such request.

1927 (b)(2) Treat Within Specified Number of Days Each pregnant woman who seeks and would benefit from substance abuse treatment services must be admitted to such program that (A) has the capacity to provide treatment services to the woman; or (B) if no program has the capacity to admit the woman, make interim services available to the woman not later than 48 hours after such request.

Providers must immediately contact NorthCare Network SUD Services by telephone whenever a Federal Priority Populations Waiting List Exception occurs, as noted above. If Provider is unable to locate/provide interim services, the NorthCare SUD Services will assist in this process. Documentation of the specific Waiting List Exception must also be submitted to the NorthCare SUD Services via Confidential Fax 1-248-406-1286 (use reporting form entitled Documentation when Federal Priority Population Waiting List Exception Occurs).

Client BH-TEDS Data Uploads (Admissions and Discharges) – generated from ELMER data

The NorthCare Network SUD Services submits batches of regional client SA Treatment admissions and discharges to the State, monthly. These files are used by MDHHS for the Federal BH-TEDS (Treatment Episode Data Set). Admission and Discharge information is used for Performance Indicators and NOMS (National Outcome Measures), as well. This data is used to help determine treatment funding needs. It is essential that Providers enter this information into the ELMER website in a timely, accurate manner so that the NorthCare Network SUD Services can submit reliable data to the State. Providers are asked to regularly check accuracy of data and run the ELMER Open Client Summary to keep Discharge up to date. This information forms the basis for statistics related to our region and reflects trends in Michigan.

Client Satisfaction Surveys

Providers are required, on an ongoing basis, to survey anonymously their open and/or closed client satisfaction.

Treatment Providers distribute their own Client Satisfaction Surveys, which must include one "Over-All Satisfaction" question. The Provider must be able to interpret the answer to this "Over-All Satisfaction" question as either "Satisfied" or "Not Satisfied," over-all, with the Treatment Provider's Program. Another way to ask this question is, "Would client refer family or friends for Treatment with this Treatment Provider?" Treatment Provider should *survey* an individual client only once in a fiscal year to avoid duplication of respondents in summary to NorthCare SUD Services.

Immediate Provider Report – EVENT Notification

MDHHS requires immediate reporting of an "unexpected occurrence" involving a person receiving services involving unexpected death, homicide, or action by the person receiving services that requires immediate notification to MDHHS to allow MDHHS to address any required immediate follow-up actions including statements to the media, or removal of others from a group setting. This report shall be submitted to NorthCare within 24 hours of learning of the event. NorthCare will then submit a report of the event to MDHHS, via the CRM, within 48 hours. This includes:

- Any death that occurs because of suspected staff member action or inaction or any death that is the subject of a recipient rights, licensing, or police investigation.

NorthCare SUD Treatment Providers are required to report Event Types #2, #3, and #4, listed below, when SUD clients are involved or affected. Providers must fax the NorthCare SUD Event Notification Report form (an updated reporting form has been distributed to SUD providers for use beginning in FY23), via confidential fax 1-248-406-1286, to the NorthCare Clinical Director, *within two business days of the Event's occurrence*. NorthCare then reports these events electronically to MDHHS, via the Incident Report Module:

- #2 Relocation of consumer's placement due to licensing issues
- #3 An occurrence that requires the relocation of any PIHP Regional Entity or Provider Panel service site, governance, or administrative operation for more than 24 hours
- #4 The conviction of a PIHP Regional Entity, or Provider Panel Staff member for any offense related to the performance of their job duties or responsibilities.

Residential Provider Required Event Reporting

Residential SUD Treatment Providers are to report within three business days, any critical incident via the NorthCare SUD Event Notification Report form. NorthCare requires a complete Root Cause Analysis report in the event that a critical incident is determined to be a Sentinel Event, except for most arrests and/or convictions. Within three days of a critical incident, the provider reporting organization must determine if the event meets the sentinel event standards. If it does meet that standard the provider reporting organization has two days from the date of that determination to start the root cause analysis of the incident. Refer to the

NorthCare website for the entire Incident, Event, & Death Reporting, Monitoring & Oversight policy.

The following are examples of Critical Incidents, which may be determined to be Sentinel Events:

- Death of a recipient
- Serious illness requiring admission to hospital.
- Alleged cause of abuse or neglect
- Accident resulting in injury to recipient requiring emergency room visit and/or admission to hospital.
- Behavioral episode
- Arrest and/or conviction (Note: always count each as a Sentinel Event, but typically not required to do Root Cause Analysis)
- Medication error

Any Critical Incident falling into the categories listed above should be thoroughly reviewed to determine whether it meets the criteria for Sentinel Event (defined below) and if it is also related to practice of care.

Grievance and Appeal Reporting

Individuals receiving substance use disorder services have the right to a fair and efficient process for resolving disagreements regarding their services and supports. Providers shall educate beneficiary and staff on the beneficiary's right to file a grievance or appeal and the process to do so. Beneficiaries wanting to file a grievance or appeal are to be referred directly to NorthCare. Providers shall provide contact information for NorthCare and assist individuals in reaching the appropriate contact at NorthCare as needed. If an individual makes a complaint that is not related to services or supports and the individual prefers immediate resolution by the Provider, the Provider may address the complaint and log it for review by NorthCare upon request or at time of site review. *The client must still be given an opportunity to file the complaint with NorthCare if they so desire.* Please see Regional SUD Reporting Requirement Chart below for details.

Other Reporting

On occasion, the NorthCare Network SUD Services may survey its Providers on substance abuse related issues or request specialized information. Providers' cooperation in these instances is essential to ensure quality programming that is responsive to clients.

Please note that the inadvertent omission of a required report in this Provider Manual does not relieve Providers of the responsibility for completing requirements previously, or subsequently, requested by the NorthCare Network SUD Services.

REGIONAL SUD REPORTING REQUIREMENT CHART

NorthCare Network Substance Use Disorder Services

1230 Wilson Street, Marquette MI 49855

Phone: (906) 225-7222 Toll Free: (800) 305-6564 Fax: (248) 406-1286

Report and Frequency	*Annual:* Report Month and Due Date											
	1st 6 Months						*2nd 6 Months*					
	1st Qtr.			*2nd Qtr.*			*3rd Qtr.*			*4th Qtr.*		
	Oct due Nov 15	Nov due Dec 15	Dec due Jan 15	Jan due Feb 15	Feb due Mar 15	Mar due Apr 15	Apr due May 15	May due June 15	June due July 15	July due Aug 15	Aug due Sept 15	Sept due Oct 15
Immediate: Please report immediately to NorthCare Network any of these 3 events:	Immediate reporting to NorthCare Network is required for the following: 1. Immediate (24 business hours) Notification Report for Sentinel Event or Critical Incident: *Residential Providers, only* 2. Immediate phone call to NorthCare Clinical Director when Federal Priority Populations Waiting List Exception occurs. 3. Immediate Event Notification (e.g., a "newsworthy" Event) involving a NorthCare client.											
Monthly: *1. "Federal Priority Pops Waiting List Exception Report"* *2. "90% Capacity Mgt. Rpt."*	√	√	√	√	√	√	√	√	√	√	√	√

OUT OF REGION SUD REPORTING REQUIREMENT CHART

NorthCare Network Substance Use Disorder Services

1230 Wilson Street, Marquette MI 49855

Phone: (906) 225-7222 Toll Free: (800) 305-6564 Fax: (248) 406-1286

Report and Frequency	*Annual:* Report Month and Due Date											
	1st 6 Months						*2nd 6 Months*					
	1st Qtr.			*2nd Qtr.*			*3rd Qtr.*			*4th Qtr.*		
	Oct due Nov 15	Nov due Dec 15	Dec due Jan 15	Jan due Feb 15	Feb Due Mar 15	Mar due Apr 15	Apr due May 15	May due June15	June due July15	July due Aug. 15	Aug due Sept 15	Sept due Oct 15
Immediate: Please report immediately to NorthCare Network any of these 3 events: Call 1-800-305-6564 and ask for the SUD Clinical Director	Immediate reporting to NorthCare Network is required for the following: 1. Immediate (24 business hours) Notification Report for Sentinel Event or Critical Incident. *Residential Providers, only.* 2. Immediate phone call to NorthCare Network when Federal Priority Populations Waiting List Exception occurs. 3. Immediate Event Notification (NorthCare "newsworthy" Event)											

Definitions

Access system – Provides prompt, responsive, timely and easy access to specialty services and support for all beneficiaries. The access system functions as the front door for obtaining behavioral health services and they provide an opportunity for callers with perceived problems resulting from trauma, crisis, or problems with functioning to be heard, understood, and provided with options including treatment and Provider options. The access system is available, accessible, and welcoming to all individuals on a telephone and walk-in basis.

Admission – is that point in an individual's relationship with an organized treatment service when the intake process has been completed and the individual is determined eligible to receive services of the treatment program.

ASAM – refers to the American Society for Addiction Medicine.

ASAM Continuum – exclusive assessment tool required by MDHHS.

Care Coordination – is the deliberate organization of client care activities between two or more Providers/agencies/participants involved in a client's care to collaboratively facilitate the appropriate delivery of clinically necessary services.

Case Management – refers to a substance use disorder case management program that coordinates, plans, provides, evaluates, and monitors services or recovery from a variety of resources on behalf of and in collaboration with a client who has a substance use disorder. A working collaboration with the substance use disorder treatment team and as guided by the individualized treatment planning process.

CMHSP – stands for Community Mental Health Services Program. There are five CMHPS in the Upper Peninsula; Copper Country Community Mental Health, Gogebic County Community Mental Health, Hiawatha Behavioral Health, Northpointe Behavioral Health System, and Pathways Community Mental Health.

Continued Service Criteria – is when, in the process of client assessment, certain problems and priorities are identified as justifying admission to a level of care. Continued Service Criteria describe the degree of resolution of those problems and priorities and indicate the intensity of services needed. The level of function and clinical severity of a client's status in each of the six assessment dimensions is considered in determining the need for continued service.

Co-Occurring – Individuals who have at least one mental disorder as well as an alcohol or drug use disorder (SAMSHA). Use of the term carries no implication as to which disorder is primary and which is secondary, which disorder occurred first, or whether one disorder caused the other.

Critical Incident – Examples to be reported by residential Providers; death of a recipient, injury requiring emergency room visit and/or admission to hospital, serious illness requiring admission to hospital, alleged case of abuse or neglect, serious challenging behavior, arrest and/or conviction, and medication error. (MDHHS)

Cultural Competency – is defined as a set of values, behaviors, attitudes, and practices within a system, organization, and program or among individuals and which enables them to work effectively cross culturally. It refers to the ability to honor respect the beliefs (religious or otherwise), language, interpersonal styles and behaviors of individuals and families receiving services, as well as staff who are providing such services. Cultural competence is a dynamic, ongoing, developmental process that requires a long-term commitment and is achieved over time.

Discharge Summary – is the written summary of the client's treatment episode. The elements of a discharge summary include description of the treatment received, its duration, a rating scale of the clinician's perception of investment by the client, a client self-rating score, description of the treatment and non-treatment goals attained while the client was in treatment, and detail those goals not accomplished with a brief statement as to why. Formal discharge summary must be in the client's chart within fourteen-days of discharge.

Discharge/Transfer Criteria – is when, in the process of client assessment, certain problems and priorities are identified as justifying treatment in a level of care. Discharge/Transfer Criteria describe the degree of resolution of those problems and priorities and thus are used to determine when a client can be treated at a different level of care or discharged from treatment. Also, the appearance of new problems may require services that can be provided effectively only at a more or less intensive level of care. The level of function and clinical severity of a client's status in each of the six assessment dimensions is considered in determining the need for a discharge or transfer.

DSM-V – refers to the Diagnostic and Statistical Manual of Mental Disorders (5th Edition), developed by the American Psychiatric Association (APA). It is the standard classification of mental health disorders used by mental health professionals in the United States. It is intended to be used in clinical settings by clinicians for determining behavioral health diagnosis that are part of the assessment and inform development of an individualized treatment plan with the medically necessary level of care.

DRA – Deficit Reduction Act established the Medicaid Integrity Program under Section 6034 of the Social Security Act, signed into law February 8, 2006. (cms.gov)

Early Intervention – is a specifically focused treatment program including stage – based intervention for individuals with substance use disorders as identified through a screening or assessment process including individuals who may not meet the threshold of abuse or dependence.

ELMER – Electronic Medical Record System that NorthCare Network utilizes across the region.

FASDs – "Fetal Alcohol Spectrum Disorders" is an umbrella term describing the range of effects that can occur in an individual whose mother drank alcohol during pregnancy. These effects may include physical, mental behavioral, and/or learning disabilities with possible lifelong implications (SAMHSA).

HMP – Healthy Michigan Plan – health care coverage for individuals who; are age 19-64 years, have income at or below 133% of the federal poverty level under the modified adjusted gross income methodology, do not qualify for or are not enrolled in Medicare, do not qualify for, or are not enrolled other Medicaid programs, are not pregnant at the time of application, are resident of the State of Michigan.

Interim Service Requirements – Services the Providers must supply in lieu of recipient admitted within the admission priority requirements (MDHHS). Is a provisional service(s) provided while a client is waiting for an appropriate level of care. Interim services must begin within forty-eight (48) hours for (1) injecting drug users who cannot be admitted to formal treatment within fourteen (14) days and (2) pregnant women who cannot get into formal treatment immediately.

Length of service – is the number of days (for residential care) or units/visits/encounter (for outpatient care) of service provided to a client, from admission to discharge, at a particular level of care.

Level of Function – is an individual's relative degree of health and freedom from specific signs and symptoms of a mental or substance-related disorder, which determine whether the individual requires treatment.

Level of Service – as used in ASAM Criteria, 3rd Edition, this term refers to broad categories of patient placement, which encompass a range of clinical services such as early intervention, detoxification, or opioid maintenance therapy services and levels of care such as intensive outpatient treatment or clinically managed medium-intensity residential treatment.

MAPS – stands for Michigan's Automated Prescription Service. It is a web-based service to monitor prescriptions for individuals in Michigan.

MDHHS – stands for Michigan Department of Health and Human Services.

Medicaid Health Plans, or MHPs – are insurance companies who contract with the State to provide coverage for the physical health care and mild-moderate behavioral health care benefits of Medicaid enrollees.

Medical Necessity – is determination that a specific service is medically (clinically) appropriate and necessary to meet a client's treatment needs, consistent with the client's diagnosis, symptoms, and functional impairments and consistent with clinical Standards of Care.

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

OHH – Opioid Health Home

OUD – Opioid Use Disorder

Peer Recovery Associate – the name given to individuals who assist the peer recovery coach by engaging in designated peer support activities. These persons have been provided an orientation and brief training in the functional aspect of their role by the entity that will utilize

them to provide supports. These individuals are not trained to the same degree as a peer recovery coach.

Peer Recovery Coach – the name given to peers who have been specifically trained to provide advanced peer recovery support services in Michigan. A peer recovery coach works with individuals during their recovery journey by linking them to the community and its resources. They serve as personal guide or mentor, helping the individual overcome personal and environmental obstacles.

PIHP – Prepaid Inpatient Health Plan. NorthCare Network is the PIHP for Region 1, which is made up of the 15 counties in the Upper Peninsula of Michigan.

Primary Care Coordination – substance use disorder treatment services must be coordinated with primary health care. (MDHHS)

Recipient – individual receiving services

Re-disclosure – additional disclosure of information is prohibited unless further disclosure is expressly permitted by the written consent of the person to whom is pertains or as otherwise permitted by 42 C.F.R. Part 2 (Federal Regulation 42 C.F.R. Part 2).

Recovery – a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential (SAMHSA).

RCSS – stands for Recovery Coach Support Services. A recovery coach support is an individual who has lived experience in receiving services and/or supports for a substance use condition. They service as a guide to initiate, achieve, and sustain long-term recovery from addiction including medication assisted, faith based, 12-step and other pathways to recovery. Recovery coaches provide connections in navigating recovery supportive systems and resources including professional and non-professional services.

ROSC – stands for Recovery Oriented System of Care, which describes a paradigm shift from an acute model of treatment to a care model that views SUD as a chronic illness. A ROSC is a coordinated network of community-based services and supports that is person-centered and build over a period of months and/or years on the strengths and resilience of individuals, families, and communities to achieve abstinence and improved health, wellness, and quality of life for those with or at risk of alcohol and drug problems.

SAMHSA – stands for Substance Abuse and Mental Health Services Administration. It is the federal agency which oversees the funding to the states for substance use disorder and mental health services. It is a department within the U.S. Department of Health and Human Services.

SAPT – stands for Substance Abuse, Prevention, and Treatment grant sometimes called a "block" grant. It is the community grant funding from SAMHSA for substance use disorder treatment and prevention services in the 50 states.

Sentinel Event – is an "unexpected occurrence" involving death (not due to the natural course of a health condition) or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes permanent 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. (TJC, 1998) Any injury or death that occurs from the use of any behavior intervention is considered a sentinel event.

Support Services – are those readily available to program through affiliation, contract or because of their availability to community at large. They are used to provide services beyond the capacity of the staff of the program on a routine basis or to augment the services provided by the staff.

Treatment – is the application of planned procedures to identify and change patterns of behavior that are maladaptive, destructive and/or injurious to health; or to restore appropriate levels of physical, psychological and/or social functioning.

Opioid Health Home (OHH) Appendix

OHH SERVICES

OHH services includes care coordination for integrated, person-centered, and comprehensive care to Medicaid beneficiaries with an opioid use disorder. Providers are required to follow the OHH Handbook found in the provider section of the State of Michigan's OHH website (www.michigan.gov/ohh). OHH services are provided by an interdisciplinary care team that addresses the individual's unique needs. To complete this, OHH providers are required to have a specific number of Full-Time Employees (FTE) for the OHH Team. Any team member may be assigned "lead" for any of the beneficiaries. OHH services are required to be authorized every six months, at a minimum, and are paid on a Per Member Per Month basis. Any OHH service that falls under the allowable services, per the OHH Handbook, are billed using the S0280 HG service code.

OPIOID HEALTH HOME BENEFICIARY ENROLLMENT

OHH Providers are required to identify eligible individuals and ensure these individuals meet OHH enrollment criteria. The procedures below outline what the OHH Providers responsibilities are as well as the responsibilities of NorthCare Network for beneficiary enrollment into the Opioid Health Home.

OHH Provider Enrollment Process

- Identification of potential beneficiaries.
- Provides information on OHH program to qualified beneficiaries.
- Ensures all requirements for enrollment into the OHH as defined in the OHH Handbook (current at the time of enrollment) are met by the beneficiary **before** initiating the enrollment process.
- OHH Provider completes a comprehensive introduction of the OHH program with the beneficiary; documentation that supports program orientation took place must be recorded in OHH provider EMR.
- OHH Provider reviews and completes required documentation as outlined below with beneficiary:
  - MDHHS 5515 Consent to Share Behavioral Health Information Form
    - Signed by client in appropriate spot.
    - Agencies to communicate are completed.
    - Items to be communicated are filled out.
    - The MDHHS 5515 form that is submitted with the enrollment request must be signed **on or before** the date that the Informed Health Home program Enrollment Consent form is signed.
  - Diagnostic Verification indicating Opioid Use Disorder.
    - This must be signed by a qualified professional including M.D., D.O., LLP, LPC, LMSW, NP, PA, or an RN within their scope of practice.
  - NorthCare Informed Health Home Program Enrollment Consent.

        - Signed and dated.
        - As enrollment into the OHH is voluntary and the potential enrollee must agree to and provide consent to receive health home services prior to being fully enrolled – the Health Home Program Enrollment Consent form should be completed when the beneficiary receives full orientation to the program provided by OHH provider staff member.
        - This is the first, in person date of OHH service.
    - Initial Care Plan or existing Care Plan with an amendment which includes a health home goal.
- OHH Provider Submits enrollment and authorization requests in the ELMER system.
    - OHH Provider faxes in the following completed documents to the NorthCare Network SUD Fax line at 248-406-1287
        - MDHHS 5515 Consent to Share Behavioral Health Information Form
        - Certification of eligibility
    - Complete OHH Enrollment Request in ELMER
        - OHH provider completes the SUD Authorization Request for S0280:HG and processes the Request for NorthCare Approval
            - Select to request OHH Service Code S0280:HG
            - Individual S0280:HG authorizations can be requested for up to 180 days.
            - The S0280:HG authorization can be included with other service request codes – however, the timeframes will be dependent upon each treatment request code.
        - Select “Process the Request”
    - Upon processing the authorization request for the OHH service, the OHH provider is given a one-time “warning” message reminding them to use the OHH enrollment request link to upload supporting documentation to complete the request for submission to NorthCare for approval.
        - Selecting OK to the message completes the process and generates the “OHH Enrollment Requests” form link.
        - The OHH Enrollment Request form list displays the OHH Partners name, client’s name, and the date of enrollment request.
        - The current Request Status at this stage is Not Yet Completed.
        - Select the Change link to complete the Enrollment Request. The Enrollment Request form includes the current authorization number.
        - OHH provider adds required documents using either scan OR upload attachments link.
        - OHH Provider changes the Request Status to Pending Review once the Enrollment Request form with required documentation is completed.
            - If this step is not completed, NorthCare will not be aware that there are requests to review.
            - The OHH provider is responsible for ensuring that both enrollment and authorization requests are submitted within the timeframes specified in the Authorization Requirements section of this manual.

NorthCare Network Enrollment Process

- OHH Coordinator completes a review of the enrollment & authorization requests, attachments, and MDHHS 5515 Consent to Share Behavioral Health Information Form.
  - NorthCare Health Home Program Enrollment Consent.
  - Diagnostic Verification documentation indicating Opioid Use Disorder.
  - Care plan that includes a health home goal.
- OHH Coordinator selects the appropriate Disposition as defined below.
  - Disposition Definitions
    - Not Eligible– Denied: Beneficiary did not meet the diagnostic or Medicaid Benefit Plan criteria for enrollment to the OHH program.
      - OHH Coordinator will discuss reason for denial with designated OHH provider staff.
    - Applicant Declined: Beneficiary enrollment into OHH program declined.
      - If OHH Provider does not submit a care plan within the 60-day timeframe after initial engagement, the enrollment will be declined.
    - Eligible – Approved: Beneficiary enrollment to the OHH program is fully approved; no further documentation required.
    - Returned to Requester: See Disposition Reason for return of application.
      - The enrollment will not be approved, and services may not be authorized until the reason for return is resolved and request is resubmitted to NorthCare.
      - Please note returned authorization requests that are not resolved within the allotted time (17 days for the initial 14 days for the Re-authorization from the date of request) may result in denial. Please refer to the "Returned Requests" section of this manual for further detail on Returned Authorization Requests.
- NorthCare will enroll the beneficiary into the OHH via the WSA.
  - OHH Coordinator will confirm eligibility in the WSA, and upload required documentation to complete enrollment.

The OHH Provider and NorthCare Network will work together to continuously verify data found within the WSA reports, OHH Provider service delivery, beneficiary eligibility and participation to determine if continued enrollment or disenrollment should occur on an individual basis. Outlined below are what both OHH Providers responsibilities are as well as the responsibilities of NorthCare Network for enrolled beneficiaries.

<u>OHH PROVIDER RESONSIBILITES FOR ENROLLED BENEFICIARIES</u>

- Provide, at a minimum, one of the six core Health Home services as defined in the OHH handbook per month, per beneficiary.
  - The OHH Provider is responsible for self-monitoring OHH service provision for their enrolled beneficiaries.

- Work with beneficiaries to support on-going eligibility and enrollment in the OHH.
    - The OHH Provider is responsible for continued verification of eligibility for each enrolled OHH beneficiary before any provision of service, as beneficiaries may be eligible one day but not the next.
        - Beneficiaries who lose Medicaid/HMP benefits are not eligible for Health Home services until benefits are restored.
        - The beneficiary's status current on the day an OHH service is provided will be used to determine eligibility for payment.
    - It is recommended that OHH Provider's provide more than one core service per beneficiary per month to increase beneficiary outcomes.
    - OHH Providers are required to provide and document outreach attempts to beneficiaries to confirm eligibility status during active enrollment.
- OHH Provider will promptly alert NorthCare's OHH Coordinator via ELMER secure messaging if there is any change to eligibility, enrollment status, and/or to an existing authorization and/or re-authorization request for OHH services, of a beneficiary should they occur.
- Follow timeliness standards for the submission of enrollment, authorization and re-authorization requests, early terminations, and claim submissions, as outlined in this manual.
    - OHH Provider will regularly check enrolled beneficiaries' ELMER authorization status and authorization renewal dates.
    - OHH Provider will submit either a re-authorization or a disenrollment request, as appropriate.
        - Re-authorization of S0280:HG may not be approved if there is an unexplained lapse in services.
        - An explanation, as outlined in the OHH Monthly service standard guidance document below, must be submitted with the re-authorization request.
    - If more than **30** days accumulate between an OHH authorization for an enrolled beneficiary, the OHH Provider will contact NorthCare's OHH Coordinator with clarification on currently known status of beneficiary, intention of continued enrollment in the OHH, and future Health Home service delivery.
        - If there is no communication from the OHH Provider to NorthCare's OHH Coordinator after 90 days of inactivity in OHH, it will be assumed that the beneficiary is no longer receiving Health Home services and will be disenrolled.

<u>NORTHCARE NETWORK RESONSIBILITES FOR ENROLLED BENEFICIARIES</u>

- NorthCare will monitor and track OHH services to ensure OHH service delivery is occurring at least monthly as required by MDHHS – and will reach out to designated OHH Provider staff to discuss any issues, if necessary.

- NorthCare's OHH Coordinator will monitor reports within the WSA and communicate any identified potential disenrollment's to the OHH Provider's identified OHH lead contact to determine the continuation of enrollment in the OHH.

Please Note: timeliness standards apply to all Opioid Health Home functions. This includes the timely submission of claims, enrollment, authorization, and re-authorization requests and authorization early terminations.

Opioid health Home (OHH) Monthly Service Standard

MDHHS requires that OHH beneficiaries receive a minimum monthly OHH service. Please provide the information outlined below when submitting re-authorization requests in which the minimum monthly service requirements for OHH service provision have not been met. Responses should be entered into the "Provider Selection" of the re-authorization request form in ELMER.

If the reauthorization request is submitted without the information outlined below, it will be returned. NorthCare Utilization Management staff will include a request for the necessary information, and once re-submitted, authorization guidelines outlined in this manual will be used to determine if the request for the additional S0280 encounters will be approved based on the information provided.

Please include the following:

- Beneficiary was enrolled in the OHH on (date).
    - Please explain the lapse in service/claims.
- Does the beneficiary intend to continue participation in the OHH program?
    - If yes,
        - Please communicate your intent in service provision going forward:
            - Submit the next scheduled appointment date.
            - Submit the next scheduled billable S0280 encounter.
    - If no,
        - A disenrollment request as outlined in the NorthCare Beneficiary Health Home Disenrollment/re-enrollment/transfer process is required.

OPIOID HEALTH HOME BENEFICIARY DISENROLLMENT

It is essential that providers be vigilant in checking Medicaid and Health Home eligibility. Verification must continue monthly, and/or before any provision of OHH services. Beneficiaries who lose Medicaid/HMP benefits for a particular month are not eligible for Health Home services. OHH Providers will work with beneficiaries to support on-going eligibility and enrollment.

NorthCare Network will review eligibility for enrolled beneficiaries each month by running the Potential Disenrollment report within the WSA. If any enrolled beneficiaries are identified with a potential disenrollment status, NorthCare's OHH Coordinator will notify the OHH Providers identified lead staff using ELMER secure messaging. OHH Providers are required to provide outreach to beneficiaries to confirm status and submit disenrollment's as appropriate.

OHH PROVIDER RESONSIBILITES

- Ensure contractually required outreach efforts have been made and documented by the OHH Providers prior to initiating the disenrollment.
- The S0280 authorization must be early terminated in ELMER by the OHH Provider for the last date an S0280 service was provided.
- The OHH Provider sends an ELMER secure message to the NorthCare OHH coordinator with the following information:
    - ELMER MCO ID number
    - Date of last Health Home service
    - Reason for disenrollment
- An Adverse Benefit Determination (ABD) must be sent by the OHH Providers in all situations described below except for "deceased" and attached to the beneficiary's chart in ELMER.

Health Home Disenrollment Reasons*:*

- Deceased
- Administrative Dismissal
    - Beneficiary is unable to continue participating in services due to inability to follow agency rules, violence toward staff, etc.
    - Beneficiary is discharged from all services at the OHH Provider and closed in the ELMER system.
- Beneficiary is not actively participating in care and has not responded to outreach efforts.
    - Beneficiary stopped participating in services for a minimum of 90 days, OHH Provider is unable to contact the recipient
        - The OHH Provider is responsible for outreach efforts as outlined in the OHH Handbook guidelines and must appropriately document these efforts in the beneficiary's chart.
- Change in Health Home Setting/Change in Health Home Provider
- Moved
    - Beneficiary moved out of state or moved into a non-OHH county and no longer receiving services.
- Voluntary Disenrollment
    - To be used when client chooses to opt-out of Health Home program.
- Loss of Medicaid eligibility
- Not eligible for Health Home Program
    - The beneficiary is no longer enrolled in a required benefit plan or is enrolled

in an excluded benefit plan.

- Incarceration
  - If less than 90 days, the beneficiary should not be disenrolled from the Opioid Health Home program.
  - OHH Provider is responsible to ensure beneficiary has Medicaid post release from incarceration, before resuming services.
  - The OHH Lead staff at the OHH Provider should communicate any knowledge of potential or confirmed incarcerations to NorthCare's OHH Coordinator.

TRANSFER/RE-ENROLLMENT OF OHH BENEFICIARY

Transfer of Enrolled Opioid Health Home Beneficiary to Another Health Home Partner:

- When a beneficiary requests to receive Health Home Services from another Health Home Provider (HHP):
- The initial HHP will notify NorthCare of the beneficiary request to transfer health home services via ELMER secure messaging and will work together to identify a Health Home setting appropriate for the beneficiary's needs.
- NorthCare will inform the initial HHP of available HHP's to accept the beneficiary's transfer request.
- After receiving the recommendation from NorthCare and the OHH Provider, the beneficiary will have the opportunity to choose their preferred HHP.
- Once the beneficiary has chosen their preferred HHP, a new MDHHS-5515 Consent to Share Behavioral Health Form is required to be submitted to NorthCare by the initial/current HHP.
  - The MDHHS-5515 Consent to Share Behavioral Health Form must include **both** the current and future HHP.
  - The inclusion of other health providers involved in the beneficiary's care, i.e., Primary Physician, Specialty Physicians, and Community Service providers is recommended as applicable and desired by the beneficiary.
- The current and future HHP must coordinate the beneficiary's transition of care.
- The transfer of HHP should occur on the first day of the next month with respect to the new HHP appointment availability.
  - ***NOTE:*** Only one HHP may be paid per beneficiary per month for health home services.

Re-Enrollment into the OHH

- If beneficiary chooses to re-enroll in Health Home services, the following elements are required to be submitted by the HHP:
  - a new NorthCare program enrollment consent form.
  - a new authorization request for the S0280/Health Home services.
  - updated care plan completed with the beneficiary.
  - A MDHHS-5515 Consent to Share Behavioral Health Form, as necessary.

OHH and SUBSTANCE USE DISORDER (SUD) RESIDENTIAL TREATMENT SETTING

Due to the potential overlap of services, NorthCare, as per the provision of service requirements outlined in both the OHH Handbook and the Michigan Medicaid Provider Manual (MMPM), has established the following guidelines to assist our OHH partners in determining the most appropriate and allowable billing/payment source.

- For beneficiaries who are currently receiving SUD Residential Treatment, new enrollment in the OHH program is allowable under the following circumstances:
  - For orientation purposes (e.g., introduction to the OHH program, OHH enrollment paperwork, OHH care plan development, etc.)
  - The initial OHH service must take place in person (this is subject to revision in accordance with state and federal guidelines and with guidance from MDHHS/BHDDA , Michigan Department of Health and Human Services/Behavioral Health and Developmental Disabilities Administration and/or any relevant Executive Order.
  - The OHH service is directly linked to the OHH, (e.g., orientation to the OHH program, etc.) and supported by the appropriate documentation.
  - The OHH service is initiated and documented by the outpatient OHH provider. Any S0280 claims submitted through a residential program will be rejected. Claims can be accepted from an outpatient provider who may also be a residential staff member and who is also an OHH provider team member. The outpatient program must be used for claim submission.
  - For beneficiaries in a residential setting who are enrolling in the OHH program, the enrollment process remains the same.
  - A second, outpatient admission must be added which corresponds with the date the beneficiary was enrolled in the OHH and the OHH service was provided. There must also be a valid MDHHS 5515 consent completed.
    - NorthCare SUD Access must be contacted to request a referral to be opened for the provider to add an outpatient admission. The MDHHS 5515 consent does not need to be re-submitted for this request. The provider may also fax a request for an outpatient referral which must include the location of the outpatient services on the fax cover sheet. S0280 claims must be supported by the appropriate documentation and tied to the OHH care plan.
  - All claims submitted are subject to NorthCare review and potential recoupment if they are determined to not meet the criteria outlined in this guidance, or the guidelines established in the OHH Handbook.
  - The six federally required OHH core services are detailed in the OHH Handbook.
  - **OHH service, while in a residential facility is limited to OHH program orientation and enrollment** to prevent any potential duplication of service. This service must be delivered by an OHH team member.
- For currently enrolled OHH beneficiaries who enter a SUD Residential Treatment setting:

- The beneficiary may remain enrolled in the OHH; however, no services may be provided, and any claims will not be paid.
- Once the beneficiary is discharged back to the outpatient setting, OHH services and claims may resume.

If the S0280 authorization expires while the beneficiary is still in the residential setting, the OHH Provider may submit a re-authorization request with a note that includes the expected residential discharge date. Please note, however, that any S0280 claims which take place during a Residential stay for an enrolled OHH beneficiary will be rejected.

OHH Authorization Requirements

Providers providing both Substance Use Disorder treatment services and OHH services to a beneficiary must first submit an authorization request for the treatment services. OHH services may be requested within the same authorization request as the treatment services or in a separate OHH specific authorization request. If OHH services are included with treatment services in an authorization request, timeframes and requirements of the treatment service authorization request are followed. For OHH services requested separately, authorization requirements remain in effect with the exception of the length of the authorization which can be six months in length.

OHH Beneficiary Care Plan Requirements

The OHH care team must work with the beneficiary to develop an OHH care plan, which must be submitted to NorthCare Network upon request for enrollment to the opioid health home program.

The OHH care plan must be developed with the OHH care team, the beneficiary, and can include the beneficiary's support system (family, caregiver, etc.) if appropriate. Any member of the OHH care team (as listed in the OHH Handbook under Minimum Health Home Provider Infrastructure) may develop the OHH care plan with the beneficiary. It is best practice that the beneficiary and the OHH care team agree to and sign off on the care plan before it is implemented.

The OHH care plan is a fluid document which should be reviewed and revised with the OHH care team and the beneficiary frequently. The OHH care plan should be updated at least annually, however should be updated as often as necessary based on the beneficiary's progress and changing needs. An example of the components to include in the care plan is available on the MDHHS webpage MDHHS - Opioid Health Home (michigan.gov).

The OHH care plan must align with the six statutorily required health home services, act as a plan to guide the care and support services to be provided by the OHH care team, and integrate the beneficiary's physical health, behavioral health, and social support needs.

The OHH care plan must have SMART goals that are specific, measurable, achievable, realistic, and timely.

At a minimum, the care plan should include the following:

- The tasks to be completed by each OHH team member.
- The tasks to be completed by the beneficiary.
- SMART goals and objectives developed by and agreed upon by the beneficiary, and OHH care team to achieve improved health outcomes.
- Align with the six required health home services.
- Integrate the beneficiary's physical health, behavioral health, and social support needs.
- A plan to monitor the opioid health home care plan progress and update goals.

While MDHHS provides latitude to the Lead Entities (LEs) and Health Home Partners (OHH PROVIDERs) to develop, implement, and monitor care plans for beneficiaries enrolled in the Opioid Health Home (OHH), the individualized care plan must align with statutorily required Health Home core services, including: Comprehensive Care Management, Care Coordination, Health Promotion, Comprehensive Transitional Care, Individual and Family Support, and Referral to Community and Social Support Services. Considering this, the following table is an *example* of standards that should be considered when developing the individualized care plan for an enrolled OHH beneficiary. The individual care plan should be developed with the care team, beneficiary, and the beneficiary's support system (e.g., family, caregiver, etc.) when able. All parties must agree to and sign off on the care plan before the plan is implemented.

Example:

Focus Area	Goal(s)	Outcome(s)
Diagnosis *The care plan should address and monitor the following focus areas of a beneficiary's health. Specific goals should be developed to improve health conditions as agreed upon by the care team and beneficiary.* • Physical health • Behavioral health • Risk Factors/co- morbidities	Goal 1: Level of confidence to complete goal: **Not Sure** 0 1 2 3 4 5 6 7 8 9 10 **Very Sure**	Description: 1. Goal completed 2. Goal in progress 3. Goal revised 4. Goal discontinued, explanation

Patient Engagement *The care plan should focus on engaging the beneficiary to achieve better health outcomes and to promote positive beneficiary behavior. The beneficiary should feel empowered to participate in their care.* • Readiness to change (document on a standard scale) on separate page – here is what the readiness to change template can look like. • Patient activation • Health literacy • Goal setting and self-care plans • Coaching and support	Goal 1: Level of confidence to complete goal: **Not Sure** 0 1 2 3 4 5 6 7 8 9 10 **Very Sure**	Description: 1. Goal completed 2. Goal in progress 3. Goal revised 4. Goal discontinued, explanation

Barriers to Success/Areas of Concern *The care plan should identify areas which might inhibit the beneficiary of obtaining the identified goals outlined in the care plan. Barriers or areas of concerns can include items outside of healthcare such as transportation, housing, food, medication access, social support, etc.* • Social Determinants of Health	Goal 1: Level of confidence to complete goal: **Not Sure** 0 1 2 3 4 5 6 7 8 9 10 **Very Sure**	Description: 1. Goal completed 2. Goal in progress 3. Goal revised 4. Goal discontinued, explanation
Plan Activation *The care plan should include steps on how the beneficiary and care team will work together to achieve the goals set forth in the care plan. The beneficiary's support system should be included whenever possible.* • Steps to implement the plan • Agreement by patient, care team, and family/caregiver support	Goal 1: Level of confidence to complete goal: **Not Sure** 0 1 2 3 4 5 6 7 8 9 10 **Very Sure**	Description: 1. Goal completed 2. Goal in progress 3. Goal revised 4. Goal discontinued, explanation