Substance Use Disorder Treatment and Access Special Provisions

I. Substance Use Disorder Grant General Provisions

The Grantee agrees to comply with the Provisions outlined in this agreement. The Grantee also agrees to comply with the requirements described in the relevant SUBSTANCE USE DISORDER POLICIES AND TECHNICAL ADVISORIES, which is part of this agreement, outlined under each grant project.

The SUD Policies and Technical Advisories are also available at:
https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/drugcontrol/reportstats/reportcontent/policies-and-advisories

A. Substance Use Disorder Recipient Rights Training

Register or login at

https://www.improvingmipractices.org/practice-areas/substance-use-disorder

Search for **Recipient Rights for Substance Abuse Services**

B. Substance Use Disorder Recipient Rights Resource Documents

Michigan Department of Licensing & Regulatory Affairs, Bureau of Community and Health Systems maintains Substance Use Disorder Recipient Rights Resource Documents at

https://www.michigan.gov/lara/0,4601,7-154-89334_63294_30419_79925---,00.html

C. Selected Specific Grant Requirements

1. Block Grant funds shall not be used to pay for inpatient hospital services except under conditions specified in federal law.
2. Funds shall not be used to make cash payments to intended recipients of services.
3. Funds shall not be used to purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or any other facility or purchase major medical equipment.
4. Funds shall not be used to satisfy any requirement for the expenditure of non-Federal funds as a condition for the receipt of Federal funding.
5. Funds shall not be used to provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs.
6. Funds shall not be used to enforce state laws regarding the sale of tobacco products to individuals under the age of 21.
7. Funds shall not be used to pay the salary of an individual at a rate in excess of Level I of the Federal Executive Schedule.

D. Marijuana Restriction

Grant funds may not be used, directly or indirectly, to purchase, prescribe, or provide marijuana or treatment using marijuana. Treatment in this context includes the treatment of opioid use disorder. Grant funds also cannot be provided to any individual who or organization that provides or permits marijuana use for the purposes of treating substance use or mental disorders. See, e.g., 45 C.F.R. 75.300(a) (requiring HHS to ensure that Federal funding is expended in full accordance with U.S. statutory requirements.); 21 U.S.C. 812(c) (10) and 841 (prohibiting the possession, manufacture, sale, purchase, or distribution of marijuana). This prohibition does not apply to

those providing such treatment in the context of clinical research permitted by the DEA and under an FDA-approved investigational new drug application where the article being evaluated is marijuana or a constituent thereof that is otherwise a banned controlled substance under federal law.

E. Inability to Pay

Services may not be denied because of an individual's inability to pay. If a person's income falls within the regional sliding fee scale, clinical need must be determined through the standard assessment and patient placement process. If a financially and clinically eligible person has third party insurance, that insurance must be utilized to its full extent. Then, if benefits are exhausted, or if the person needs a service not fully covered by that third party insurance, or if the co-pay or deductible amount is greater than the person's ability to pay, Community Grant funds may be applied. Community Grant funds may not be denied solely on the basis of a person having third party insurance.

F. Risk Monitoring

Federal authorities conduct national cross-site evaluation at their discretion. Requests may come from federal authorities that require additional reporting. Grantees will receive notice when these requests are made and be given time to respond appropriately.

G. Residency in PIHP Region

The Grantee may not limit access to the programs and services funded by this portion of the Agreement only to the residents of the PIHP's region, because the funds provided by the Department under this Agreement come from federal and statewide resources. Members of federal and state-identified priority populations must be given access to screening and to assessment and treatment services, consistent with the requirements of this portion of the Agreement, regardless of their residency. However, for non-priority populations, the Grantee may give its residents priority in obtaining services funded under this portion of the Agreement when the actual demand for services by residents eligible for services under this portion of the Agreement exceeds the capacity of the agencies funded under this portion of the Agreement.

H. Reimbursement Rates for Services

The Grantee must pay the same rate when purchasing the same service from the same provider, regardless of fund source.

I. Media Campaigns

A media campaign, very broadly, is a message or series of messages conveyed through mass media channels including print, broadcast, and electronic media. Messages regarding the availability of services in the PIHP region are not considered to be media campaigns. Media campaigns must be compatible with MDHHS values and policies. The Grantee shall not finance any media campaign using administered funding without prior written approval by the LRE.

J. National Outcome Measures (NOMS)

Complete, accurate, and timely reporting of treatment data is necessary for the Department to meet its federal reporting requirements. For the SUD Treatment NOMS, it is the grantee shall ensure that the client information reported on these records accurately describes each client's status at admission first date of service (admission) and on the last day of service (discharge).

K. Claims Management System

The Grantee shall make timely payments to all providers for clean claims. This includes payment at 90% or higher of clean claims from network providers within 60 days of receipt, and 99% or higher of all clean claims within 90 days of receipt.

A clean claim is a valid claim completed in the format and time frames specified by the LRE and that can be processed without obtaining additional information from the provider. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity. A valid claim is a claim for services that LRE is responsible for under this Agreement.

L. Charitable Choice

The Grantee is required to comply with all applicable requirements of the Charitable Choice regulations (45 CFR part 96). The Grantee must ensure that treatment clients and prevention service recipients are notified of their right to request alternative services.

M. Licensure of Grantee

The Grantee shall enter into agreements for substance use disorder treatment, and recovery services only with providers appropriately licensed for the service provided as required by Section 6234 of P.A. 501 of 2012, as amended.

The Grantee must ensure that network providers residing and providing services in bordering states meet all applicable licensing and certification requirements within their state that such providers are accredited per the requirements of this Agreement, and that provider staff are credentialed per the requirements of this Agreement.

N. Accreditation of Grantee

The Grantee shall enter into agreements for treatment services provided through outpatient, Methadone, sub-acute detoxification and residential providers only with providers accredited by one of the following accrediting bodies: The Joint Commission (TJC); Commission on Accreditation of Rehabilitation Facilities (CARF); the American Osteopathic Association (AOA); Council on Accreditation of Services for Families and Children (COA); National Committee on Quality Assurance (NCQA), or Accreditation Association for Ambulatory Health Care (AAAHC). The Grantee must determine compliance through review of correspondence from accreditation bodies to providers.

Accreditation is not needed in order to provide Access Management System (AMS) services, whether these services are operated by a PIHP or through an agreement with a PIHP or for the provision of broker/generalist case management services. Accreditation is required for AMS providers that also provide treatment services and for case management providers that either also provide treatment services or provide therapeutic case management. Accreditation is not required for peer recovery and recovery support services when these are provided through a prevention license.

II. Treatment and Access Management Special Provisions

A. LRE Substance Use Disorder Provider Manual

Grantee will comply with requirements outlined in the **LRE Substance Use Disorder Provider Manual**

a. Manual Link: https://www.lsre.org/for-providers/provider-network

B. **Purpose**

The focus of the program is to provide for the administration and coordination of substance use disorder (SUD) services within the designated Pre-paid Inpatient Health Plan (PIHP) region. Substance Abuse Block Grant (SABG) grantees should direct this funding to prioritize and address the unique SUD prevention, intervention, treatment, and recovery support needs and gaps in their region's service systems.

The MDHHS Behavioral and Physical Health and Aging Services Administration (BPHASA), Bureau of Specialty Behavioral Health Services, Division of Adult Home and Community-Based Services, Substance Use, Gambling and Epidemiology Section (SUGE) is responsible for oversight of clinical services within the SUD Treatment System.

C. **Substance Use Disorder Policies & Technical Advisories**

The Grantee agrees to comply with the requirements described in the following policies and technical advisories that can be found at: https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/drugcontrol/reportstats/reportcontent/policies-and-advisories

SUBSTANCE USE DISORDER SERVICES POLICIES Treatment		
Document #	**Effective Date**	**Document Name**
P-T-01	09/21/2007	Obsolete
P-T-02	11/01/2012	Acupuncture
P-T-03	10/01/2006	Buprenorphine
P-T-04	12/01/2006	Off-Site Dosing Requirements for Medication Assisted Treatment
P-T-05	10/01/2012	Criteria for Using Methadone for Medication-Assisted Treatment and Recovery See MDHHS Substance Use Disorder Services Policies page for link to Consent for an Adolescent to Participate in Opioid Pharmacotherapy Treatment form
P-T-06	04/02/2012	Individualized Treatment and Recovery Planning
P-T-07	11/30/2011	Access Management System: Replaced with PIHP Attachment P4.1.1 and CMHSP Attachment P3.1.1
P-T-08	01/01/2008	Substance Abuse Case Management Program Requirements
P-T-09	03/15/2017	Outpatient Treatment Continuum of Service
P-T-10	05/03/2013	Residential Treatment Continuum of Services
P-T-11	10/01/2009	Fetal Alcohol Spectrum Disorders
P-T-12	10/01/2010	Women's Treatment Services
P-T-13	07/01/2017	Withdrawal Management Continuum of Services
P-T-14	06/01/2018	Adolescent Substance Use Treatment Services Policy
P-T-15	07/19/2019	Young Adult and Transitional Age Youth Treatment Services
P-T-16	10/01/2022	SUD Credentialing and Staff Qualifications

SUBSTANCE USE DISORDER SERVICES TECHNICAL ADVISORIES Treatment		
Document #	**Effective Date**	**Document Name**
TA-A-01	10/01/2006	Advisory Council
TA-T-01	10/01/2006	Replaced by P-T-03

TA-T-02	12/01/2006	Replaced by P-T-04
TA-T-03	01/01/2008	Replaced by P-T-08 on 1/1/08
TA-T-04	10/01/2009	Replaced by P-T-11
TA-T-05	10/01/2006	Welcoming
TA-T-06	08/10/2007	Counseling Requirement for Clients Receiving Methadone Treatment
TA-T-07	09/01/2012	Peer Recovery Support Services
TA-T-08	07/01/2020	Enhanced Women's Services
TA-T-09	11/30/2011	Early Intervention
TA-T-11	09/01/2012	Recovery Housing
TA-T-12	07/30/2019	Recovery Policy Practice Advisory
	09/17/2014	Medication Assisted Treatment Guidelines for Opioid Use Disorders

D. SUD Records Maintenance/Retention

1. Grantee shall prepare and maintain complete and accurate records, in either paper or electronic form, for all Individuals receiving services. For purposes herein, references to any Individual's clinical and/or program records shall mean such records in either paper or electronic form. The records shall contain such information as may be required by LRE, MDHHS and any other State or Federal agency with jurisdiction over the delivery of services contemplated under this Agreement. LRE shall supply Grantee with copies of its clinical protocols and Grantee must use the protocols in planning and providing treatment to Individuals. Unless a longer period applies under Michigan law, Grantee shall retain all Individual medical records for at least seven (7) years after services are rendered, regardless of any change in ownership or termination of service for any reason, and, in the case of minor Individuals, until seven (7) years after such minor attains the age of majority.

2. Grantee shall make Individual records available to LRE, MDHHS and other State and Federal regulatory bodies having jurisdiction over the delivery of services to Individuals for purposes of assessing the quality of care or investigating individual grievances or complaints any time within ten (10) years of the termination of this Agreement.

3. Grantee shall retain all records in accordance with the retention schedules in place by the Department of Technology, Management and Budget's (DTMB) General Schedule #20 at https://www.michigan.gov/dtmb/0,5552,7-358-82548_21738_31548-56101--,00.html and MCL 333.16213, unless these records are transferred to a successor organization or LRE is directed otherwise in writing by MDHHS. Medical records of an individual with SUD may not be disclosed to LRE without the Individual's consent except as allowed by State and Federal law, including 42 CFR Part 2. The provisions of this section shall survive the expiration or termination of this Agreement regardless of cause, including non-payment by LRE, insolvency or breach of this Agreement by either Party.

4. Upon receipt of written request from LRE, Grantee shall transfer to LRE copies of all Individual records, and other data in the possession or control of Grantee pertaining to the named Individual within ten (10) business days of such notice. In the event of an agency or program closure, Grantee shall transfer to LRE copies of all Individual medical records, and other data in the possession or control of Grantee pertaining to the named Individual within ten (10) business days of such notice.

5. Records shall be maintained by Grantee consistent with Michigan and Federal law, including 1978 PA 368 and 42 CFR Part 2, and 42 USC 290dd-2. Grantee will permit access to records by authorized representatives of LRE, MDHHS, the Federal Grantor Agency, Comptroller General of the United States, or any of their duly authorized representatives as allowed by State and Federal law, including 42 CFR Part 2.
6. The obligations set forth in this Section are intended to carry on beyond the terms of this Agreement, irrespective of whether this Agreement is terminated as provided herein or expires by its own terms.

E. <u>Sentinel Event Reporting Requirements</u>

Sentinel Event reporting is to be consistent with the MDHHS/PIHP Medicaid Managed Specialty Supports and Services Program contract, as outlined in the Quality Assessment and Performance Improvement Program (QAPIP) standards and Residential Services guidelines.

F. <u>ASAM LOC Requirements for Subcontractors</u>

The Grantee shall enter into agreements for SUD treatment with organizations that provide services based on the American Society of Addiction Medicine (ASAM) Level of Care (LOC) only. This requirement is for community grant and all Medicaid/Healthy Michigan Plan funded services. The Grantee must ensure that to the extent licensing allows all of the following LOCs are available for adult and adolescent populations:

ASAM Level	ASAM Title
0.5	Early Intervention
1	Outpatient Services
2.1	Intensive Outpatient Services
2.5	Partial Hospitalization Services
3.1	Clinically Managed Low Intensity Residential Services
3.3*	Clinically Managed Population Specific High Intensity Residential Services
3.5	Clinically Managed High Intensity Residential Services
3.7	Medically Monitored Intensive Inpatient Services
OTP Level 1**	Opioid Treatment Program
1-WM	Ambulatory Withdrawal Management without Extended On-Site Monitoring
2-WM	Ambulatory Withdrawal Management with Extended On-Site Monitoring
3.2-WM	Clinically Managed Residential Withdrawal Management
3.7-WM	Medically Monitored Inpatient Withdrawal Management

G. <u>Minimum Subcontractor Information to be Retained by Grantee</u>

Budgeting Information for Each Service.

Documentation of How Fixed Unit Rates Were Established: The PIHP shall maintain documentation regarding how each of the unit rates used in its agreements was established. The process of establishing and adopting rates must be consistent with criteria in OMB Circular 2 CFR 200 Subpart E, and with the requirements of individual fund sources.

Indirect Cost Documentation: The Grantee shall review subcontractor indirect cost documentation in accordance with OMB Circular 2 CFR 200 Subpart E, as applicable.

Equipment Inventories: All allowable Grantee contractor's equipment purchase(s) supported in whole or in part through this agreement must be listed in the supporting Equipment Inventory

Schedule. Equipment means tangible, non-expendable, personal property having useful life of more than one (1) year and an acquisition cost of $5,000 or more per unit. Title to items having a unit acquisition cost of less than $5,000 shall vest with the Grantee upon acquisition.

H. Subcontracts with Hospitals

Funds made available through the Department shall not be made available to public or private hospitals which refuse, solely on the basis of an individual's substance use disorder, admission or treatment for emergency medical conditions.

I. Purchasing Drug Screens

(This item does not apply to medication-assisted services)

Department-administered treatment funds can be used to pay for drug screens, if all of the following criteria are met:

No other responsible payment source will pay for the screens. This includes self-pay, Medicaid, and private insurance. Documentation must be placed in the client file;

The screens are justified by specific medical necessity criteria as having clinical or therapeutic benefit; and

Screens performed by professional laboratories can be paid for one time per admission to residential or detoxification services, if specifically justified. Other than these one-time purchases, Department funds may only be used for in house "dip stick" screens.

J. Purchasing HIV Early Intervention Services

Department-administered Community Grant funds (blended SAPT Block Grant and General Fund) cannot be used to pay for HIV Early Intervention Services because Michigan is not a Designated State for HIV.

K. Persons Associated with the Corrections System

Grantee is responsible for medically necessary community-based substance use disorder treatment services for individuals under the supervision of the MDOC once those individuals are no longer incarcerated. These individuals are typically under parole or probation orders and excludes individuals referred by court and services through local community corrections (PA 5ll) systems.

L. MDOC Referrals, Screening and Assessment

Individuals under MDOC supervision are considered a priority population for assessment and admission for substance use disorder treatment services due to the public safety needs related to their MDOC involvement. The Grantee must ensure timely access to supports and services in accordance with this Contract and **Attachment 1a: SUD Provider Manual**.

The MDOC Supervising Agent will refer individuals in need of substance use disorder treatment through the established referral process. The Supervising Agent will make best efforts to obtain from the individual a signed Michigan Behavioral Health Standard Consent Form, MDHHS-5515, and provide it to the Grantee and/or designated access point along with any pertinent background information and the most recent MDOC Risk Assessment summary.

The Supervising Agent will assist the individual in calling the Grantee or designated access point for a substance abuse telephonic screening for services. Individuals that are subsequently referred for substance use disorder treatment as a result of a positive screening must receive an in-person

assessment. If the individual referred is incarcerated, the Supervising Agent will make best efforts to facilitate service initiation and appropriate contact with the Contractor/Designated Access Point. Provided that it is possible to do so, the Grantee must make best efforts to ensure the individual receives a telephonic, video or in-person screening for services at the designated location as arranged by MDOC Supervising Agent. The Contractor/designated access point may not deny an individual an in-person assessment via phone screening.

Assessments must be conducted in accordance with MDHHS-approved assessment instruments (if any) and admissions decisions based on MDHHS-approved medical necessity criteria included in this Contract. In the case of MDOC supervised individuals, these assessments should include consideration of the individual's presenting symptoms and substance use/abuse history prior to and during incarceration and consideration of their SUD treatment history while incarcerated. To the extent consistent with HIPAA, the Michigan Mental Health Code and 42 CFR Part 2, and with the written consent of the individual, the Contractor/designated provider will provide notice of an admission decision to the Supervising Agent within one business day, and if accepted, the name and contact information of the individual's treatment provider. If the individual is not referred for treatment services, the Contractor/designated access point will provide information regarding community resources such as AA/NA or other support groups to the individual.

The Grantee will not honor Supervising Agent requests or proscriptions for level or duration of care, services or supports and must base admission and treatment decisions only on medical necessity criteria and professional assessment factors.

M. <u>Primary Care Coordination</u>

The Grantee must take all appropriate steps to assure that substance use disorder treatment services are coordinated with primary health care. Treatment case files must include, at minimum, the primary care physician's name and address, a signed release of information for purposes of coordination, or a statement that the client has refused to sign a release.

Care coordination agreements or joint referral agreements, by themselves, are not sufficient to show that the Grantee has taken all appropriate steps related to coordination of care. Client case file documentation is also necessary.

N. <u>Treatment</u>

Using criteria for medical necessity, a Grantee may:

1. Deny services
    a. that are deemed ineffective for a given condition based upon professionally and scientifically recognized and accepted standards of care;
    b. that are experimental or investigational in nature: or c) 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
    c. 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;
2. Not deny SUD 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 industry standards and consistent with this contract, and that are provisional and subject to modification based on individual clinical needs and clinical progress.

O. Satisfaction Surveys

The Grantee shall assure that all network subcontractors providing treatment conduct satisfaction surveys of persons receiving treatment at least once a year. Clients may be active clients or clients discharged up to 12 months prior to their participation in the survey. Surveys may be conducted by mail, telephone, or face-to-face.

P. Clinical Eligibility: DSM - Diagnosis

In order to be eligible for treatment services purchased in whole or part by state-administered funds under the agreement, an individual must be found to meet the criteria for one or more selected substance use disorders found in the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM). Reimbursable disorders are listed in the TEDS Instructions.

Q. Intensive Outpatient Treatment – Weekly Format

The Grantee may purchase Intensive outpatient treatment (IOP) only if the 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.

R. Opioid Treatment Services

The Medication Assisted Treatment Guidelines for Opioid Use Disorders shall be used to facilitate Grantee compliance with the treatment of opioid use disorders in all publicly funded opioid treatment programs. In reference to this document the term 'Guideline' shall be utilized in the medical sense, as research and application of technology/protocols and treatment pathways provided as a 'guidance' to physicians. PIHPs will work with the Department to establish and implement a timeline and benchmarks toward full implementation of the Guidelines.

1. **Medication Assisted Treatment (MAT)** is a standard of care that is broadly recognized as an essential pillar in any comprehensive approach to the national opioid addiction and overdose epidemic. The State of Michigan seeks to ensure that no consumer is denied access to or pressured to reject the full-service array of evidence-based and potentially life-saving treatment options, including MAT, that are determined to be medically necessary for the individualized needs of that consumer.

   Treatment options should be discussed in an objective way so each consumer can make an informed decision based on research and outcome data. The State of Michigan expects that PIHP-contracted SUD treatment providers will do the following:

   a. Adopt a MAT-inclusive treatment philosophy that recognizes multiple pathways to recovery;

   b. Reject pressuring MAT clients to adopt a tapering schedule and/or a mandated period of abstinence;

   c. Develop and/or strengthen policies that prohibit disparaging, delegitimizing, and/or stigmatizing of MAT either with individual clients or in the public domain;

   d. When a consumer on MAT (or considering MAT) is seeking treatment services at the point of access, access staff will respect MAT as a choice without judgment, stigma, or pressure to change recovery pathways.

If a provider does not have capacity to work with a person receiving MAT, the provider will work with the consumer and LRE or appropriate Access Departments to facilitate a warm handoff/transfer to another provider, who can provide ancillary services (counseling, case management, recovery supports, recovery housing) while the client pursues his or her chosen recovery pathway.

S. Fetal Alcohol Spectrum Disorders

Substance abuse treatment programs are in a unique position to have an impact on the fetal alcohol spectrum disorder (FASD) problem in two ways. First, it is required that these programs include FASD prevention within their treatment regimen for those women that are included in the selective or indicated group based on Institute of Medicine (IOM) prevention categories. Second, for those treatment programs that have contact with the children born to women who have used alcohol it is required that the program screen these children for FASD and, if appropriate, refer for further diagnostics services.

T. Fetal Alcohol Prevention Activities

FASD prevention should be a part of all substance abuse treatment programs that serve women. Providing education on the risks of drinking during pregnancy and FASD detection and services are easily incorporated into the treatment regimes. The IOM Committee to Study Fetal Alcohol Syndrome has recommended three prevention approaches. The universal approach involves educating the public and influencing public policies. The selective approach is targeting interventions to groups that have increased risk for FASD problems such as women of childbearing age that drink. The indicated approach looks at groups who have already exhibited risk behaviors, such as, pregnant women who are drinking or who gave birth to a child who has been diagnosed with FASD. This policy recommends using one of the FASD prevention curriculums for women in the selected or indicated group.

U. Sub-Acute Detoxification

Sub-acute detoxification is defined as supervised care for the purpose of managing the effects of withdrawal from alcohol and/or other drugs as part of a planned sequence of addiction treatment. Detoxification is limited to the stabilization of the medical effects of the withdrawal and to the referral to necessary ongoing treatment and/or support services. Licensure as a sub-acute detoxification program is required. Sub-acute detoxification is part of a continuum of care for substance use disorders and does not constitute the end goal in the treatment process. The detoxification process consists of three essential components: evaluation, stabilization, and fostering client readiness for, and entry into, treatment. A detoxification process that does not incorporate all three components is considered incomplete and inadequate.

Detoxification can take place in both residential and outpatient settings, and at various levels of intensity within these settings. Client placement to setting and to level of intensity must be based on ASAM PPC 2-R and individualized determination of client need. The following combinations of sub-acute detoxification settings and levels of intensity correspond to the LOC determination based on the ASAM PPC 2-R.

1. In an Outpatient Setting
    a. Ambulatory Detoxification without extended on-site monitoring corresponding to ASAM Level I-D, or ambulatory detoxification with extended on-site monitoring (ASAM Level II-D).

b. Outpatient setting sub-acute detoxification must be provided under the supervision of a Substance Abuse Treatment Specialist. Services must have arrangements for access to licensed medical personnel as needed. ASAM Level II-D ambulatory detoxification services must be monitored by appropriately certified and licensed nurses.

2. In a Residential Setting

   a. Clinically Managed Residential Detoxification - Non-Medical or Social Detoxification Setting: Emphasizes peer and social support for persons who warrant 24-hour support (ASAM Level III.2-D). These services must be provided under the supervision of a Substance Abuse Treatment Specialist. Services must have arrangements for access to licensed medical personnel as needed.

   b. Medically Managed Residential Detoxification - Freestanding Detoxification Center: These services must be staffed 24-hours-per-day, seven-days-per-week by a licensed physician or by the designated representative of a licensed physician (ASAM LevelIII.7- D). 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 professionals in a hospital setting.

V. Residential Treatment

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 certified professional staff, including substance abuse specialists. Residential treatment must be staffed 24-hours-per-day. The clinical program must be provided under the supervision of a Substance Abuse Treatment Specialist with either full licensure or limited licensure as a psychologist, master's social worker, professional counselor, marriage and family therapist or physician. Services may be provided by a substance abuse treatment specialist or a non-degreed staff. This intensive therapeutic service is limited to those beneficiaries who, because of specific cognitive and behavioral impairments, need a safe and stable environment to benefit from treatment.

W. Access Timeliness Standards

Access timeliness requirements are the same as those to Medicaid substance use disorders services, as specified in the agreement between BPHASA and the PIHPs. Access must be expedited when appropriate, based on the presenting characteristics of individuals.

X. Admission Preference and Interim Services

The Code of Federal Regulations and the Michigan Public Health Code define priority population clients. The priority populations are identified as follows and in the order of importance:

1. Pregnant injecting drug user.
2. Pregnant.
3. Injecting drug user.
4. Parent at risk of losing their child(ren) due to substance use.
5. Any MDOC involved individual.

6. All others.

Y. <u>Admission Priority Requirements Chart</u>

The admission priority standard for each population along with the current interim service requirements and suggested services are outlined in **Attachment 1a: LRE SUD Provider Manual**.