STATEMENT OF WORK

Please note: Items in this Statement of Work have been placed into one of three categories: General; Administrative and Financial; and Services. This categorization is for convenience of reference only. It is not intended, and should not be interpreted, as limiting the applicability or scope of any item or items.

General

1. General Statement of Work

The general responsibilities of the coordinating agency (CA) under this Agreement, based on P.A. 368 of 1978, as amended, are to:

a. Develop comprehensive plans for substance abuse treatment and rehabilitation services and prevention services consistent with guidelines established by the Department.
b. Review and comment to the Department on applications for licenses submitted by local treatment, rehabilitation, and prevention organizations.
c. Provide technical assistance for local substance abuse service organizations.
d. Collect and transfer data and financial information from local organizations to the Department.
e. Submit an annual budget request to the Department for use of state administered funds for its city, county, or region for substance abuse treatments and rehabilitation services and prevention services in accordance with guidelines established by the Department.
f. Make contracts necessary and incidental to the performance of the Agency functions. The contracts may be made with public or private agencies, organizations, associations, and individuals to provide for substance abuse treatment and rehabilitation services and prevention services.
g. Annually evaluate and assess substance abuse services in the city, county, or region in accordance with guidelines established by the Department and federal goals.

2. Action Plan

The CA will carry out its responsibilities under this Agreement consistent with the CA's most recent Action Plan as approved by the Department.

3. Substance Abuse Prevention and Treatment (SAPT) Block Grant Requirements and Applicability to State Funds

Federal requirements deriving from Public Law 102-321, as amended by Public Law 106-310, and federal regulations in 45 CFR Part 96 are pass-through

requirements. Federal Substance Abuse Prevention and Treatment (SAPT) Block Grant requirements that are applicable to states are passed on to CAs unless otherwise specified.

42 CFR Parts 54 and 54a, and 45 CFR Parts 96, 260, and 1050, pertaining to the final rules for the Charitable Choice Provisions and Regulations, are applicable to CAs as stated elsewhere in this Agreement.

Sections from PL 102-321, as amended, that apply to CAs and contractors include but are not limited to: 1921(b); 1922 (a)(1)(2); 1922(b)(1)(2); 1923; 1923(a)(1) and (2), and 1923(b); 1924(a)(1)(A) and (B); 1924(c)(2)(A) and (B); 1927(a)(1) and (2), and 1927(b)(1); 1927(b)(2); 1928(b) and (c); 1929; 1931(a)(1)(A), (B), (C), (D), (E) and (F); 1932(b)(1); 1941; 1942(a); 1943(b); 1947(a)(1) and (2).

Selected specific requirements applicable to CAs are as follows:

a. Block Grant funds shall not be used to pay for inpatient hospital services except under condition specified in federal law.
b. Funds shall not be used to make cash payments to intended recipients of services.
c. 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.
d. 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.
e. Funds shall not be used to provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs.
f. Funds shall not be used to enforce state laws regarding the sale of tobacco products to individuals under the age of 18.
g. 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, or approximately $186,600.

SAPT Block Grant requirements also apply to the Michigan Department of Community Health (MDCH) administered state funds, unless a written exception is obtained from MDCH.

4. Staff Qualifications

TO BE DETERMINED

5. Licensure of Subcontractors

The CA shall enter into agreements for prevention and treatment services only with providers appropriately licensed for the service provided as required by Section 6231 of P.A. 368 of 1978, as amended.

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

6. Accreditation of Subcontractors

The CA shall enter into agreements for treatment services provided through outpatient, early intervention, Methadone, sub-acute detoxification and residential providers only with providers accredited by one of the following accrediting bodies: Joint Commission on Accreditation of Health Care Organizations (JCAHO); Commission on Accreditation of Rehabilitation Facilities (CARF); the American Osteopathic Association (AOA); Council on Accreditation of Services for Families and Children (COA); or National Committee on Quality Assurance (NCQA). The CA must determine compliance through review of original 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 CA or through an agreement with a CA 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 or recovery support services when these are provided through a prevention license.

If the CA plans to purchase case management services or recovery support services, and only these services, from an agency that is not accredited per this agreement, the CA may request a waiver of the accreditation requirement.

7. SAMHSA/DHHS License

The federal awarding agency, Substance Abuse and Mental Health Services Administration, Department of Health and Human Services (SAMHSA/DHHS), reserves a royalty-free, nonexclusive and irrevocable license to reproduce, publish or otherwise use, and to authorize others to use, for federal government purposes: (a) The copyright in any work developed under a grant, sub-grant, or contract under a grant or sub-grant; and (b) Any rights of copyright to which a grantee, sub-grantee or a contractor purchases ownership with grant support.

8. Cooperation with External Medicaid Evaluation

The CA is expected to cooperate with Department efforts in external evaluation of Medicaid services, if the CA administers Medicaid services. The CA is expected to ensure that CA-funded providers will provide necessary data and will facilitate access to individuals' files and other records as required.

9. Monitoring of Subcontractors

The CA is required to assure that subcontractors comply with all applicable requirements contained in this agreement. To this end, the CA must adopt written policy and must implement procedures regarding monitoring of subcontractors. The monitoring policy and procedures must be consistent with requirements in this agreement, with the current MDCH substance abuse audit guidelines, and with applicable federal Office of Management and Budget (OMB) circulars. The CA must prepare a report of monitoring findings, and must make this report available to the public at least biannually.

Part II of the agreement, section I.H on Sub-recipient/Vendor Monitoring, requires that contractors conduct monitoring and risk-based assessments of sub-recipients during the period of the agreement. The CA must conduct monitoring and risk-based assessments of all subcontractors, during the period of the agreement, including subcontractors that are vendors.

Administrative and Financial

1. Match Rules

Pursuant to Section 6213 of Public Act No. 368 of 1978, as amended, Michigan has promulgated match requirement rules. Rules 325.4151 through 325.4153 appear in the 1981 Annual Administrative Code Supplement. In brief, the rule defines allowable matching fund sources and states that the allowable match must equal at least ten percent of each comprehensive CA budget (see Attachment B to the Agreement) - less direct federal and other state funds. Match requirements apply both to budgeted funds during the agreement period and to actual expenditures at year-end.

"Fees and collections" as defined in the Rule include only those fees and collections that are associated with services paid for by the CA.

If the CA is found not to be in compliance with Match requirements, or cannot provide reasonable evidence of compliance, the Department may withhold payment or recover payment in an amount equal to the amount of the Match shortfall.

2. Reporting Fees and Collections Revenues

The CA is required to report on the Revenue and Expenditures Report (RER) all fees and collections revenue received by the CA and all fees and collections revenue received and reported by its contracted services providers (see Attachment B to this Agreement). "Fees and collections" are as defined in the Annual Administrative Code Supplement, Rule 325.4151 and in the Match Rule section of this Attachment.

3. Management of Department-Administered Funds

The CA shall manage all Department-administered funds under its control in such a way as to assure reasonable balance among the separate requirements for each funds source.

4. Sliding Fee Scale

The CA shall implement a sliding fee scale. All treatment providers shall utilize the scale. The CA must adopt written policies and implement procedures for determining when an individual has no ability to pay for services and for determining when payment liability is to be waived.

Financial information needed to determine ability to pay (financial responsibility) must be reviewed annually or at a change in an individual's financial status, whichever occurs sooner.

The CA sliding fee scale must be applied to all persons (except Medicaid, MIChild, and ABW recipients) seeking substance use disorders services funded in whole or in part by the CA. The CA has the option to charge fees for AMS services, or not to charge. If the CA charges for AMS services, the same sliding fee scale as applied to treatment services must be used.

The CA must assure that all available sources of payments are identified and applied prior to the use of Department-administered funds. The CA must have written policies and procedures to be used by network providers in determining an individual's ability to pay, and in identifying all other liable third parties. The CA must also have policies and procedures for monitoring providers and for sanctioning noncompliance.

5. Inability to Pay

Services may not be denied because of inability to pay. If a person's income falls within the CA's 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.

6. 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 disorders or substance dependence, admission or treatment for emergency medical conditions.

7. Residency in CA Region

The CA may not limit access to the programs and services funded by this Agreement only to the residents of the CA'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 AMS and/or treatment services, consistent with the requirements of this Agreement, regardless of their residency. However, for non-priority populations, the CA may give its residents priority in obtaining services funded under this Agreement when the actual demand for services by residents eligible for services under this Agreement exceeds the capacity of the programs funded under this Agreement.

8. Out-of- Network and Out-of-Region Services

The CA must have written policies and procedures for authorizing and purchasing treatment services from out-of-network and out-of-region providers for residents of the CA region who need care from such providers.

9. Reimbursement Rates for Community Grant, Medicaid and Other Services

The CA must pay the same rate when purchasing the same service from the same provider, regardless of whether the services are paid for by Community Grant funds, Medicaid funds, or other Department administered funds, including Adult Benefit Waiver (ABW) and MIChild funds.

10. Reimbursement for Primary Health Care with Communicable Diseases (CD) Funds

CD funds shall not be used to purchase primary health care unless the Department approves such use in writing.

11. Minimum Criteria for Reimbursing for Services to Persons with Co-Occurring Disorders

Department funds made available to the CA through this Agreement, and which are allowable for treatment services, may be used to reimburse providers for integrated mental health and substance use disorder treatment services (in addition to substance abuse treatment services) to persons with co-occurring substance use and mental health disorders.

The CA may reimburse a Community Mental Health Services Program (CMHSP) or Pre-paid Inpatient Health Plan (PIHP) for substance use disorders treatment services for such persons who are receiving mental health treatment services through the CMHSP or PIHP. The CA may also reimburse a provider, other than a CMHSP or PIHP, for substance use disorders treatment provided to persons with co-occurring substance use and mental health disorders. As always, when reimbursing for substance use disorders treatment, the CA must have an agreement with the CMHSP (or other provider); and the CMHSP (or other provider) must meet all minimum qualifications, including licensure, accreditation and data reporting.

12. 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 CA region are not considered to be media campaigns. Media campaigns must be compatible with MDCH values, be coordinated with MDCH campaigns whenever feasible and costs must be proportionate to likely outcomes. The CA shall not finance any media campaign using MDCH funding without preapproval by MDCH.

13. Notice of Funding Excess or Insufficiency

The CA must advise the Department in writing by May 1 if the amount of Department funding may not be used in its entirety or appears to be insufficient.

14. Subcontractor Information to be Retained at the CA

a. Budgeting Information for Each Service.

b. Documentation of How Fixed Unit Rates Were Established:
The CA 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 A-87 or A-122, whichever is applicable, and with the requirements of individual fund sources.

c. Indirect Cost Documentation:
The CA shall review subcontractor indirect cost documentation in accordance with OMB Circular A-87 or A-122, as applicable.

d. Equipment Inventories:
The CA must follow record keeping and reporting procedures, as indicated in Part I, 2.B., and in Attachment B to this Agreement.

e. Fidelity Bonding Documentation:
The CA shall maintain fidelity bonding documentation.

15. Reporting Requirements

a. General Requirements

Requirements concerning specific reports are contained elsewhere in the Agreement, including in Attachment C. The following requirements generally pertain to reports that are to be submitted to MDCH/ODCP:

1. Each report must be submitted by the specified due date. Reports successfully e-mailed or uploaded to the Electronic Grants Administration and Management System (EGrAMS) by the due date are considered timely.
2. Reports must be sent to the addressee and via the submission route (e.g., uploaded, e-mailed, etc.) specified in this Agreement. Reports that are not sent to the specified addressee are subject to being determined not timely or not received.
3. Reports must be submitted on the form and in the format specified in this Agreement (if form and format are specified).

b. Legislative Reports (LRs) and Final Financial Reports (RERs)

If the contractor does not submit the LR or the final RER within fifteen (15) calendar days of the due date, the Department may withhold from the current year funding an amount equal to five (5) percent of that funding (not to exceed $100,000) until the Department receives the required report. The Department may retain the amount withheld if the contractor is more than forty-five (45) calendar days delinquent in meeting the filing requirements.

c. Data Reporting Timeliness and Completeness Standards

MDCH monitors the timeliness of submission for all required reports. Reports that arrive after the established due date are recorded as late. If the submission arrives more than five (5) calendar days past due, a letter will be sent to the CA Director to notify the CA of the lack of compliance

with the published due date. Sanctions for noncompliance (depending on the severity and frequency) may include a requirement for a corrective action plan or may include an adjustment in prepayments.

For data transactions that are submitted via the Date Exchange Gateway (DEG), including admission, discharge, and encounter batches, the processing system logs the dates and times the batches were transferred and processed. When the system is in production, monthly submissions by the CAs are required. Data submissions are monitored daily by MDCH staff.

d. Data Completeness

The CA is responsible for submitting 100% of required records. Initial submissions combined with error corrections and resubmissions must result in an accuracy rate of 100%.

On the second business day of every calendar month, the Department will send to the CA an error rate or acceptance rate notification based on the number of errors in its error master file. This notification will serve as an advisory for both MDCH and the CA.

On or before April 30, the CA is required to submit a live count (e-mail transaction) from its information system noting the first six-month total counts of admissions, discharges, and encounters (by code). This is required for consultation purposes to identify whether the CA's submissions to MDCH show shortages compared to its local counts. The Department will notify the CA of its acceptance rate. If the CA's acceptance rates are less than 98% for admission/discharge data and less than 95% for encounters, the Department will notify the CA that improvement is needed.

On or before November 30, the CA is required to submit the full 12-month FY total counts of admissions, discharges, and encounters (by code). This will also be submitted via e-mail. MDCH will calculate and acceptance rate for all three, and generate a report back to the CA. Once the acceptance rates are returned, if the 98% (admissions and discharges) or 95% (encounters) acceptance thresholds are not met, out of compliance CAs will have until December 31 to meet the acceptance threshold.

The FY data sets will be finalized the first week of January, and shortages in admissions, discharges, and/or encounters will be reflected in all of MDCH's reports both to the public and to the legislature.

e. National Outcome Measures (NOMS)

The emergence of the NOMS increases the importance of the completeness, accuracy and timeliness of all treatment and prevention data that are necessary for ODCP to meet federal reporting requirements. Concerning the Treatment NOMS, it is the responsibility of the CA to ensure that the client information reported on these records accurately reflects client status at admission and on the last day of service.

f. Prevention Data Set

Beginning October 1, 2007, CAs are required to implement the collection of the state-required prevention data elements throughout the prevention provider network either through participation in the Prevention Data Set or through upload of the state-required prevention data records to the state system on a monthly basis. CAs are responsible for monitoring the accuracy of the reported data.

16. Critical Incidents and Sentinel Events

The CA must require all of its residential treatment providers to prepare and file critical incident reports and sentinel event reports that include the following components:

1. Provider determination whether critical incidents are sentinel events.

2. Following identification as a sentinel event, the provider must ensure that a root cause analysis or investigation takes place.

3. Based on the outcome of the analysis or investigation, the provider must ensure that a plan of action is developed and implemented to prevent further occurrence of the sentinel event. The plan must identify who is responsible for implementing the plan, and how implementation will be monitored. Alternatively, the provider may prepare a rationale for not pursuing a preventive plan.

The CA is responsible for oversight of the above processes.

Requirements for reporting data on Sentinel Events are contained in Attachment E. These reporting requirements are narrower in scope than the responsibility to identify and follow up on critical incidents and sentinel events.

A ***Critical Incident*** is any of the following that should be reviewed to determine whether it meets the criteria for a sentinel event below:

1. Death of a recipient.

2. Serious illness requiring admission to hospital.
3. Alleged cause of abuse or neglect.
4. Accident resulting in injury to recipient requiring emergency room visit or hospital admission.
5. Behavioral episode.
6. Arrest and/or conviction.
7. Medication error.

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

17. Claims Management System

The CA 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 CA 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 the CA is responsible for under this Agreement. It includes services authorized by the CA.

The CA must have a provider appeal process to promptly and fairly resolve provider-billing disputes.

18. Care Management

The CA may pay for care management as a service designed to support CA resource allocation as well as service utilization. Care management is in recognition that some clients represent such service or financial risk that closer monitoring of individual cases is warranted. Care management must be purchased and reported consistent with the instructions for the Administrative Expenditures Report in Attachment B to this agreement.

Services

1. General Services

a. 12-Month Availability of Services

The CA shall assure that, for any subcontracted treatment or prevention service, each subcontractor maintains service availability throughout the fiscal year for persons who do not have the ability to pay.

b. Persons Associated with the Corrections System

When the CA or its AMS services receives referrals from the Michigan Department of Corrections (MDOC), the CA shall handle such referrals as per all applicable requirements in this agreement. This would include determining financial and clinical eligibility, authorizing care as appropriate, applying admissions preferences, and other steps. MDOC referrals may come from probation or parole agents, or from MDOC Central Office staff.

When persons who are on parole or probation seek treatment on a voluntary basis from the CA's AMS services or from a panel provider, these self-referrals must be handled like any other self-referral to the MDCH-funded network. AMS or provider staff may seek to obtain releases to communicate with a person's probation or parole agent but in no instance may this be demanded as a condition for admission or continued stay.

The CA may collaborate with MDOC, and with the Office of Community Corrections (OCC) within MDOC, on the purchase of substance use disorders services and supports. This may include collaborative purchasing from the same providers, and for the same clients. In such situations, the CA must assure that:

1. All collaborative purchasing is supported by written agreements among the participants.
2. Rates paid to providers, whether by a single purchaser or two or more purchasers, do not exceed provider costs.
3. Rates paid to providers are documented and are developed consistent with applicable OMB Circular(s).
4. No duplication of payment occurs.

c. State Disability Assistance (SDA)

MDCH continues to allocate SDA funding and to delegate management of this funding to the CA. The SDA funding is identified in the CA's allocation letter. The CA is responsible for allocating these funds to qualified providers. Minimum provider qualifications are MDCH licensure as a residential treatment provider and accreditation by one of the five approved accreditation bodies (identified elsewhere in this Agreement). A provider may be located within the CA's region or outside of the region.

SDA funds shall not be used to pay for room and board in conjunction with sub-acute detoxification services.

When a client is determined to be eligible for SDA funding, the CA must arrange for assessment and authorization for SDA room and board funding and must reimburse for SDA expenditures based on billings from providers, consistent with CA/provider agreements. In addition, the CA may authorize such services for its own residents at providers within or outside its region.

The CA shall not refuse to authorize SDA funds for support of an individual's treatment solely on the basis of the individual's current or past involvement with the criminal justice system.

Qualified providers may be reimbursed up to twenty-four dollars ($24.00) per day for room and board costs for SDA-eligible persons during their stays in Residential treatment.

To be eligible for MDCH-administered SDA funding for room and board services in a substance use disorders treatment program, a person must be determined to meet Michigan Department of Human Services' (MDHS) eligibility criteria; determined by the CA or its designee to be in need of residential treatment services; authorized by the CA for residential treatment when the CA expects to reimburse the provider for the treatment; at least 18 years of age or an emancipated minor, and in residence in a residential treatment program each day that SDA payments are made.

The CA may employ either of two methods for determining whether an individual meets MDHS eligibility criteria:

1. The CA may refer the individual to the local MDHS office. This method must be employed when there is a desire to qualify the individual for an incidental allowance under the SDA program.

   Or,

2. The CA may make its own determination of eligibility by applying the essential MDHS eligibility criteria. See this DHS link for details: http://www.michigan.gov/dhs/0,1607,7-124-5453_5526---,00.html

   For present purposes only, these criteria are:

   - Residency in substance use disorders residential treatment.
   - Michigan residency and not receiving cash assistance from another state.

- U.S. citizenship or have an acceptable alien status.
- Asset limit of $3,000 (cash assets only are counted).

Regardless of the method used, the CA must retain documentation sufficient to justify determinations of eligibility.

The CA must have a written agreement with a provider in order to provide SDA funds.

d. Persons Involved With the Michigan Department of Human Services (MDHS)

The CA must work with the MDHS office(s) in its region to facilitate access to prevention, assessment and treatment services for persons involved with MDHS, including families in the child welfare system and public assistance recipients.

e. Primary Care Coordination

The CA must take all appropriate steps to assure that substance use disorders treatment services are coordinated with primary health care. In the case of CAs that are under contract with PIHPs for the Medicaid substance abuse program, CAs are reminded that coordination efforts must be consistent with these contracts.

Treatment case files must include, at 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 this waiver.

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

f. Cultural Competence

CA must have a written cultural competency plan implemented in practice at their agency and at all provider agencies. The plan must include:

1. The CA's identification and assessment of the cultural needs of potential and active clients based on population served.

2. The CA's identification of how access to services is facilitated for persons with diverse cultural backgrounds and Limited English Proficiency (LEP).

3. The CA's identification standards for the recruitment and hiring of culturally competent staff members.

4. The CA's identification of how ongoing staff training needs in cultural competency will be assessed and met and the evidence that staff members receive training.

5. The CA's process for ensuring that panel providers comply with all applicable requirements concerning the provision of culturally competent services.

6. The CA's process for annually assessing its compliance with the CA's cultural competence plan.

g. Charitable Choice

The September 30, 2003 Federal Register (45 CFR part 96) contains federal Charitable Choice SAPT block grant regulations, which apply to both prevention and treatment providers/programs. In summary, the regulations require: 1) that the designation of religious (or faith-based) organizations as such be based on the organization's self-identification as religious (or faith based), 2) that these organizations are eligible to participate as providers—e.g. a "level playing field" with regard to participating in the CA provider panel, 3) that a program beneficiary receiving services from such an organization who objects to the religious character of a program has a right to notice, referral, and alternative services which meet standards of timeliness, capacity, accessibility and equivalency—and ensuring contact to this alternative provider, and 4) other requirements, including-exclusion of inherently religious activities and non-discrimination.

The CA is required to comply with all applicable requirements of the Charitable Choice regulations. The CA must ensure that treatment clients and prevention service recipients are notified of their right to request alternative services. Notice may be provided by the AMS or by providers that are faith-based. Notification must be in the form of the model notice contained in the final regulations, or the CA may request written approval from MDCH of an equivalent notice.

The CA must also ensure that its AMS administer the processing of requests for alternative services.

The model notice contained in the federal regulations is:

"No provider of substance abuse services receiving Federal funds

from the U.S. Substance Abuse and Mental Health Services Administration, including this organization, may discriminate against you on the basis of religion, a religious belief, a refusal to hold a religious belief, or a refusal to actively participate in a religious practice.

If you object to the religious character of this organization, Federal law gives you the right to a referral to another provider of substance abuse services. The referral, and your receipt of alternative services, must occur within a reasonable period of time after you request them. The alternative provider must be accessible to you and have the capacity to provide substance abuse services. The services provided to you by the alternative provider must be of a value not less than the value of the services you would have received from this organization."

h. Americans with Disabilities Act

The CA and its 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).

i. Limited English Proficiency

The CAs must insure a current Limited English Proficiency (LEP) policy is in place and in practice. The CA must also have documentation that all providers have implemented the required LEP policy and procedures and are in compliance with related Federal and State requirements. The LEP policies and procedures must include the following, as required by the Office of Civil Rights.

1. Procedures for identifying and assessing the language needs of the CA, individual provider and the geographic area served. Needs must be based on current local and regional census data, as well as other state and regional data.

2. Identified range of oral language assistance options appropriate to the CAs circumstances.

3. How the CA provides notice to LEP persons, in their primary language, of the right to free language assistance.

4. What staff training and program monitoring is performed related to LEP policies and procedures.

5. Provisions for written materials in language other than English where a significant number or percentage of the affected population needs services or information in a language other than English, to communicate effectively.

6. Provisions for language interpreters who are trained and competent.

7. Statements explaining timely assistance.

8. Statements explaining there will be no charge to the LEP recipient for these services.

9. Provisions regarding use of family member and/or friend as a language interpreter must not be required. Should the consumer choose to use family or friend as an interpreter, both the offering of other resources, and the consumer's choice, must be documented in writing. Availability of consumer family and friends as translator/interpreter will not waive other LEP requirements herein described.

2. Treatment Services

a. Medical Necessity Criteria For Substance Use Disorders Supports And Services

The CA must assure that treatment service authorization and reauthorization decisions are consistent with the following Medical Necessity Criteria. These criteria are substantively the same as the applicable criteria for substance use disorders Medicaid services.

1.0 Medical Necessity Criteria

1.1 "Medically necessary" substance abuse services are supports, services, and treatment:
- 1.1.1 Necessary for screening and assessing the presence of substance use disorder; and/or
- 1.1.2 Required to identify and evaluate a substance use disorder; and/or
- 1.1.3 Intended to treat, ameliorate, diminish or stabilize the symptoms of a substance use disorder; and/or
- 1.1.4 Expected to arrest or delay the progression of a substance use disorder; and/or

1.1.5 Designed to assist the individual to attain or maintain a sufficient level of functioning in order to achieve his/her goals of community inclusion and participation, independence, recovery or productivity.

1.2 The determination of a medically necessary support, service or treatment must be:
- 1.2.1 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
- 1.2.2 Based on clinical information from the individual's primary care physician or clinicians with relevant qualifications who have evaluated the individual; and
- 1.2.3 Based on individualized treatment planning; and
- 1.2.4 Made by appropriately trained substance abuse professionals with sufficient clinical experience; and
- 1.2.5 Made within federal and state standards for timeliness; and
- 1.2.6 Sufficient in amount, scope and duration of the service(s) to reasonably achieve its/their purpose.

1.3 Supports, services and treatment authorized by the CA must be:
- 1.3.1 Delivered in accordance with federal and state standards for timeliness in a location that is accessible to the individual; and
- 1.3.2 Responsive to particular needs of multi-cultural populations and furnished in a culturally relevant manner; and
- 1.3.3 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
- 1.3.4 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.

1.4 Using criteria for medical necessity, a CA may:
- 1.4.1 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

1.4.2 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.

1.4.3 A CA may not deny 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 1.3.4 above, and that are provisional and subject to modification based on individual clinical needs and clinical progress.

b. Clinical Eligibility: DSM IV-TR 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 Diagnostic and Statistical Manual of Mental Disorders (DSM IV-TR). 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.

303.90	Alcohol Dependence
305.00	Alcohol Abuse
303.00	Alcohol Intoxication
291.80	Alcohol Withdrawal
304.40	Amphetamine Dependence
305.70	Amphetamine Abuse
292.89	Amphetamine Intoxication
292.00	Amphetamine Withdrawal
304.30	Cannabis Dependence
305.20	Cannabis Abuse
292.89	Cannabis Intoxication
304.20	Cocaine Dependence
305.60	Cocaine Abuse
292.89	Cocaine Intoxication
292.00	Cocaine Withdrawal

304.50	Hallucinogen Dependence
305.30	Hallucinogen Abuse
292.89	Hallucinogen Intoxication
304.60	Inhalant Dependence
305.90	Inhalant Abuse
292.89	Inhalant Intoxication
304.00	Opioid Dependence
305.50	Opioid Abuse
292.89	Opioid Intoxication
292.00	Opioid Withdrawal
304.60	Phencyclidine Dependence
305.90	Phencyclidine Abuse
292.89	Phencyclidine Intoxication
304.10	Sedative, Hypnotic, or Anxiolytic Dependence
305.40	Sedative, Hypnotic, or Anxiolytic Abuse
292.89	Sedative, Hypnotic, or Anxiolytic Intoxication
292.00	Sedative, Hypnotic, or Anxiolytic Withdrawal
304.90	Other (or Unknown) Substance Dependence
305.90	Other (or Unknown) Substance Abuse
292.89	Other (or Unknown) Substance Intoxication
292.00	Other (or Unknown) Substance Withdrawal

c. Outpatient Level of Care Continuum

TO BE DETERMINED

d. Satisfaction Surveys

The CA shall assure that all network subcontractors providing treatment conduct satisfaction surveys of persons receiving treatment at least once a year. Surveys may be conducted by individual providers or may be conducted centrally by the CA. 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. The CA must compile findings and results of client satisfaction surveys for all providers, and must make findings and results, by provider, available to the public.

e. MIChild

MIChild Covered Services

The CA must use its standardized assessment process, including the American Society of Addiction Medicine (ASAM) Patient Placement Criteria, to determine clinical eligibility for services based on medical necessity.

Substance use disorders services are covered when medically necessary as determined by the CA. This benefit should be construed the same as are medical benefits in a managed care program. Inpatient (hospital-based) services are covered, but the CA is permitted to substitute less costly services outside the hospital if they meet the medical needs of the patient. In the same way, the CA may substitute services for inpatient or residential services if they meet the child's needs and they are more cost effective.

Covered services are as follows:

1. Outpatient Treatment
2. Residential Treatment
3. Inpatient Treatment
4. Laboratory and Pharmacy

These benefits apply only when a CA's employed or contracted physician writes a prescription for pharmacy items or lab.

Eligibility

Eligible persons are persons of age 18 or less who are determined eligible for the MIChild program by the MDCH and enrolled by the Department's administrative vendor and live in the region covered by the CA. The CA is responsible for determining eligibility and for charging all authorized and allowable services to the MIChild program up to the CA's annual MIChild revenues.

Per Enrolled Child Per Month

Quarterly, MDCH will provide the CA with the federal share of MIChild funds as a per capita payment based upon a Per Enrolled Child Per Month (PECPM) methodology for MIChild covered services. Included with these funds will be an electronic copy of the names of the MIChild enrollees forming the basis of these calculations. In consideration for accepting the federal funding pushed to the CA, the CA agrees to redirect existing state general fund dollars to match the MIChild federal FMAP funds (Title XXI State Children's Health Insurance Program) and carry out the associated substance use disorders program requirements. The PEPCM rate is $0.47 (47 cents) per month. For the current fiscal year, the federal share is 70.67%, or approximately 33 cents per month, and the state share is 29.33%, or approximately 14 cents.

The PECPM funding is a per capita payment for medically necessary MIChild-covered services including outpatient, residential and inpatient

services as authorized by the CA. If the MIChild capitation is not sufficient to serve the MIChild enrollees, use of state-allocated Community Grant funds is allowed. Federal SAPT Block Grant funds may not be used for inpatient care.

Data Collection and Reporting

The CA must account separately for expenses related to MIChild enrollees. Reporting of MIChild revenues and expenditures will be through the Revenues and Expenditures Report as indicated in Attachment B to this Agreement. In the event that program costs are less than PECPM revenues, the CA may retain the balance as local funds.

Enrollees who receive substance use disorders services must be entered into the Substance abuse Statewide Client Data System following the instructions in the data reporting specifications.

For the required reporting of encounters for MIChild eligible clients, the CA will report these encounters via the 837 as follows:

2000B	Subscriber Hierarchical Level
SBR	Subscriber Information
SBR04	Insured Group Name: Use "MIChild" for the group name.

Access Timeliness

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

f. Adult Benefit Waiver

In consideration for accepting the federal funding pushed to the CA for the State Medical Program (SMP) eligible under an approved Health Insurance Flexibility and Accountability (HIFA) Adult Benefit Waiver (ABW), the CA agrees to redirect existing state general fund dollars to match the ABW federal FMAP funds (Title XXI State Children's Health Insurance Program) and carry out the associated substance use disorders program requirements. Program requirements are contained in this agreement and in the Department's Medicaid Provider Manual's chapter on Adult Benefits Waiver I, which is available at the Department's web site, www.michigan.gov/mdch. The ABW program is contingent on continued federal approval of the program.

The total ABW funding applied to program expenditures (federal plus general fund match) shall not exceed $3.80 per enrolled eligible member per month (PEPM). MDCH shall push the federal portion of the eligible amount to the CA (PEPM X $3.80 X .7067) based on program enrollment. MDCH will issue the payment for each month not later than the second Wednesday of that month. The amount of general fund dollars applied by the CA to program costs shall equal 29.33 percent of the total PEPM during the agreement period following the date of program initiation. In the event that program costs are less than the federal and state applicable match requirement amount, the CA shall retain the balance as local dollars. In the event that program costs are greater than the federal and state match amount, the CA may use other State Agreement funds budgeted for treatment in this Agreement. Use of these funds must be consistent with requirements pertaining to these other State Agreement funds.

ABW Covered and Discretionary Services

ABW covered and discretionary services, as contained in the Medicaid Provider Manual, are listed below.

Covered Services:

1. Initial assessment, diagnostic evaluation, referral and patient placement;
2. Outpatient Treatment;
3. Intensive Outpatient Treatment; and
4. Federal Food and Drug Administration (FDA) approved pharmacological supports for Methadone.

ABW Discretionary Services:

1. Other substance use disorders services may be provided, at the discretion of the CA, to enhance outcomes.

The CA is required to pay for medically necessary and requested covered services, within applicable benefit limitations, for the enrolled population in excess of the combined federal and applicable match funds. The CA may apply available SAPT Block Grant funds and state general funds to pay for ABW covered services when ABW funds (federal and state shares combined) have been exhausted.

The CA may also choose to pay for non-covered and discretionary services for ABW beneficiaries with other available funds. Any use of SAPT Block Grant and state general funds to pay for discretionary or non-

covered services must be consistent with provisions in this agreement that are applicable to these funds.

ABW beneficiaries who receive ABW covered services shall be treated according to all applicable requirements of the ABW program, regardless of source of funds for these services. ABW beneficiaries who receive ABW discretionary services shall be treated according to applicable ABW program requirements when the source of funds is ABW funds.

The CA may not charge fees or co-pays to ABW beneficiaries for covered services or for discretionary services purchased with ABW funds.

ABW funds may not be used to purchase care for persons who are residents in institutions for mental diseases (IMDs).

Access Timeliness

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

Appeals by ABW Enrollees

ABW beneficiaries must be provided written notice of right to appeal proposed denials, reductions, suspensions or terminations of covered services through the administrative hearing process, as described in All Provider Bulletin 03-10.

Encounter Data and Quality Improvement Data

Enrollees who receive substance use disorders services must be entered into the Substance abuse Statewide Client Data System following the coding instructions in the data reporting specifications.

For the required reporting of encounters for ABW Eligible clients, the CA will report these encounters via the 837 as follows:

2000B	Subscriber Hierarchical Level
SBR	Subscriber Information
SBR04	Insured Group Name: Use “ABW” for Adult Benefits Waiver.

The combined federal share and the GF match share amounts should be reported separately by using the Primary, Secondary, and Tertiary Payer guidelines under the 2000B Loop (Subscriber Hierarchical Loop SBR01 Data Element – Payer Responsibility Sequence Number Code). These

codes were covered at the Health Insurance Portability and Accountability Act (HIPAA) Readiness Seminars in 2003.

Revenue and Expenditures Reporting

Revenue and expenditures reporting requirements are contained in Attachment B to this Agreement.

Benefit Limits

This is a limited benefit program. Utilization control procedures consistent with best practice standards and the three criteria stated below must be used. The CA may provide or authorize ABW covered and discretionary services only when these services:

1. Meet the medical necessity criteria contained in this Agreement;
2. Are based on individualized determination of need; and
3. Meet the AMS service requirements contained in this Agreement, including a level of care determination based on an evaluation of the six assessment dimensions of the current ASAM Patient Placement Criteria.

The CA must assure that all persons admitted to treatment have an individualized treatment plan that emphasizes appropriate treatment and recovery.

The CA shall not discontinue or interrupt ABW services when ABW beneficiaries have been admitted to treatment, have exhausted their ABW benefit, and are financially and clinically eligible for continued treatment under the Community Grant program.

Initial Assessment, Diagnostic Evaluation, Referral and Patient Placement

The CA will perform a screening and when warranted by the screening results, the CA will perform an initial assessment and a diagnostic evaluation for ABW beneficiaries who meet medical necessity criteria. The CA will make referrals and/or patient placements based on individual need.

The CA may perform or pay for no more than one assessment for a beneficiary in any six-month period.

Outpatient Treatment

The CA may authorize up to 15 outpatient units in a twelve-month period based on medical necessity criteria, individualized determination of need, AMS service requirements, and best practice standards.

The CA may authorize additional units based on these same criteria plus:

1. The beneficiary's commitment to treatment based on participation and attendance;
2. Progress in meeting goals in the individualized treatment plan, and
3. Evidence that the beneficiary will benefit from additional units.

Intensive Outpatient Treatment

The CA may authorize up to 12 days in a twelve-month period based on Medical Necessity Criteria, individualized determination of need, AMS service requirements, and best practice standards.

The CA may authorize additional units based on these same criteria plus:

1. The beneficiary's commitment to treatment based on participation and attendance; and
2. Progress in meeting goals in the individualized treatment plan; and
3. Evidence that the beneficiary will benefit from additional units.

FDA Approved Pharmacological Supports for Methadone

The CA may authorize up to ninety (90) days of Methadone treatment based on medical necessity criteria, individualized determination of need, AMS service requirements, best practice standards, and the criteria, contained in this Agreement, for Opioid dependent substance use disorders treatment with Methadone (Treatment Policy #05 contained in Attachment E).

The CA may authorize additional treatment in increments of up to ninety (90) days each based on these same criteria.

g. Intensive Outpatient Treatment – Weekly Format

The CA 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.

h. Services for Pregnant Women, Women with Dependent Children, Women Attempting to Regain Custody and Their Children

The CA must assure that providers screen and/or assess pregnant women, women with dependent children, and women attempting to regain custody of their children to determine whether these women need and request the defined federal services that are listed below. All federally mandated services must be made available within each CA region.

Financial Requirements

The CA has been assigned an expenditure target for Women's Specialty Services in the CA's allocation letter. State general fund dollars and the state share of Medicaid dollars, as well as SAPT Block Grant dollars, can be counted toward the expenditure target. CAs must report on their RERs, in the Women's Specialty column, all allowable expenditures for Women's Specialty Services, and only allowable expenditures.

Encounter Reporting Requirements

TO BE DETERMINED

Requirements Regarding Providers

Women's Specialty Services may only be provided by providers that are gender-competent and that meet standard panel eligibility requirements. The provider may be designated by ODCP as Women's Specialty providers, but such designation is not required. The CA must continue to provide choice from a list of providers who offer gender competent treatment and identify providers that provide the additional services specified in the federal requirements.

Federal Requirements

Federal requirements are contained in 45 CRF (Part 96) section 96.124, and may be summarized as:

Treatment programs receiving funding from the Block Grant set aside for pregnant women and women with dependent children must *provide or arrange* for the following:

1. Primary medical care for women, including referral for prenatal care if pregnant, and while the women are receiving such treatment, child care;

2. Primary pediatric care for their children, including immunizations;

3. Gender specific substance use disorders 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;

4. 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; and

5. 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, including especially primary medical care, may be provided through the MDCH/CA agreement only when no other source of support is available and when no other source is financially responsible.

i. 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. All others.

Access timeliness standards and interim services requirements for these populations are provided in the next section.

j. 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 in italics:

Admission Priority Requirements

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 pre-natal care 3. *Early Intervention Clinical Services*	CFR 96.121; CFR 96.131; Treatment Policy #04 Recommended
Pregnant Substance Use Disorders	1) Screened and referred within 24 hours 2) Detoxification, Methadone or Residential – Offer admission within 24 business hours Other Levels or Care – Offer Admission within 48 Business hours	**Begin within 48 hours** 1. Counseling and education on: a) HIV and TB b) Risks of transmission to sexual partners and infants c) Effects of alcohol and drug use on the fetus 2. Referral for pre-natal care 3. *Early Intervention Clinical Services*	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 seven calendar days. Capacity to offer Admission within 14 days	**Begin within 48 business hours** *Early Intervention Clinical Services*	Michigan Public Health Code Section 6232 Recommended
All Others	Screened and referred within seven calendar days. Capacity to offer Admission within 14 days	**Not Required**	CFR 96.131(a) – sets the order of priority; ODCP and CA contract

k. Problem Gambling Screening and Referral Project *(applies only to agencies with allocations for this program)*

Implement the Problem Gambling Screening and Referral Project, utilizing funds made available through the Department to carryout the following requirements:

- Perform gambling prescreening of substance abuse clients in the coordinating agency's region. Those clients responding positive to the prescreening must be given the NORC DSM Screen for Gambling Problems (NODS). Those clients who score five (5) or more on the NODS must be referred to the Neighborhood Services Organization's Problem Gambling Help-line;

- Report project expenditures on the coordinating agency's quarterly Revenues and Expenditures Report (RER), utilizing one of the "OTHER" columns of the RER. Title the column "Gambling Screening and Referral Project." The coordinating agency may bill up to $16.50 for each screening. The coordinating agency's referral and administration costs are also included in this $16.50; and

- Submit monthly progress reports on the number of clients screened, the number of clients referred, and demographics and case management activities, utilizing the Problem Gambling Screening and Referral Project Report form. See Attachments C and E for further information.

3. Prevention Services

a. Prevention Requirements

Prevention funds may be used for needs assessment and related activities. All prevention services must be based on a formal local needs assessment.

The Department's intent is to move toward a community-based, consequence-driven model of prevention. In the meantime, based on needs assessment, prevention activities must be targeted to high-risk groups and must be directed to those at greatest risk of substance use disorders and/or most in need of services within these high-risk groups. CAs are not required to implement prevention programming for all high-risk groups. The CA may also provide targeted prevention services to the general population.

The high risk subgroups include but are not limited to: children of substance abusers; pregnant women/teens; drop-outs; violent and delinquent youth; persons with mental health problems; economically

disadvantaged citizens; persons who are disabled; victims of abuse; persons already using substances; and homeless and/or runaway youth. Additionally, children exposed prenatally to ATOD are identified as a high-risk subgroup.

Prevention services must be provided through strategies identified by CSAP**.** These strategies are: information dissemination; education; alternatives; problem identification and referral; community based processes; and environmental change.

Prevention-related funding limitations the CA must adhere to are: 1) A maximum of 35% of prevention funding may be used for school based activities as part of the usual school day, 2) CA expenditure requirements for prevention, including Synar, as stipulated in the CA's allocation letter, 3) 90% of prevention expenditures are expected to be directed to programs which are implemented as a result of an evidence-based decision making process, 4) Alternative strategy activities, if provided must reflect evidence-based approaches and best practices such as multi-generational and adult to youth mentoring, and 5) state-administered funds used for information dissemination must be part of a multi-faceted regional prevention strategy, rather than independent, stand-alone activity.

The CA must monitor and evaluate prevention programs at least annually to determine if the program outcomes, milestones and other indicators are achieved, as well as compliance with state and federal requirements. Indicators may include integrity to prevention best practice models including those related to planning prevention interventions such as risk/protective factor assessment, community assets/resource assessment, levels of community support, evaluation, etc. A written monitoring procedure, which includes requirements for corrective action plans to address issues of concern with a provider, is required.

b. Strategic Prevention Framework/State Incentive Grant (SPF/SIG) Prevention Project

The CA's use of SPF/SIG funds is governed by terms and conditions of the SPF/SIG Notice of Award and all applicable requirements in the MDCH/CA contract agreement.