OVERSIGHT POLICY BOARD

Regular Board Meeting

Patrick Barrie Conference Room
3005 Boardwalk Drive, Suite 200
Ann Arbor, MI
Thursday, July 28, 2022
9:30 a.m. – 11:30 a.m.

To Join by Phone:
1-312-626-6799; 1-646-876-9923; or
1-346-248-7799
Meeting ID: 133 461 219

To Join by Computer:
https://us02web.zoom.us/j/133461219
Passcode: 513544

Agenda

1. Introductions, Welcome Board Members & Review Open Meetings Act Procedures– 10 minutes
2. Approval of Agenda **(Board Action)** – 2 minutes
3. Approval of May 26, 2022 OPB Minutes {Att. #1} **(Board Action)** – 5 minutes
4. Audience Participation – 3 minutes per person
5. Old Business
   a. Finance Report {Att. #2} (Discussion) – 10 minutes
   b. FY22 Block Grant Spending Trends (Discussion) – 10 minutes
   c. FY23 RFI Responses and Funding Update {Att. #3} (Discussion) – 40 minutes
6. New Business
   a. Policy Updates (Board Approval) – 15 minutes
      1. Integrated Community Housing {Att. #4a, 4b}
      2. Medication Assisted Treatment – Methadone {Att. #4c, 4d}
      3. Medication Assisted Treatment – Buprenorphine/Suboxone {Att. #4e, 4f}
      4. SUD Residential Room and Board – State Disability Assistance (SDA) {Att. #4g, 4h}
   b. SUD Access Update (Discussion) – 15 minutes
   c. OPB Membership Update (Discussion) – 5 minutes
7. Report from Regional Board (Discussion) {Att. #5} – 5 minutes
8. SUD Director Updates (Discussion) – 5 minutes
   a. CEO Update {Att. #6}
   b. Staffing Update
   c. Back to office plans
9. Adjournment **(Board Action)**

***Next meeting: Thursday, August 25, 2022**
Location: 3005 Boardwalk, Suite 200; Patrick Barrie Room

Oversight Policy Board Minutes
May 26, 2022
Patrick Barrie Conference Room
3005 Boardwalk Drive, Suite 200
Ann Arbor, MI 48108

Members Present:	Mark Cochran, Kim Comerzan (remote), James Goetz, Ricky Jefferson, Dianne McCormick, Molly Welch Marahar, Dave Oblak (remote), Dave O'Dell, Monique Uzelac, Tom Waldecker
Members Absent:	Amy Fullerton, Susan Longsworth, Frank Nagle, Carol Reader, Ralph Tillotson
Guests:	
Staff Present:	Stephannie Weary, James Colaianne, Nicole Adelman, Matt Berg, CJ Witherow, Alyssa Tumolo, Rebecca DuBois, Danielle Brunk, Jessica Sahutoglu, Joelen Kersten, Kate Hendricks, Jessica Sahutoglu, Joelen Kersten, Jackie Bradley (Lenawee)

Board Chair M. Cochran called the meeting to order at 9:45 a.m.

1. Introductions

2. Approval of the Agenda
   Motion by M. Uzelac, supported by D. McCormick, to approve the agenda
   Motion carried

   Agenda Revisions:
   - Switch the order Old Business items PA2/Block Grant Spending Plan and FY22 ARPA Funding Update.
   - Move SUD Dashboard update to the first spot in New Business.
   - Add Overdose Education and Naloxone Report topic to New Business.

3. Approval of the February 24, 2022 Oversight Policy Board minutes
   Motion by T. Waldecker, supported by J. Goetz, to approve the February 24, 2022 OPB minutes
   Motion carried

4. Audience Participation

5. Old Business
   a. Finance Report
      - M. Berg presented.
   b. PA2/Block Grant Spending Plan FY23
      - FY23 will be a continuation year, staff will review existing programs and how they're performing, in conjunction with how much is available to spend. N. Adelman will send a communication to providers advising of the plan to request an RFI. The RFI will be sent within the next 2 weeks.
   c. FY22 American Rescue Plan Act Funding Update
      - Nicole provided an overview of the programs that are being funded with FY22 ARPA
6. New Business
   a. SUD Dashboard Update

- OPB reviewed the quarterly dashboard report, provided feedback on how they would like to see the information going forward, including showing comparison data between quarters.

b. Overdose Education and Naloxone Distribution (OEND) Update
   - Staff will provider mid-year and year-end reports going forward.
   - Staff no longer collects data indicating use by community lay person or law enforcement as it proved very difficult to collect.

c. Strategic Initiatives Mid-Year Update
   - The mid-year report provides an update of how programs are doing. This data will help to inform the FY23 continued funding decisions that will be made later this year.

d. SUD and CMHPSM Strategic Plan Updates
   - The Strategic Plan is on track.

e. Request for PA2 Funds for Livingston
   - An FY21 payment was missed. There are now reports in place now to avoid this. Funds were allocated, just weren't received.

   Motion by J. Goetz, supported by M. Welch Marahar, to approve $10,766 in FY22 PA2 funds to Livingston County Community Mental Health Authority for the Livingston Women's Specialty Services (WSS) Program for an outstanding FY21 invoice
   Motion carried

f. Opioid Settlement Funds
   - The PIHP has been reaching out to the local municipalities in our region who have received an allocation to make sure the funds are used. Funds should be used for opioid abatement.
   - N. Adelman will provide the OPB with the total amount awarded to the region.
   - M. Cochran requested an informational flyer that OPB members can share locally.

g. Mini Grant Request
   - N. Adelman provided an overview of the mini grant request from Unified HIV Health and Beyond that was recently approved to provide fentanyl testing strips to the region upon request.

7. Report from Regional Board
   - The Regional Board received the annual presentation from the organization's auditor.
   - The Regional Board approved a 5-year contract for the CEO following a largely positive annual performance review.
   - The Regional board discussed attendance, which has been a barrier. The Regional Board decided to amend the policy attached to the bylaws to indicate that participation means in-person.

8. SUD Director Updates
   a. CEO Update
      - N. Adelman provided updates from the CEO update, details of which can be found in the document in the packet.
   b. Staffing Update

- The PIHP added a second SUD Utilization and Treatment Specialist to the SUD team and has filled the position.

c. SOR I Report
   - Summary and highlights are in packet. Staff can send the full report via email if anyone wants.

d. Back to Office Plans
   - The PIHP has backed off the 5/30/22 full reopening plan since Washtenaw County is back on high alert re: COVID.

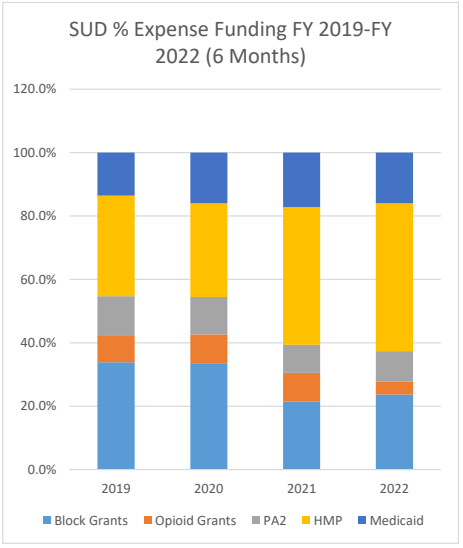
9. Adjournment
   Motion by M. Welch Marahar, supported by J. Goetz, to adjourn the meeting
   Motion carried

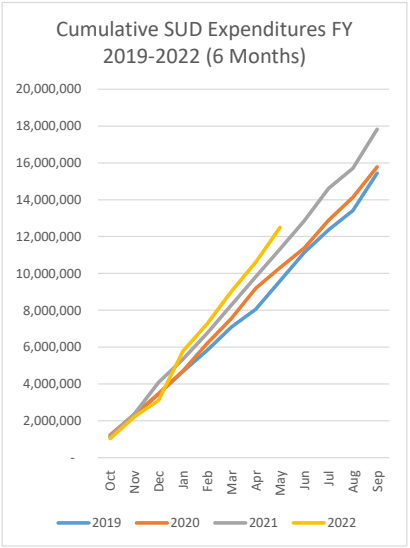
   - Meeting adjourned at 11:10 a.m.

***Next meeting: Thursday, June 23, 2022**
Location 3005 Boardwalk, Suite 200; Patrick Barrie Room

Community Mental Health Partnership Of Southeast Michigan
SUD SUMMARY OF REVENUE AND EXPENSE BY FUND
May 2022 FYTD

Summary Of Revenue & Expense	Funding Source							Total Funding Sources	FY21 YTD
	Medicaid	Healthy Michigan	Block Grants	OHH	Opioid Grants	Gambling Prev	SUD-PA2		
Revenues									
Funding From MDHHS	2,414,741	7,047,622	3,574,179	106,064	627,191	47,132		**$ 13,816,929**	$ 11,925,460
PA2/COBO Tax Funding Current Year							941,893	**$ 941,893**	$ 824,240
PA2/COBO Reserve Utilization							497,074	**$ 497,074**	$ 813,288
Other (transfer to ISF)			-		-	-	-	**$ -**	
Total Revenues	**$ 2,414,741**	**$ 7,047,622**	**$ 3,574,179**	**$ 106,064**	**$ 627,191**	**$ 47,132**	**$ 1,438,967**	**$ 15,255,895**	$ 13,562,988
Expenses									
Funding for County SUD Programs									
CMHPSM			$ 71,084	$ 34,406	$ 627,191	$ 47,132		**779,813**	1,232,788
Lenawee	260,840	684,720	436,882				$ 179,724	**1,562,166**	1,489,831
Livingston	146,584	493,768	586,806				290,566	**1,517,724**	1,449,122
Monroe	372,049	865,395	1,064,099				290,488	**2,592,031**	2,000,120
Washtenaw	725,576	2,433,948	1,255,264				678,189	**5,092,976**	4,276,523
Total SUD Expenses	$ 1,505,050	$ 4,477,831	$ 3,414,133	$ 34,406	$ 627,191	$ 47,132	$ 1,438,967	**$ 11,544,709**	$ 10,448,384
Administrative Cost Allocation	201,995	568,326	160,046	21,213			-	**$ 951,580**	$ 877,542
Total Expenses	**1,707,045**	**5,046,157**	**$ 3,574,179**	**$ 55,619**	**$ 627,191**	**$ 47,132**	**$ 1,438,967**	**$ 12,496,290**	$ 11,325,926
Revenues Over/(Under) Expenses	**707,696.85**	**2,001,465**	**(0)**	**50,445**	**$ (0)**	**$ -**	**(0)**	**$ 2,759,606**	$ 2,237,062





FY 2022 PA2 Current Expenses and Budget

	Revenues	Expenditures	Revenues Over/(Under) Expenses
PA2 by County			
Lenawee	79,438	179,724	(100,287)
Livingston	241,609	290,566	(48,957)
Monroe	179,846	290,488	(110,642)
Washtenaw	441,001	678,189	(237,188)
Totals	$ 941,893	$ 1,438,967	$ (497,074)

Unallocated PA2	FY 22 Beginning Balance (Prelim)	FY22 Budgeted Utilization	FY22 Projected Ending Balance	FY 21 YE Over/(Under) Expenses
Lenawee	524,050	(347,226)	176,824	(199,668)
Livingston	3,741,037	(198,708)	3,542,328	93,773
Monroe	303,906	(69,131)	234,775	(125,039)
Washtenaw	1,621,374	(599,327)	1,022,048	(418,078)
Total	$ 6,190,367	$ (1,214,391)	$ 4,975,976	$ (649,012)

FY23 Funding Sample Scenario and Estimates

OVERVIEW	FY22 Funding	FY23 RFI requests
Lenawee	$ 894,029	$ 940,336
Livingston	$ 1,388,000	$ 1,562,100
Monroe	$ 2,458,262	$ 2,494,524
Washtenaw	$ 2,293,167	$ 2,329,130
Regional	$ 720,105	$ 805,498
Total	$ 7,753,563	$ 8,131,588

This table shows how much funding providers received through SOR, BG, COVID BG, PA2 and ARPA in FY22. It also shows how much continuation funding was requested through the RFI process.

PA2	FY23 estimated available	Draft RFI Allocation	FY23 Year End Estimate
Len	$ 328,634	$ 201,562	$ 127,072
Liv	$ 4,004,054	$ 954,318	$ 3,049,736
Mon	$ 578,469	$ 354,917	$ 223,552
Wash	$ 1,077,548	$ 883,314	$ 194,234

This table shows how much PA2 is estimated to be available at the start of FY23. It is based on the *estimated* FY22 year end, as well as the *estimated* FY23 revenue (based on FY22 revenue). It shows a draft RFI allocation if most of what is expected from the state is received, and if most of what is requested is funded. The final column shows the *estimated* year end reserve before any FY24 revenue is received.

Treatment Block Grant	MDHHS Estimated Allocation	FFS, Admin Allocation Estimate	Programs Allocation Estimate
FY23 Tx	$ 1,732,683	$ 1,132,683	$ 600,000
FY23 Prev	$ 679,000	$ 84,870	$ 594,130
FY22 Tx	$ 1,732,683	$ 882,683	$ 850,000
FY22 Prev	$ 679,000	$ 96,427	$ 582,573
Total	$ 4,823,366	$ 2,196,663	$ 2,626,703

This table shows the expected allocation for Block Grant Treatment funds from MDHHS. It is expected to be the same as last year, however, Block Grant FFS funds are estimated to have increased significantly this year. This will continue to be watched closely, as the amount of funds available for programs could change (increase or decrease). Prevention BG is expected to remain mostly level from FY22 to FY23.

Community Mental Health Partnership of Southeast Michigan/PIHP	*Policy* *Integrated Community Housing*
Department: SUD Services	**Regional Operations Committee Review Date** **06/27/2022**
Implementation Date **(1st of month following approval)**	**Oversight Policy Board Approval Date**

I. PURPOSE

To ensure consistency across the region in meeting standards of good clinical practice in respecting and supporting the housing preferences and choices of people with severe and persistent mental illness, developmental disabilities, and substance use disorders (SUD) while fulfilling the mandates of the ADA with respect to community integration.

II. REVISION HISTORY

DATE	MODIFICATION
2014	New policy, written to meet the requirements of the Application for Participation.
Will be the OPB approval	Added Reference

III. APPLICATION

This policy applies to all staff, students, volunteers, and contractual organizations within the provider network of the Community Mental Health Partnership of Southeast Michigan (CMHPSM).

IV. POLICY

The CMHPSM recognizes housing to be a basic need and affirms the right of all consumers of public behavioral health services to pursue housing options of their choice. The CMHPSM, in its contract arrangements with the Regional Partner CMHSPs, shall foster the provision of services and supports independent of where the consumer lives. This policy is not intended to subvert or prohibit occupancy in or participation with community-based treatment settings such as an adult foster care home when needed by an individual recipient.

V. DEFINITIONS

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

Habitable and Safe: Housing standards established in each community that define and require basic conditions for tenant/resident health, security, and safety.

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

Community Mental Health Partnership of Southeast Michigan (CMHPSM): The Regional Entity that serves as the PIHP for Lenawee, Livingston, Monroe and Washtenaw for mental health, developmental disabilities, and substance use disorder services.

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

Regional Entity: The entity established under section 204b of the Michigan Mental Health Code to provide specialty services and supports.

VI. STANDARDS

A. Using Person Centered Planning processes, staff of the CMHSP shall educate consumers about housing options and supports available, and shall assist consumers in locating habitable, safe and affordable housing. The Person-Centered Planning process shall provide for ongoing assessment of the consumer's housing needs.

B. The process of locating suitable housing shall be directed by the consumer's interests, involvement, and informed choice. The process shall be sensitive to the consumer's cultural and ethnic preferences and give consideration to them.

C. Housing choices shall encourage and support the consumer's self-sufficiency. Staff shall provide assistance to consumers in coordinating available resources to meet their basic needs. CMHSPs may give consideration to the use of housing subsidies when consumers have a need for housing that cannot be met by the other resources which are available to them.

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

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

F. Housing arranged or subsidized by the CMHSPs shall be accessible to the

consumer and in compliance with applicable state and local standards for occupancy, health and safety.

G. Independent housing arrangements in which the cost of housing is subsidized by the CMHSP are to be secured with a lease or deed in the consumer's name or that of his or her legal representative.

H. Home and Community Based Services (HCBS) are types of person-centered care delivered in the home and community. This program addresses the needs of people with functional limitations who need assistance with everyday activities. The program is designed to enable people to stay in their own home environment.

VI. EXHIBITS

None

VII. REFERENCES

Medicaid Managed Specialty Supports and Services Concurrent 1915(b)(c) Waiver Program, FY 13: Attachment P6.8.2.2, HOUSING PRACTICE GUIDELINE

Person Centered Planning Policy, a PIHP Policy for the Community Mental Health Partnership of Southeastern Michigan.

US Centers for Medicare & Medicaid Services, *Home-and Community-Based Services.* *https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/LTSS-TA-Center/info/hcbs.* (2021, December 1).

COMMUNITY MENTAL HEALTH PARTNERSHIP OF SOUTHEAST MICHIGAN/PIHP	***Policy*** ***Integrated Community Housing***
Department: **Author:**	**Local Policy Number (if used)**
Approval Date **5/5/14**	**Implementation Date** **5/12/14**

I. PURPOSE

To ensure consistency across the region in meeting standards of good clinical practice in respecting and supporting the housing preferences and choices of people with severe and persistent mental illness, developmental disabilities, and substance use disorders (SUD) while fulfilling the mandates of the ADA with respect to community integration.

II. REVISION HISTORY

DATE	REV. NO.	MODIFICATION
2014		New policy, written to meet the requirements of the Application for Participation.
2/2022		Added Reference

III. APPLICATION

This policy applies to all staff, students, volunteers and contractual organizations within the provider network of the Community Mental Health Partnership of Southeast Michigan (CMHPSM).

IV. POLICY

The CMHPSM recognizes housing to be a basic need and affirms the right of all consumers of public behavioral health services to pursue housing options of their choice. The CMHPSM, in its contract arrangements with the Regional Partner CMHSPs, shall foster the provision of services and supports independent of where the consumer lives. This policy is not intended to subvert or prohibit occupancy in or participation with community based treatment settings such as an adult foster care home when needed by an individual recipient.

V. DEFINITIONS

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

Habitable and Safe: Housing standards established in each community that define and require basic conditions for tenant/resident health, security and safety.

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

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Regional Entity: The entity established under section 204b of the Michigan Mental Health Code to provide specialty services and supports.

VI. STANDARDS

A. Using Person Centered Planning processes, staff of the CMHSP shall educate consumers about housing options and supports available, and shall assist consumers in locating habitable, safe and affordable housing. The Person Centered Planning process shall provide for ongoing assessment of the consumer's housing needs.

B. The process of locating suitable housing shall be directed by the consumer's interests, involvement, and informed choice. The process shall be sensitive to the consumer's cultural and ethnic preferences and give consideration to them.

C. Housing choices shall encourage and support the consumer's self-sufficiency. Staff shall provide assistance to consumers in coordinating available resources to meet their basic needs. CMHSPs may give consideration to the use of housing subsidies when consumers have a need for housing that cannot be met by the other resources which are available to them.

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

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

F. Housing arranged or subsidized by the CMHSPs shall be accessible to the

consumer and in compliance with applicable state and local standards for occupancy, health and safety.

G. Independent housing arrangements in which the cost of housing is subsidized by the CMHSP are to be secured with a lease or deed in the consumer's name or that of his or her legal representative.

H. Home and Community Based Services (HCBS) are types of person-centered care delivered in the home and community. This program addresses the needs of people with functional limitations who need assistance with everyday activities. The program is designed to enable people to stay in their own home enviroment.

VI. EXHIBITS

None

VII. REFERENCES

Medicaid Managed Specialty Supports and Services Concurrent 1915(b)(c) Waiver Program, FY 13: Attachment P6.8.2.2, HOUSING PRACTICE GUIDELINE

Person Centered Planning Policy, a PIHP Policy for the Community Mental Health Partnership of Southeastern Michigan.

US Centers for Medicare & Medicaid Services, *Home-and Community-Based Services. https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/LTSS-TA-Center/info/hcbs.* (2021, December 1).

Community Mental Health Partnership of Southeast Michigan/PIHP	***Policy*** **Medication Assisted Treatment – Methadone**
Department: SUD Services	**Regional Operations Committee Review Date 06/27/2022**
Implementation Date (1st of month following approval)	**Oversight Policy Board Approval Date**

I. PURPOSE

To have a uniform policy and procedure for all CMHPSM funded individuals requesting Methadone as their Opioid Replacement Therapy (ORT) as a pharmacological support in Opioid Treatment Programs (OTPs) that meets required MDHHS Enrollment Criteria for Methadone Maintenance and Detoxification Programs.

II. REVISION HISTORY

DATE	MODIFICATION
March 2012	
July 2016	Update language, replaces Methadone policy
June 2021	Update language
December 2021	Update language/add suggestions
Will be OPB approval date	Updated language; separation into Methadone specific policy

III. APPLICATION

This policy applies to any individual requesting Medication Assisted Treatment (MAT) to include Methadone as a pharmacological support; Opioid Treatment Program (OTP) Providers; and Utilization Review Staff.

IV. DEFINITIONS

Community Mental Health Partnership of Southeast Michigan (CMHPSM): The Regional Entity that serves as the PIHP for Lenawee, Livingston, Monroe and Washtenaw for mental health, developmental disabilities, and substance use disorder services.

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

Regional Entity: The entity established under section 204b of the Michigan Mental Health Code to provide specialty services and supports.
CRCT INFORMATION MANAGEMENT SYSTEM**:** The CMHPSM's web-based information management system for interfacing with providers; Access and Utilization Management, Finance and medical records

MEDICAL DIRECTOR/DESIGNEE: The Medical Director/Designee of the CMHPSM may designate a consulting physician with additional expertise to assist with concurrent review determinations in questionable Methadone cases

MEDICAID MEDICAL NECESSITY REQUIREMENT: The Medicaid Provider Manual lists the medical necessity requirements that shall be used to determine the need for Methadone as an adjunct treatment and recovery service. The Medicaid- covered substance use disorder benefit for Methadone services includes the provision and administration of Methadone, nursing services, physician encounters, physical examinations, lab tests (including initial blood work, toxicology screening, and pregnancy tests) and physician-ordered TB skin tests. The medical necessity requirements and services also apply to all non-Medicaid covered individuals.

MEDICATION ASSISTED TREATMENT (MAT)/MEDICATIONS FOR OPIOID USE DISORDER (MOUD) – These terms refer to medications used to treat Opioid Use Disorder (OUD). They are most commonly referred to as MAT, MOUD is a newer term being used to replace MAT in cases when OUD is the primary diagnosis. Naltrexone can also be used to for treatment of Alcohol Use Disorder (AUD).

METHADONE: Methadone Use in Medication-Assisted Treatment and Recovery: Methadone is an opioid medication used in the treatment and recovery of opioid dependence to prevent withdrawal symptoms and opioid cravings, while blocking the euphoric effects of opioid drugs. In doing so, Methadone stabilizes the individual so that other components of the treatment and recovery experience, such as treatment and case management, are maximized in order to enable the individual to reacquire life skills and maintain recovery. Methadone is not a medication for the treatment and recovery from non-opioid drugs.

MAPS REPORT: Michigan Automated Prescription System- under the Michigan Licensing and Regulatory Affairs, the MAPS system monitors all schedule 2-5 medications prescribed and dispensed in the state in order to identify and prevent diversion at the prescriber, pharmacy and patient levels.

OPIOID TREATMENT PROGRAM: Opioid Treatment Programs (OTPs) are certified by the federal Substance Abuse and Mental Health Services Administration (SAMHSA). An OTP using Methadone for the treatment of opioid dependency must be:

1) Licensed by the state as a Methadone provider,
2) Accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF), the Council on Accreditation (COA) or the Joint Commission on Accreditation of Healthcare Organizations (JCAHO),
3) Certified by the SAMHSA as an OTP and
4) Registered by the Drug Enforcement Administration (DEA).
5) Approved by State Opioid Treatment Authority (SOTA)
6) Must comply with the following codes, regulations and manuals:

- ***Methadone Treatment and Other Chemotherapy****,* Michigan Administrative Code, Rule 324, 14401-325, 14423.
- ***Certification of Opioid Treatment Programs***, U.S. Code of Federal Regulations, 42 CFR Part 8
- ***Michigan Medicaid Provider Manual***

Methadone treatment is well established as an effective and safe approach to controlling Opioid Use Disorder (OUD). Properly prescribed Methadone is not intoxicating or

sedating, and its effects do not interfere with ordinary activities such as driving a car. The medication is taken orally and it suppresses narcotic withdrawal for 24 to 36 hours.

V. POLICY

All individuals requesting Methadone Treatment for Opioid Use Disorder are evaluated under state and federal guidelines and must meet ASAM and medical necessity criteria for initial and continuing care. It is the expectation that the course of Opioid Replacement Therapy (ORT) be completed when medically necessary. A titration protocol may be attempted which would be driven by the individualized treatment plan. Some individuals with substance use disorder may have an extended need for Methadone or other MOUD.

VI. BACKGROUND

Methadone Use in Medication-Assisted Treatment and Recovery
Methadone is an opioid medication used in the treatment and recovery of Opioid Use Disorder (OUD) to prevent withdrawal symptoms and opioid cravings, while blocking the euphoric effects of opioid drugs. In doing so, Methadone stabilizes the individual so that other components of the treatment and recovery experience, such as counseling and case management, are maximized in order to enable the individual to reacquire life skills and recovery. Methadone is not a medication for the treatment and recovery from non-opioid drugs.

The Medicaid Provider Manual lists the medical necessity requirements that shall be used to determine the need for Methadone as an adjunct treatment and recovery service. The Medicaid-covered substance use disorder benefit for Methadone services includes the provision and administration of Methadone, nursing services, physician encounters, physical examinations, lab tests (including initial blood work, toxicology screening, and pregnancy tests) and physician-ordered tuberculosis (TB) skin tests. The medical necessity requirements and services also apply to all non-Medicaid covered individuals.

Consistent with good public health efforts among high-risk populations, and after consultation with the local health department, an OTP may offer Hepatitis A and B, as well as other adult immunizations and communicable disease testing recommended by the health department, or they should refer the individual to an appropriate health care provider. Smoking cessation classes or referrals to local community resources may also be made available.

Consistent with good public health efforts among high-risk populations, and after consultation with the local health department, an OTP may offer Hepatitis A and B, as well as other adult immunizations recommended Medicaid Managed Specialty Supports and Services Program FY20 Attachment PII.B.A by the health department, or they should refer the individual to an appropriate health care provider. Smoking cessation classes or referrals to local community resources may also be made available.

The American Society of Addiction Medicine (ASAM) Level of Care (LOC 2-R) indicated for individuals receiving Methadone is usually outpatient. The severity of the opioid dependency and the medical need for Methadone should not be diminished because Medication Assisted Treatment has been classified as outpatient. Treatment services should be conducted by the OTP that is providing the Methadone whenever possible

and appropriate. When the ASAM LOC is not outpatient or when a specialized service is needed, separate service locations for Methadone dosing and other substance use disorder services are acceptable, as long as coordinated care is present and documented in the individual's record.

If Methadone is to be self-administered off site of the OTP, off-site dosing must be in compliance with the current Michigan Department of Health and Human Services (MDHHS) ***Treatment Policy #4: Off- Site Dosing Requirements for Medication-Assisted Treatment***. This includes Sunday and holiday doses for those individuals not deemed to be responsible for managing take-home doses.

All six dimensions of the ASAM patient placement criteria must be addressed:

1. Acute intoxication and/or withdrawal potential.
2. Biomedical conditions and complications.
3. Emotional/behavioral conditions and complications (e.g., psychiatric conditions, psychological or emotional/behavioral complications of known or unknown origin, poor impulse control, changes in mental status, or transient neuropsychiatric complications).
4. Treatment acceptance/resistance.
5. Relapse/continued use potential.
6. Recovery/living environment.

In using these dimensions, the strengths and supports, or recovery capital of the individual will be a major factor in assisting with the design of the individualized treatment and recovery plan.

CASE MANAGEMENT WITH ORT:

In many situations, case management or care coordination services may be needed by individuals to further support the recovery process. These services can link the individual to other recovery supports within the community such as medical care, mental health services, educational or vocational assistance, housing, food, parenting, legal assistance, and self-help groups. Documentation of such referrals and follow up must be in the treatment plan(s) and progress notes within the individual's chart. If it is determined that case management or care coordination is not appropriate for the individual, the rationale must be documented in the individual's chart.

VIII. PROCEDURES

ADMISSION CRITERIA

Decisions to admit an individual for Methadone maintenance must be based on medical necessity criteria, satisfy the LOC determination using the six dimensions of the ASAM Patient Placement Criteria, and have an initial diagnostic impression of opioid dependency for at least one year based on current DSM criteria. It is important to note that each individual, as a whole, must be considered when determining LOC, as Methadone maintenance therapy may not be the best answer for every individual. For exceptions, see "Special Circumstances for Pregnant Women and Adolescents" on page six (6). Consistent with the LOC determination, individuals requesting Methadone must be presented with all appropriate options for substance use disorder treatment, such as:

- Medical Detoxification
- Sub-acute Detoxification
- Residential Care

- Buprenorphine/naloxone
- Non-Medication Assisted Outpatient

In addition to these levels of care, providers can also offer case management services, treatment for co-occurring disorders, early intervention and peer recovery and recovery support services. These additional service options can be provided to individuals with Opioid Use Disorder (OUD) who do not meet the criteria for adjunct Methadone treatment. Individuals should be encouraged to participate in treatment early in their addiction before Methadone is necessary.

Admission procedures require a physical examination. This examination must include a medical assessment to confirm the current DSM diagnosis of opioid dependency of at least one year, as was identified during the screening process. The physician may refer the individual for further medical assessment as indicated.

Individuals must be informed that all of the following are required:

1. Daily attendance at the clinic is necessary for dosing, including Sundays and holidays if criteria for take home medication are not met.
2. Compliance with the individualized treatment and recovery plan, which includes referrals and follow-up as needed.
3. Monthly random toxicology testing.
4. Coordination of care with all prescribing practitioners (physicians, dentists, and any other health care provider) over the past year.

It is the responsibility of the OTP, as part of the informed consent process, to ensure that individuals are aware of the benefits and hazards of Methadone treatment. It is also the OTP's responsibility to obtain consent to contact other OTPs within 200 miles to monitor for enrollments in other programs (42 CFR §2.34). Decisions on services should be determined in collaboration with the individual, the program physician, the individual's primary counselor and the clinical supervisor.

OTPs must request that individuals provide a complete list of all prescribed medications. Legally prescribed medication, including controlled substances, must not be considered as illicit substances when the OTP has documentation that it was prescribed for the individual. Copies of the prescription label, pharmacy receipt, pharmacy print out, or a Michigan Automated Prescription System (MAPS) report must be included in the individual's chart or kept in a "prescribed medication log" that must be easily accessible for review.

Michigan law allows for individuals with the appropriate physician approval and documentation to use medical marijuana. For enrolled individuals, there must be a copy of the MDHHS registration card for medical marijuana issued in the individual's name in the chart or the "prescribed medication log." Following these steps will help to ensure that an individual who is using medical marijuana per Michigan law will not be discriminated against in regard to program admission and exceptions for dosing. Individuals utilizing Block Grant who have a medical marijuana card specifically for treating a mental health or substance use disorder must include a treatment plan goal to end such use. Medical marijuana cards for physical health issues are allowable for those utilizing Block Grant.

If an individual is unwilling to provide medical marijuana information, the OTP must include a statement to this effect, signed by the individual, in the chart. These individuals will not be eligible for off-site dosing, including Sunday and holiday doses. OTPs must advise individuals to include Methadone when providing a list of medications to their healthcare providers. The OTP physician may elect not to admit the individual for Methadone treatment if the coordination of care with health care providers and/or prescribing physicians is not agreed to by the individual.

Consistent with good public health efforts among high-risk populations, and after consultation with the local health department, an OTP may offer Hepatitis A and B, as well as other adult immunizations recommended by the health department, or they should refer the individual to an appropriate health care provider. Smoking cessation classes or referrals to local community resources may also be made available.

COORDINATION OF CARE

All MMT individuals prescribed Schedule I through V substances (including marijuana, Opioids, benzodiazepines and sedatives) must agree to coordination of care between the Methadone provider and the prescriber of the controlled substance. This is for the safety and protection of the individuals as well as the prescribers due to the potential for dangerous interactions between Methadone and other CNS depressants, along with the promotion of Recovery-Oriented System of Care principles. The prescribing physicians of all other controlled substances need to be aware of the individual's current dosage as this may impact dosing of other medications. Individuals who don't comply with Coordination of Care will not be eligible for off-site or take-home dosing, including Sundays and holidays.

Off-site dosing, including Sundays and holidays, is not allowed without coordination of care (or documentation of efforts made by the OTP for coordination) by the OTP physician, the prescriber of the identified controlled substance (opioids, benzodiazepines, muscle relaxants), and the physician who approved the use of medical marijuana. This coordination must be documented in either the nurse’s or the doctor’s notes. The documentation must be individualized, identifying the individual, the diagnosis, and the length of time the individual is expected to be on the medication. A MAPS report must be completed at admission. A MAPS report should be completed before off-site doses, including Sundays and holidays, are allowed and must be completed when coordination of care with other physicians could not be accomplished.

If respiratory depressants are prescribed for any medical condition, including a dental or podiatry condition, the prescribing practitioners should be encouraged to prescribe a medication which is the least likely to cause danger to the individual when used with Methadone. Individuals who have coordinated care with prescribing practitioners, and are receiving medical care or mental health services, will be allowed dosing off site, if all other criteria are met. If the OTP is closed for dosing on Sundays or holidays, arrangements shall be made to dose the individual at another OTP if the individual is not deemed responsible for off-site dosing.

SPECIAL CIRCUMSTANCE FOR PREGNANT WOMEN AND ADOLESCENTS

Pregnant women

Pregnant women requesting treatment are considered a priority for admission and must be screened and referred for services within 24 hours. Pregnant individuals who have a documented history of OUD, regardless of age or length of time, may be admitted to an OTP provided the pregnancy is certified by the OTP physician, and treatment is found to be justified. For pregnant individuals, evidence of current physiological dependence is not necessary. Pregnant individuals with OUD must be referred for prenatal care and other pregnancy-related services and supports, as necessary.

OTPs must obtain informed consent from pregnant women and all women admitted to Methadone treatment that may become pregnant, stating that they will not knowingly put themselves and their fetus in jeopardy by leaving the OTP against medical advice. Because Methadone and Opioid withdrawal are not recommended during pregnancy, due to the increased risk to the fetus, the OTP shall not discharge pregnant women without making documented attempts to facilitate a referral for continued treatment with another provider.

Pregnant adolescents
For an individual under 18 years of age, a parent, legal guardian, or responsible adult designated by the State Opioid Treatment Authority, must provide consent for treatment in writing. A copy of this signed, informed consent statement must be placed in the individual's medical record. This signed consent is in addition to the general consent that is signed by all individuals receiving Methadone, and must be filed in the medical record.

Non-Pregnant adolescents
An individual under 18 years of age is required to have had at least two documented unsuccessful attempts at short-term detoxification and/or drug-free treatment within a 12-month period to be eligible for maintenance treatment. No individual under 18 years of age may be admitted to maintenance treatment unless a parent, legal guardian, or responsible adult designated by the state opioid treatment authority consents, in writing, to such treatment. A copy of this signed informed consent statement must be placed in the individual's medical record. This signed consent is in addition to the general consent that is signed by all individuals receiving Methadone, and must be filed in their medical record. [See 42CFR Subpart 8.12 (e) (2)]

Treatment and Continued Recovery Using Methadone
Individual needs and rate of progress vary from person-to-person and, as such, treatment and recovery must be individualized and treatment and recovery plans must be based on the needs and goals of the individual (see MDHHS: ***Treatment Policy #06: Individualized Treatment Planning***). Referrals for medical care, mental health issues, vocational and educational needs, spiritual guidance, and housing are required, as needed, based on the information gathered as part of the assessment and other documentation completed by the individual. The use of case managers, care coordinators, and recovery coaches is recommended for individuals whenever possible. Increasing the individual's recovery capital through these supports, will assist the recovery process and help the individual to become stable and more productive within the community.

Compliance with dosing requirements or attendance at counseling sessions alone is not sufficient to continue enrollment. Reviews to determine continued eligibility for Methadone dosing and treatment services must occur at least every 90 days by the OTP

physician and other clinical staff. An assessment of the ability to pay for services and a determination for CMHPSM coverage must be conducted at that time, as well.

An individual may continue with services if all of the following criteria are present:

a. Applicable ASAM criteria are met.
b. The individual provides evidence of willingness to participate in treatment.
c. There is evidence of progress.
d. There is documentation of medical necessity.
e. The need for continuation of services is documented in writing by the OTP physician.

Individuals, who continue to have a medical need for Methadone, as documented in their medical record by the OTP physician, are not considered discharged from services; nor are individuals who have been tapered from Methadone, but still need treatment services.

All substances of ab/use, including alcohol, must be addressed in the treatment and recovery plan. Treatment and recovery plans and progress notes are expected to reflect the clinical status of the individual along with progress, or lack of progress in treatment. In addition, items such as extra treatment services, or specialized groups provided, and off-site dosing privileges that have been initiated, rescinded, or reduced should also be reflected in progress notes. Referrals and follow-up to those referrals must be documented.

For individuals who are struggling to meet the objectives in their individual treatment and recovery plans, OTP medical and clinical staff must review, with the individual, the course of treatment and recovery and make adjustments to the services being provided. Examples of such adjustments may be changing the Methadone dosage, including split dosing, increasing the length or number of treatment sessions, incorporating specialized group sessions, initiating case management services, providing adjunctive acupuncture treatment, and recommending to a more appropriate LOC.

Medical Maintenance Phase of Treatment:
As individuals progress through recovery, there may be a time when the maximum therapeutic benefit of treatment has been achieved. At this point, it may be appropriate for the individual to enter the medical maintenance (Methadone only) phase of treatment and recovery if it has been determined that ongoing use of the medication is medically necessary and appropriate for the individual. To assist the OTP in making this decision, ***TIP 43: Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs*** offers the following criteria to consider when making the decision to move to medical maintenance these decisions to be made on an individualized basis:

- Two years of continuous treatment.
- Abstinence from illicit drugs and from abuse of prescription drugs for the period indicated by federal and state regulations (at least two years for a full 30-day maintenance dosage).
- No alcohol use problem.
- Stable living conditions in an environment free of substance use.
- Stable and legal source of income.
- Involvement in productive activities (e.g., employment, school, volunteer work).
- No criminal or legal involvement for at least three years and no current parole or probation status.

- Adequate social support system, self help or 12 step attendance and absence of significant un-stabilized co-occurring disorders.

Discontinuation of Services:
Individuals must discontinue treatment with Methadone when treatment is completed with respect to both the medical necessity for the medication and for treatment services according to their treatment plan. In addition, individuals may be terminated from services and referred elsewhere if they are not benefiting from services at the OTP. If an individual is terminated, the OTP must attempt to make a referral for a more appropriate LOC or for placing the individual at another OTP, and must make an effort to ensure that the individual follows through with the referral. These efforts must be documented in the medical record. The OTP must follow the procedures of the funding authority in coordinating these referrals. Any action to terminate treatment of a Medicaid recipient requires a notice of "action" be given to the individual. The individual has a right to appeal this decision and services must continue and dosage levels maintained while the appeal is in process.

Discontinuation of Service Forms:
Notice of Adverse Benefit Determination
Request for Internal Appeal Form (Medicaid)
Request for Local Appeal Form (Non-Medicaid)

The following are reasons for discontinuation/termination:

1. Completion of Treatment – The decision to discharge an individual must be made by the OTP's physician with input from clinical staff and the individual. Completion of treatment is determined when the individual has fully or substantially achieved the goals listed in his/her individualized treatment and recovery plan and when the individual no longer needs Methadone as a medication. As part of this process, a reduction of the dosage to a medication-free state (tapering) should be implemented within safe and appropriate medical standards.

2. Administrative Discontinuation – The OTP must work with the individual to explore and implement methods to follow the individualized treatment plan. Administrative discontinuation relates to inability to follow through with treatment and recovery recommendations, and/or engaging in activities or behaviors that impact the safety of the OTP environment or other individuals who are receiving treatment. The repeated or continued use of illicit opioids and non-opioid drugs, including alcohol, should be addressed in treatment plan goals. OTPs must perform toxicology tests for Methadone metabolites, buprenorphine, buprenorphine metabolites, opioids, cannabinoids, benzodiazepines, cocaine, amphetamines, and barbiturates (***Administrative Rules of Substance Abuse Services Programs in Michigan***, R 325.1383). Individuals whose toxicology results do not indicate the presence of Methadone metabolites must be considered, with the same actions taken as if illicit drugs (including non-prescribed medication) were detected.

OTPs must test for alcohol use if: 1) prohibited under their individualized treatment and recovery plan; or 2) the individual appears to be using alcohol to a degree that would make dosing unsafe. The following actions are also considered to be non-compliant:

- Refusal to provide to toxicology sampling as requested.

- Refusal to follow individualized treatment plan including treatment services or other recommended services.
- Lack of managing medical concerns/conditions, including adherence to physician treatment and recovery services and prescription medications that may interfere with the effectiveness of Methadone and may present a physical risk to the individual.
- Lack of follow through on other treatment and recovery plan related referrals. [1] ***Administrative discharge should be considered on an individual basis and only after the OTP has taken steps to assist individuals in following treatment plans.***

The commission of acts by the individual that jeopardize the safety and well-being of staff and/or other individuals, or negatively impact the therapeutic environment, is not acceptable and can result in immediate discharge. Such acts include, but are not limited to the following:

- Possession of a weapon on OTP property.
- Assaultive behavior against staff and/or other individuals.
- Threats (verbal or physical) against staff and/or other individuals.
- Diversion of controlled substances, including Methadone.
- Diversion and/or adulteration of toxicology samples.
- Possession of a controlled substance with intent to use and/or sell on agency property or within a one block radius of the clinic.
- Sexual harassment of staff and/or other individuals.
- Loitering on the clinic property or within a one-block radius of the clinic.

Administrative discontinuation of services can be carried out by two methods:
1) Immediate Termination – This involves the discontinuation of services at the time of one of the above safety related incidents or at the time an incident is brought to the attention of the OTP.

2) Enhanced Tapering Discontinuation – This involves an accelerated decrease of the Methadone dose (usually by 10 mg or 10% a day). The manner in which Methadone is discontinued is at the discretion of the OTP physician to ensure the safety and well-being of the individual.

It may be necessary for the OTP to recommend those being administratively discharged to another level of care using the concurrent review. Justification for termination must be documented in the individual's chart.

Clarification of Substance-Dependence Treatment and Recovery with Methadone in Individuals with Prior or Existing Pain Issues
All persons assessed for a substance use disorder must be assessed using the ASAM patient placement criteria and the current Diagnostic and Statistical Manual of Mental Disorders (DSM). In the case of Opioid Use Disorder (OUD), pseudo-addiction must also be ruled out. Tolerance and physical dependence are normal consequences of sustained use of opioid analgesics and are not synonymous with an OUD. In some cases, primary care and other doctors may misunderstand the scope of the OTP and refer individuals to the OTP for pain control. The "Michigan Guidelines for the Use of Controlled Substances for the Treatment of Pain," should be consulted to assist in determining when substance use disorder treatment is appropriate, as well as the publication, Responsible Opioid Prescribing: A Michigan Physician's Guide by Scott M.

Fishman, MD. This publication was distributed to all controlled substance prescribers in Michigan by the Michigan Department of Health & Medicaid Managed Specialty Supports and Services Program FY20 Attachment PII.B.A Human Services, Bureau of Health Professions, in September of 2009. OTPs are not pain clinics, and cannot address the underlying medical condition causing the pain. The OTP and CA are encouraged to work with the local medical community to minimize inappropriate referrals to OTPs for pain.

Individuals receiving Methadone as treatment for an OUD may need pain medication in conjunction with this adjunct therapy. The use of non-opioid analgesics and other non-medication therapy is recommended whenever possible. Opioid analgesics as prescribed for pain by the individual's primary care physician (or dentist, podiatrist) can be used; they are not a reason to initiate detoxification to a drug-free state, nor does their use make the individual ineligible for using Methadone for the treatment of OUD. The Methadone used in treating OUD does not replace the need for pain medication. It is recommended that individuals inform their prescribing practitioners that they are on Methadone, as well as any other medications. On-going coordination (or documentation of efforts if prescribing practitioners do not respond) between the OTP physician and the prescribing practitioner is required for continued services at the OTP and for any off-site dosing including Sunday and holidays.

VII. EXHIBITS

a. Methadone Treatment Program CMHPSM/Individual/Provider Agreement
b. State of Michigan Substance Abuse Contract
c. CMHPSM Grievance and Appeals Policy
d. MEDICATION ASSISTED TREATMENT GUIDELINES for OPIOID USE DISORDERS; State of Michigan, Department of Health and Human Services (2014)
e. ATTACHMENT A: CMHPSM Methadone Continuing Care Evaluation

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Attachment A

COMMUNITY MENTAL HEALTH PARTNERSHIP OF SOUTHEAST MICHIGAN

Methadone Continuing Care Evaluation

To be completed by treating physician

Date: _____
Individual Name: _____
Clinic Name: _____
DSM IV Diagnosis: _____ Code: _____
HIV Status: _____
Hepatitis Status: _____

To determine whether a patient should continue in Methadone treatment, the program physician in cooperation with the clinical staff must use the following ASAM Patient Placement criteria in evaluating the individual.

1. Acute narcotics dependence and/or potential relapse (check at least one):
_____ Continued Methadone maintenance is required to prevent relapse to illicit narcotic use.
_____ The patient needs ongoing medical monitoring and access to medical management.
_____ Patient continues to have adequate support systems to ensure commitment to continuing Methadone maintenance treatment.

Explain:
_____
_____

2. Biomedical Conditions and Complications (check at least one):
_____ There is a current or chronic illness and Opioid addiction problem that requires medical monitoring and management.
_____ There is a presence of or potential for:
episodic use of drugs other than narcotics; Positive HIV Status or AIDS; Chronic health conditions that could be medically compromised with discontinuation of Methadone maintenance treatment, including but not limited to liver disease or problems with the hepatic decompensation, Pancreatitis, Gastrointestinal, cardiovascular, and other systems disorders, Sexually transmitted diseases, Concurrent psychiatric illness requiring psychotropic medications; Tuberculosis, Hepatitis.
_____ Patient is pregnant and narcotic dependent.

Explain:
_____
_____

3. Emotional/Behavioral Conditions and Complications (check at least one):
_____ Patient's emotional/behavioral functioning may be jeopardized by discontinuation of Methadone maintenance treatment.
_____ Patient demonstrates the ability to benefit from Methadone treatment but may not have achieved significant life changes.
_____ Patient s making progress toward resolution of an emotional/behavioral problem, but has not sufficiently resolved problems to benefit from a transfer from Methadone maintenance to a less intensive level of care.
_____ Patient's emotional/behavioral disorder continues to distract the patient from focusing on treatment goals, however, the patient is responding to treatment, and it is anticipated that with additional intervention the patient will meet treatment objectives.
_____ Patient continues to exhibit risk behaviors endangering self or others but the situation is improving.
_____ Patient is being detained pending transfer to a more intensive treatment service.
_____ Patient has a diagnosed but stable emotional/behavioral or neurological disorder which requires monitoring, management, and/or psychotropic medication due to the patient's history of being distracted from recovery and/or treatment.

Explain:

_____
_____

4. Treatment Acceptance/Resistance (check at least one):

_____ Patient recognizes the severity of the drug problem, however, the patient exhibits little understanding of the detrimental effects of drug use, including alcohol, yet the patient is progressing in treatment.

_____ Patient recognizes the severity of the addiction and exhibits an understanding of his/her relationship with narcotics, however, the patient does not demonstrative behaviors that indicate the patient has assumed responsibility necessary to cope with the situation.

_____ Patient is becoming aware of responsibility for addressing the narcotic addiction, but still requires current level of treatment and psychotherapy to sustain person responsibility in treatment.

_____ Patient has accepted responsibility for addiction and has determined that ongoing Methadone treatment is the best strategy for preventing relapse to narcotics dependence.

Explain: _____
_____

5. Relapse Potential (check at least one):

_____ Due to continued relapse attributable to physiological cravings, the patient requires structured outpatient psychotherapy with Methadone to promote continued progress and recovery.

_____ Patient recognized relapse occurs, but has not developed or exhibited coping skills to interrupt, postpone or neutralize gratification, or to change impulse control behavior.

_____ Narcotic symptoms are stabilized, but have not been reduced to support successful functioning without structured outpatient treatment.

_____ Pharmacotherapy (Methadone) has been effective as an adjunct to psychotherapy and as a strategy used to prevent relapse, however, withdrawal from Methadone is likely to lead to recurrence of addiction symptoms and, possibly, relapse.

Explain: _____
_____

6. Recovery Environment (check at least one):

_____ Patient has not integrated and exhibited coping skills sufficient to survive stressful situations in the work environment, or has not developed vocational alternatives.

_____ Patient has not developed coping skills sufficient to successfully deal with a non-supportive family and social support environment or has not developed alternative living support systems.

_____ Patient has not integrated and exhibited the socialization skills essential to establishing a supportive family and social support environment.

_____ Patient has responded to treatment of psychosocial problems affecting patient's social and interpersonal life; however, the patient's ability to cope with psychosocial problems would be limited if the patient is transferred to a less intensive level of treatment.

_____ Patient's social and interpersonal life has not changed or deteriorated, however, the patient needs additional treatment to cope with his/her social and interpersonal life or to take steps to secure an alternative environment.

_____ Emotional and behavioral complications of addiction are present, however, the behavioral complications are manageable in a structured outpatient program. The behaviors include: 1) criminal activity involving illicit drugs, 2) victim of abuse or domestic violence, 3) inability to maintain a stable household, including the provision of food, shelter, supervision of children and health care, or 4) inability to secure or retain employment.

Explain: _____
_____

Has individual been consistent with clean urines? Yes No

If no, explain reason and plan:

_____
_____

Has individual been consistent with attending Individual and/ or Group Therapy sessions? Yes No

If no, explain reason and plan:

_____

_____

Does the individual have any medical conditions that are currently being treated? Yes No

If yes, explain: _____

_____

Individual's Mental Status:

_____

_____

Physician comments (include any individual treatment information that is not covered in this review that must be considered for re-evaluation of medical necessity for continuing Methadone Therapy):

_____

_____

_____ _____ _____

Print Physician Name Signature Date

Attach copy of last 6 months of Urine Drug Screens, Concurrent Review Form and Treatment Plan

INDIVIDUAL: _____ CLINIC: _____ DATE: _____

TO BE COMPLETED BY REVIEWING PHYSICIAN CONSULTANT
Please initial

_____ Individual meets medical necessity for continuation of Methadone Therapy.

_____ Individual does not meet medical necessity for continuation of Methadone Therapy.
Alternative treatment is recommended.
Explain: _____

_____ Individual should be place on probationary status and re-reviewed in _____ months.
Explain: _____

_____ Face to face evaluation is needed with the individual to gather further information. Schedule within _____

_____ Physician to physician review is recommended.

Comments:
_____
_____
_____

_____ _____ _____
Print Physician Name Signature Date

Date of Face to Face Evaluation (if applicable): ___ _____ Time in: _____ Time out: _____

Comments:
_____
_____
_____

_____ _____ _____
Print Physician Name Signature Date

Date of Physician to Physician review: _____ Provider/individual's physician: _____
Comments:
_____
_____

_____ _____ _____
Print Physician Name Signature Date

Please initial for final recommendation:

_____ Individual meets medical necessity for continuation of Methadone Therapy.

_____ Individual does not meet medical necessity for continuation of Therapy.
Alternative treatment is recommended.
Explain:
_____
_____

_____ Individual should be place on probationary status and re-reviewed in _____ months.
Explain:
_____
_____

_____ _____ _____
Print Physician Name Signature Date

_____ _____ _____
Utilization Review Agency Date

Attachment #4d – July 2022

Community Mental Health Partnership of Southeast Michigan/PIHP	***Policy*** **Medication Assisted Treatment – Methadone**
Department: SUD ~~Clinical Services~~ **Author:** Marci Scalera	**Local Policy Numbers (if used)**
~~**Regional Operations Committee**~~**Oversight Policy Board** **Approval Date** ~~**9/14/2016**~~	**Implementation Date** **10/1/2016**

I. PURPOSE

To have a uniform policy and procedure for all CMHPSM funded ~~client~~individuals requesting Methadone as their Opioid Replacement Therapy (ORT) ~~or Methadone~~ as a pharmacological support in Opioid Treatment Programs (OTPs) that meets required MDHHS Enrollment Criteria for Methadone Maintenance and Detoxification Programs.

II. REVISION HISTORY

DATE	REV. NO.	MODIFICATION
March 2012		
July 2016	1	Update language, replaces Methadone policy
June 2021	2	Update language
December 2021	3	Update language/add suggestions
February 2022	4	Updated language; separation into Methadone specific policy

III. APPLICATION

This policy applies to any ~~client~~individual requesting Medication Assisted Treatment (MAT) to include Methadone as a pharmacological support; Opioid Treatment Program (OTP) Providers; ~~ROSC Core Providers~~ and Utilization Review Staff.

~~III.~~IV. DEFINITIONS

~~This policy applies to any client~~individual ~~requesting medication assisted treatment to include Methadone, Suboxone/Subutex or Vivitrol as a pharmacological support; Opioid Treatment Program (OTP) Providers; ROSC Core Providers and Utilization Review Staff.~~

Community Mental Health Partnership of Southeast Michigan (CMHPSM): The Regional Entity that serves as the PIHP for Lenawee, Livingston, Monroe and Washtenaw for mental health, developmental disabilities, and substance use disorder services.

Community Mental Health Services Program (CMHSP): A program operated under chapter 2 of the Mental Health Code as a county community mental health

agency, a community mental health authority, or a community mental health organization.

Regional Entity: The entity established under section 204b of the Michigan Mental Health Code to provide specialty services and supports.

CRCT INFORMATION MANAGEMENT SYSTEM**:** The CMHPSM's web-based information management system for interfacing with providers; Access and Utilization Management, Finance and medical records

MEDICAL DIRECTOR/DESIGNEE: The Medical Director/Designee of the CMHPSM may designate a consulting physician with additional expertise to assist with concurrent review determinations in questionable ~~methadone~~Methadone cases

MEDICAID MEDICAL NECESSITY REQUIREMENT: The Medicaid Provider Manual lists the medical necessity requirements that shall be used to determine the need for ~~methadone~~Methadone as an adjunct treatment and recovery service. The Medicaid-covered substance use disorder benefit for ~~methadone~~Methadone services includes the provision and administration of ~~methadone~~Methadone, nursing services, physician encounters, physical examinations, lab tests (including initial blood work, toxicology screening, and pregnancy tests) and physician-ordered TB skin tests. The medical necessity requirements and services also apply to all non-Medicaid covered individuals.

Medication Assisted Treatment (MAT)/Medications for Opioid Use Disorder (MOUD) – These terms refer to medications used to treat Opioid Use Disorder (OUD). They are most commonly referred to as MAT, MOUD is a newer term being used to replace MAT in cases when OUD is the primary diagnosis. Naltrexone can also be used to for treatment of Alcohol Use Disorder (AUD).~~often when in reference to people with OUD~~

METHADONE: Methadone Use in Medication-Assisted Treatment and Recovery: Methadone is an opioid medication used in the treatment and recovery of opioid dependence to prevent withdrawal symptoms and opioid cravings, while blocking the euphoric effects of opioid drugs. In doing so, ~~methadone~~Methadone stabilizes the individual so that other components of the treatment and recovery experience, such as ~~counseling~~treatment and case management, are maximized in order to enable the individual to reacquire life skills and maintain recovery. Methadone is not a medication for the treatment and recovery from non-opioid drugs.

MAPS REPORT: Michigan Automated Prescription System- under the Michigan Licensing and Regulatory Affairs, the MAPS system monitors all schedule 2-5 medications prescribed and dispensed in the state in order to identify and prevent diversion at the prescriber, pharmacy and patient levels.

~~Methadone~~

OPIOID TREATMENT PROGRAM: Opioid Treatment Programs (OTPs) are certified by the federal Substance Abuse and Mental Health Services Administration (SAMHSA). An OTP using Methadone for the treatment of opioid dependency must be:

1) Licensed by the state as a ~~methadone~~Methadone provider,
2) Accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF), the Council on Accreditation (COA) or the Joint Commission on Accreditation of Healthcare Organizations (JCAHO),
3) Certified by the SAMHSA as an OTP and
4) Registered by the Drug Enforcement Administration (DEA).
Approved by State Opioid Treatment Authority (SOTA)
5) Must comply with the following codes, regulations and manuals:

- ***Methadone Treatment and Other Chemotherapy***, Michigan Administrative Code, Rule 324, 14401-325, 14423.
- ***Certification of Opioid Treatment Programs***, U.S. Code of Federal Regulations, 42 CFR Part 8
- ***Michigan Medicaid Provider Manual***

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Methadone treatment is well established as an effective and safe approach to controlling Opioid Use Disorder (OUD). Properly prescribed Methadone is not intoxicating or sedating, and its effects do not interfere with ordinary activities such as driving a car. The medication is taken orally and it suppresses narcotic withdrawal for 24 to 36 hours.

V. POLICY

All ~~client~~individuals requesting Methadone Treatment for Opioid ~~Dependence~~Use Disorder are evaluated under state and federal guidelines and must meet ASAM and medical necessity criteria for initial and continuing care. It is the expectation that the course of Opioid Replacement Therapy (ORT) be completed ~~within a two-year timeframe, with a titration protocol attempted during that time~~when medically necessary. A titration protocol may be attempted which would be driven by the individualized treatment plan. Some individuals with substance use disorder may have an extended need for Methadone or other MOUD.

VI. ~~DEFINITIONS~~BACKGROUND

~~ASAM PATIENT PLACEMENT CRITERIA 2-R~~

Methadone Use in Medication-Assisted Treatment and Recovery

Methadone is an opioid medication used in the treatment and recovery of Opioid Use Disorder (OUD) to prevent withdrawal symptoms and opioid cravings, while blocking the euphoric effects of opioid drugs. In doing so, ~~methadone~~Methadone stabilizes the individual so that other components of the treatment and recovery experience, such as counseling and case management, are maximized in order to enable the individual to reacquire life skills and recovery. Methadone is not a medication for the treatment and recovery from non-opioid drugs.

The Medicaid Provider Manual lists the medical necessity requirements that shall be used to determine the need for ~~methadone~~Methadone as an adjunct treatment and recovery service. The Medicaid-covered substance use disorder benefit for ~~methadone~~Methadone services includes the provision and administration of

~~methadone~~Methadone, nursing services, physician encounters, physical examinations, lab tests (including initial blood work, toxicology screening, and pregnancy tests) and physician-ordered tuberculosis (TB) skin tests. The medical necessity requirements and services also apply to all non-Medicaid covered individuals.

Consistent with good public health efforts among high-risk populations, and after consultation with the local health department, an OTP may offer Hepatitis A and B, as well as other adult immunizations and communicable disease testing recommended by the health department, or they should refer the individual to an appropriate health care provider. Smoking cessation classes or referrals to local community resources may also be made available.

Consistent with good public health efforts among high-risk populations, and after consultation with the local health department, an OTP may offer Hepatitis A and B, as well as other adult immunizations recommended Medicaid Managed Specialty Supports and Services Program FY20 Attachment PII.B.A by the health department, or they should refer the individual to an appropriate health care provider. Smoking cessation classes or referrals to local community resources may also be made available.

The American Society of Addiction Medicine (ASAM) Level of Care (LOC 2-R) indicated for individuals receiving ~~methadone~~Methadone is usually outpatient. The severity of the opioid dependency and the medical need for ~~methadone~~Methadone should not be diminished because M~~m~~edication ~~a~~ Assisted T~~t~~reatment has been classified as outpatient. ~~Counseling~~Treatment services should be conducted by the OTP that is providing the ~~methadone~~Methadone whenever possible and appropriate. When the ASAM LOC is not outpatient or when a specialized service is needed, separate service locations for ~~methadone~~Methadone dosing and other substance use disorder services are acceptable, as long as coordinated care is present and documented in the individual's record.

If ~~methadone~~Methadone is to be self-administered off site of the OTP, off-site dosing must be in compliance with the current Michigan Department of Health and Human Services (MDHHS) ***Treatment Policy #4: Off- Site Dosing Requirements for Medication-Assisted Treatment*****.** This includes Sunday and holiday doses for those individuals not deemed to be responsible for managing take-home doses.~~-~~

All six dimensions of the ASAM patient placement criteria must be addressed:

1. Acute intoxication and/or withdrawal potential.
2. Biomedical conditions and complications.
3. Emotional/behavioral conditions and complications (e.g., psychiatric conditions, psychological or emotional/behavioral complications of known or unknown origin, poor impulse control, changes in mental status, or transient neuropsychiatric complications).
4. Treatment acceptance/resistance.
5. Relapse/continued use potential.
6. Recovery/living environment.

In using these dimensions, the strengths and supports, or recovery capital of the individual will be a major factor in assisting with the design of the individualized treatment and recovery plan.

CASE MANAGEMENT WITH ORT:
In many situations, case management or care coordination services may be needed by individuals to further support the recovery process. These services can link the individual to other recovery supports within the community such as medical care, mental health services, educational or vocational assistance, housing, food, parenting, legal assistance, and self-help groups. Documentation of such referrals and follow up must be in the treatment plan(s) and progress notes within the individual's chart. If it is determined that case management or care coordination is not appropriate for the individual, the rationale must be documented in the individual's chart. ~~The acupuncture detoxification five-point protocol is suggested as a means of assisting the individual with symptom management of anxiety and restorative sleep.~~

~~**E**-2 INFORMATION MANAGEMENT SYSTEM: The CMHPSM's web-based information management system for interfacing with providers; Access and Utilization Management, Finance and medical records~~

~~MEDICAL DIRECTOR/DESIGNEE: The Medical Director of the CMHPSM may designate a consulting physician with additional expertise to assist with concurrent review determinations in questionable methadone cases~~

~~MEDICAID MEDICAL NECESSITY REQUIREMENT: The Medicaid Provider Manual lists the medical necessity requirements that shall be used to determine the need for methadone as an adjunct treatment and recovery service. The Medicaid- covered substance use disorder benefit for methadone services includes the provision and administration of methadone, nursing services, physician encounters, physical examinations, lab tests (including initial blood work, toxicology screening, and pregnancy tests) and physician-ordered TB skin tests. The medical necessity requirements and services also apply to all non-Medicaid covered individuals.~~

~~METHADONE: Methadone Use in Medication-Assisted Treatment and Recovery: Methadone is an opioid medication used in the treatment and recovery of opioid dependence to prevent withdrawal symptoms and opioid cravings, while blocking the euphoric effects of opioid drugs. In doing so, methadone stabilizes the individual so that other components of the treatment and recovery experience, such as counseling and case management, are maximized in order to enable the individual to reacquire life skills and recovery. Methadone is not a medication for the treatment and recovery from non-opioid drugs.~~

~~Methadone treatment is well established as an effective and safe approach to controlling opioid addiction. Properly prescribed methadone is not intoxicating or sedating, and its effects do not interfere with ordinary activities such as driving a car. The medication is taken orally and it suppresses narcotic withdrawal for 24 to 36 hours.~~

~~Consistent with good public health efforts among high-risk populations, and after consultation with the local health department, an OTP may offer Hepatitis A and B, as well as other adult immunizations recommended by the health department, or they should refer the individual to an appropriate health care provider. Smoking cessation classes or referrals to local community resources may also be made available.~~

MAPS REPORT: Michigan Automated Prescription System – under the Michigan Licensing and Regulatory Affairs, the MAPS system monitors all schedule 2-5 medications prescribed and dispensed in the state in order to identify and prevent diversion at the prescriber, pharmacy and patient levels.

OPIOID TREATMENT PROGRAM: Opioid Treatment Programs (OTPs) are certified by the federal Substance Abuse and Mental Health Services Administration (SAMHSA). An OTP using methadone for the treatment of opioid dependency must be:

1) Licensed by the state as a methadone provider,
2) Accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF), the Council on Accreditation (COA) or the Joint Commission on Accreditation of Healthcare Organizations (JCAHO),
3) Certified by the SAMHSA as an OTP and
4) Registered by the Drug Enforcement Administration (DEA).
5) Must comply with the following codes, regulations and manuals:

- ***Methadone Treatment and Other Chemotherapy***, Michigan Administrative Code, Rule 324, 14401-325, 14423.
- ***Certification of Opioid Treatment Programs***, U.S. Code of Federal Regulations, 42 CFR Part 8
- ***Michigan Medicaid Provider Manual***

PAIN MANAGEMENT WITH OPIOID THERAPY: Should an individual's primary care physician (or other healthcare provider) prescribe opioid therapy for pain management, pseudo-addiction should also be ruled out. Tolerance and physical dependence are normal consequences of sustained use of opioid analgesics and are not synonymous with addiction. However, it is noted that individuals receiving methadone as treatment for an opioid addiction may need pain medication in conjunction with their addiction treatment. Opioid analgesics as prescribed for pain by the individuals PCP can be used; they are not a reason to detox the individual to a drug-free state. The methadone used in treating the opioid addiction does not replace the need for the pain medication. On-going coordination between the OTP physician and the prescribing practitioner is required. The following references should be consulted to assist in determining when substance abuse treatment is appropriate: "Responsible Opioid Prescribing: a Michigan Physician's Guide" by Scott M. Fishman, MD" and the "Michigan Guidelines for the Use of Controlled Substances for the Treatment of Pain". Additionally, the guidelines can be found at http://www.michigan.gov/MDHHS/0,1607,7-132-27417_27648_29876_29878-91812--,00.html.

IV. POLICY

All clientindividuals requesting Methadone Treatment for Opioid Dependence are evaluated under state and federal guidelines and must meet ASAM and medical necessity criteria for initial and continuing care. It is the expectation that the course of Opioid Replacement Therapy (ORT) be completed within a two-year timeframe, with a titration protocol attempted during that time.

V. EXHIBITS

a. None

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REFERENCES

a. ASAM American Society of Addition Medicine "Patient Placement Criteria for the Treatment of Substance-Related Disorders" 2nd Edition – Revised ASAM PPC-2-R (2005)
b. The ASAM Criteria, 3rd Edition – "Treatment Criteria for Addictive, Substance-Related and Co-Occurring Conditions"
c. Michigan Department of Health and Human Services Request for Hearing Form
d. Michigan Department of Health and Human Services, Medicaid Provider Manual, "Section 2 – Program Requirements" and "Section 12 – Substance Abuse Services" Updated 1/01/2012
e. Michigan Department of Health and Human Services, Office of Drug Control Policy, "Enrollment Criteria for Methadone Maintenance and Detoxification Program." Revised October 1, 2011
f. State of Michigan Substance Abuse Contract
g. CMHPSM Grievance and Appeals Policy
h. MEDICATION ASSISTED TREATMENT GUIDELINES for OPIOID USE DISORDERS; State of Michigan, Department of Health and Human Services (2014)
i. ATTACHMENT A: CMHPSM/ClientIndividual/Provider Agreement
j. ATTACHMENT B: CMHPSM Concurrent Review Form
k. ATTACHMENT C: CMHPSM Notice of Denial or Change of Services for Non-Medicaid Recipients
l. ATTACHMENT D: CMHPSM ClientIndividual Information Release Authorization
m. ATTACHMENT E: CMHPSM Methadone Continuing Care Evaluation

PROCEDURES

VII. REQUIREMENTS:

These codes, regulations, and manuals must be followed:
• Methadone Treatment and Other Chemotherapy, Michigan Administrative Code, Rule 325.14401- 325.14423
•
• Michigan Medicaid Provider Manual

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An OTP using methadone for the treatment and recovery of OUD must be:
1. Licensed by the state as a methadone provider.
2. Accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF), the Council on Accreditation (COA) or The Joint Commission (TJC), formerly JCAHO.
3. Certified by the Substance Abuse and Mental Health Services Administration (SAMHSA) as an OTP.
4. Registered by the Drug Enforcement Administration (DEA)

VIII. PROCEDURES

ADMISSION CRITERIA

Decisions to admit an individual for methadoneMethadone maintenance must be based on medical necessity criteria, satisfy the LOC determination using the six dimensions of the ASAM Patient Placement Criteria, and have an initial diagnostic impression of opioid dependency for at

least one year based on current DSM criteria. It is important to note that each individual, as a whole, must be considered when determining LOC, as ~~methadone~~Methadone maintenance therapy may not be the best answer for every individual. For exceptions, see "Special Circumstances for Pregnant Women and Adolescents" on page six (6). Consistent with the LOC determination, individuals requesting ~~methadone~~Methadone must be presented with all appropriate options for substance use disorder treatment, such as:

- Medical Detoxification.
- Sub-acute Detoxification.
- Residential Care.
- Buprenorphine/naloxone.
- Non-Medication Assisted Outpatient.

In addition to these levels of care, ~~ROSC~~ providers can also offer case management services, treatment for co-occurring disorders, early intervention and peer recovery and recovery support services. ~~Acupuncture detoxification may be used in all levels of care~~. These additional service options can be provided to individuals with ~~o~~Opioid ~~dependent~~ Use Disorder (OUD) ~~individuals~~ who do not meet the criteria for adjunct ~~methadone~~Methadone treatment. Individuals should be encouraged to participate in treatment early in their addiction before ~~methadone~~Methadone is necessary.

Admission procedures require a physical examination. This examination must include a medical assessment to confirm the current DSM diagnosis of opioid dependency of at least one year, as was identified during the screening process. The physician may refer the individual for further medical assessment as indicated.

Individuals must be informed that all of the following are required:

1. Daily attendance at the clinic is necessary for dosing, including Sundays and holidays if criteria for take home medication are not met.
2. Compliance with the individualized treatment and recovery plan, which includes referrals and follow-up as needed.
3. Monthly random toxicology testing.
4. Coordination of care with all prescribing practitioners (physicians, dentists, and any other health care provider) over the past year.

It is the responsibility of the OTP, as part of the informed consent process, to ensure that individuals are aware of the benefits and hazards of ~~methadone~~Methadone treatment. It is also the OTP's responsibility to obtain consent to contact other OTPs within 200 miles to monitor for enrollments in other programs (42 CFR §2.34). Decisions on services should be determined in collaboration with the individual, the program physician, the individual's primary counselor and the clinical supervisor.

OTPs must request that individuals provide a complete list of all prescribed medications. Legally prescribed medication, including controlled substances, must not be considered as illicit substances when the OTP has documentation that it was prescribed for the individual. Copies of the prescription label, pharmacy receipt, pharmacy print out, or a Michigan Automated Prescription System (MAPS) report must be included in the individual's chart or kept in a "prescribed medication log" that must be easily accessible for review.

Michigan law allows for individuals with the appropriate physician approval and documentation to use medical marijuana. ~~Although there are no prescribers of medical marijuana in Michigan, individuals are authorized by a physician to use marijuana per Michigan law.~~ For enrolled

individuals, there must be a copy of the MDHHS registration card for medical marijuana issued in the individual's name in the chart or the "prescribed medication log." Following these steps will help to ensure that an individual who is using medical marijuana per Michigan law will not be discriminated against in regards to program admission and exceptions for dosing. Individuals utilizing~~funded by~~ Block Grant who have a ~~prescription for~~ medical marijuana card specifically for treating a mental health or substance use disorder must include a treatment plan goal ~~be counseled to have a plan~~ to end such use. Medical marijuana cards ~~Prescriptions for~~ for physical health issues are allowable for those utilizing Block Grant.

If an individual is unwilling to provide ~~prescription or~~ medical marijuana information, the OTP must include a statement to this effect, signed by the individual, in the chart. These individuals will not be eligible for off-site dosing, including Sunday and holiday doses. OTPs must advise individuals to include ~~methadone~~Methadone when providing a list of medications to their healthcare providers. The OTP physician may elect not to admit the individual for ~~methadone~~Methadone treatment if the coordination of care with health care providers and/or prescribing physicians is not agreed to by the ~~client~~individual.

Consistent with good public health efforts among high-risk populations, and after consultation with the local health department, an OTP may offer Hepatitis A and B, as well as other adult immunizations recommended by the health department, or they should refer the individual to an appropriate health care provider. Smoking cessation classes or referrals to local community resources may also be made available.

COORDINATION OF CARE

All MMT ~~client~~individuals prescribed Schedule I through V substances (including marijuana, ~~opiate~~Opioids~~s~~, benzodiazepines and sedatives) must agree to coordination of care between the ~~methadone~~Methadone provider and the prescriber of the controlled substance. This is for the safety and protection of the ~~client~~individuals as well as the prescribers due to the potential for dangerous interactions between ~~methadone~~Methadone and other CNS depressants, along with the promotion of Recovery-Oriented System of Care principles. The prescribing physicians of all other controlled substances need to be aware of the ~~client~~individual's current dosage as this may impact dosing of other medications. ~~Client~~Individuals who don't comply with Coordination of Care will not be eligible for off-site or take-home dosing, including Sundays and holidays.

Off-site dosing, including Sundays and holidays, is not allowed without coordination of care (or documentation of efforts made by the OTP for coordination) by the OTP physician, the prescriber of the identified controlled substance (opioids, benzodiazepines, muscle relaxants), and the physician who approved the use of medical marijuana. This coordination must be documented in either the nurse's or the doctor's notes. The documentation must be individualized, identifying the individual, the diagnosis, and the length of time the individual is expected to be on the medication. A MAPS report must be completed at admission. A MAPS report should be completed before off-site doses, including Sundays and holidays, are allowed and must be completed when coordination of care with other physicians could not be accomplished.

If respiratory depressants are prescribed for any medical condition, including a dental or podiatry condition, the prescribing practitioners should be encouraged to prescribe a medication which is the least likely to cause danger to the individual when used with ~~methadone~~Methadone. Individuals who have coordinated care with prescribing practitioners, and are receiving medical

care or mental health services, will be allowed dosing off site, if all other criteria are met. If the OTP is closed for dosing on Sundays or holidays, arrangements shall be made to dose the individual at another OTP if the individual is not deemed responsible for off-site dosing.

SPECIAL CIRCUMSTANCE FOR PREGNANT WOMEN AND ADOLESCENTS

Pregnant women

Pregnant women requesting treatment are considered a priority for admission and must be screened and referred for services within 24 hours. Pregnant individuals who have a documented history of ~~opioid addiction~~OUD, regardless of age or length of ~~opioid dependency~~time, may be admitted to an OTP provided the pregnancy is certified by the OTP physician, and treatment is found to be justified. For pregnant individuals, evidence of current physiological dependence is not necessary. Pregnant ~~opioid dependent~~ individuals with OUD must be referred for prenatal care and other pregnancy-related services and supports, as necessary.

OTPs must obtain informed consent from pregnant women and all women admitted to ~~methadone~~Methadone treatment that may become pregnant, stating that they will not knowingly put themselves and their fetus in jeopardy by leaving the OTP against medical advice. Because ~~methadone~~Methadone and ~~opiate~~Opioid ~~opioid~~ withdrawal are not recommended during pregnancy, due to the increased risk to the fetus, the OTP shall not discharge pregnant women without making documented attempts to facilitate a referral for continued treatment with another provider.

Pregnant adolescents

For an individual under 18 years of age, a parent, legal guardian, or responsible adult designated by the State Opioid Treatment Authority, must provide consent for treatment in writing (see Attachment A). A copy of this signed, informed consent statement must be placed in the individual's medical record. This signed consent is in addition to the general consent that is signed by all individuals receiving ~~methadone~~Methadone, and must be filed in the medical record.

Non-Pregnant adolescents

An individual under 18 years of age is required to have had at least two documented unsuccessful attempts at short-term detoxification and/or drug-free treatment within a 12-month period to be eligible for maintenance treatment. No individual under 18 years of age may be admitted to maintenance treatment unless a parent, legal guardian, or responsible adult designated by the state opioid treatment authority consents, in writing, to such treatment (see Attachment A). A copy of this signed informed consent statement must be placed in the individual's medical record. This signed consent is in addition to the general consent that is signed by all individuals receiving ~~methadone~~Methadone, and must be filed in their medical record. [See 42CFR Subpart 8.12 (e) (2)]

Treatment and Continued Recovery Using Methadone

Individual needs and rate of progress vary from person-to-person and, as such, treatment and recovery must be individualized and treatment and recovery plans must be based on the needs and goals of the individual (see MDHHS: ***Treatment Policy #06: Individualized Treatment Planning***). Referrals for medical care, mental health issues, vocational and educational needs, spiritual guidance, and housing are required, as needed, based on the information gathered as part of the assessment and other documentation completed by the individual. The use of case managers, care coordinators, and recovery coaches is recommended for individuals whenever possible ~~(see MDHHS: ***Treatment Policy #8: Substance Abuse Case Management***~~

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~~***Requirements***~~). Increasing the individual's recovery capital through these supports, will assist the recovery process and help the individual to become stable and more productive within the community.

Compliance with dosing requirements or attendance at counseling sessions alone is not sufficient to continue enrollment. Reviews to determine continued eligibility for ~~methadone~~Methadone dosing and ~~counseling~~ treatment services must occur at least every ~~four~~ 90 days~~months~~ by the OTP physician and other clinical staff ~~during the first two years of service~~. An assessment of the ability to pay for services and a determination ~~for Medicaid~~ for CMHPSM coverage must be conducted at that time, as well. ~~If it is determined by the OTP physician that the individual requires methadone treatment beyond the first two years, the justification for the medical necessity of the need for methadone only needs to occur annually. However, financial review and eligibility for Medicaid is required to continue at a minimum of every six months.~~

An individual may continue with services if all of the following criteria are present:

a. Applicable ASAM criteria are met.
b. The individual provides evidence of willingness to participate in treatment.
c. There is evidence of progress.
d. There is documentation of medical necessity.
e. The need for continuation of services is documented in writing by the OTP physician.

Individuals, who continue to have a medical need for ~~methadone~~Methadone, as documented in their medical record by the OTP physician, are not considered discharged from services; nor are individuals who have been tapered from ~~methadone~~Methadone, but still need ~~counseling~~ treatment services.

All substances of ab/use, including alcohol, must be addressed in the treatment and recovery plan. Treatment and recovery plans and progress notes are expected to reflect the clinical status of the individual along with progress, or lack of progress in treatment. In addition, items such as ~~the initiation of compliance contracts,~~ extra ~~counseling~~ treatment services~~sions~~, or specialized groups provided, and off-site dosing privileges that have been initiated, rescinded, or reduced should also be reflected in progress notes. Referrals and follow-up to those referrals must be documented. ~~The funding authority may, at its discretion, require its approval of initial and/or continuing treatment and recovery plans.~~

For individuals who are struggling to meet the objectives in ~~his/her~~their individual treatment and recovery plans, OTP medical and clinical staff must review, with the individual, the course of treatment and recovery and make adjustments to the services being provided. Examples of such adjustments may be: changing the ~~methadone~~Methadone dosage, including split dosing, increasing the length or number of ~~counseling~~treatment sessions, incorporating specialized group sessions~~, using compliance contracts~~, initiating case management services, providing adjunctive acupuncture treatment, and ~~referring~~ recommending ~~the individual for screening~~ to a more appropriate~~another~~ LOC.

Medical Maintenance Phase of Treatment:
As individuals progress through recovery, there may be a time when the maximum therapeutic benefit of ~~counseling~~treatment has been achieved. At this point, it may be appropriate for the individual to enter the medical maintenance (~~methadone~~Methadone only) phase of treatment and recovery if it has been determined that ongoing use of the medication is medically necessary and appropriate for the individual. To assist the OTP in making this decision, ***TIP 43: Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs*** offers

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the following criteria to consider when making the decision to move to medical maintenance these decisions to be made on an individualized basis:

- Two years of continuous treatment.
- Abstinence from illicit drugs and from abuse of prescription drugs for the period indicated by federal and state regulations (at least two years for a full 30-day maintenance dosage).
- No alcohol use problem.
- Stable living conditions in an environment free of substance use.
- Stable and legal source of income.
- Involvement in productive activities (e.g., employment, school, volunteer work).
- No criminal or legal involvement for at least three years and no current parole or probation status.
- Adequate social support system, self help or 12 step attendance and absence of significant un-stabilized co-occurring disorders.

Discontinuation of Services:
Individuals must discontinue treatment with ~~methadone~~Methadone when treatment is completed with respect to both the medical necessity for the medication and for ~~counseling~~ treatment services according to their treatment plan. In addition, individuals may be terminated from services and referred elsewhere if they are not benefiting from services at the OTP ~~there is clinical and/or behavioral non-compliance~~. If an individual is terminated, the OTP must attempt to make a referral for ~~another~~ a more appropriate LOC ~~assessment~~ or for placing the individual at another OTP, and must make an effort to ensure that the individual follows through with the referral. These efforts must be documented in the medical record. The OTP must follow the procedures of the funding authority in coordinating these referrals. Any action to terminate treatment of a Medicaid recipient requires a notice of "action" be given to the individual. The individual has a right to appeal this decision and services must continue and dosage levels maintained while the appeal is in process.

Discontinuation of Service Forms:
Notice of Adverse Benefit Determination
Request for Internal Appeal Form (Medicaid)
Request for Local Appeal Form (Non-Medicaid)

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The following are reasons for discontinuation/termination:

1. Completion of Treatment – The decision to discharge an individual must be made by the OTP's physician with input from clinical staff and the individual. Completion of treatment is determined when the individual has fully or substantially achieved the goals listed in his/her individualized treatment and recovery plan and when the individual no longer needs ~~methadone~~Methadone as a medication. As part of this process, a reduction of the dosage to a medication-free state (tapering) should be implemented within safe and appropriate medical standards.

2. Administrative Discontinuation – The OTP must work with the individual to explore and implement methods to ~~facilitate compliance~~follow the individualized treatment plan. Administrative discontinuation relates to inability to follow through with ~~non-compliance with~~ treatment and recovery recommendations, and/or engaging in activities or behaviors that impact the safety of the OTP environment or other individuals who are receiving treatment. The repeated or continued use of illicit opioids and non-opioid drugs, including alcohol, shw~~ould~~ be addressed in treatment plan goals~~considered non-compliance~~. OTPs must perform toxicology

tests for ~~methadone~~Methadone metabolites, buprenorphine, buprenorphine metabolites, opioids, cannabinoids, benzodiazepines, cocaine, amphetamines, and barbiturates (***Administrative Rules of Substance Abuse Services Programs in Michigan***, R 325.138~~14406~~). Individuals whose toxicology results do not indicate the presence of ~~methadone~~Methadone metabolites must be considered ~~noncompliant~~, with the same actions taken as if illicit drugs (including non-prescribed medication) were detected.

OTPs must test for alcohol use if: 1) prohibited under their individualized treatment and recovery plan; or 2) the individual appears to be using alcohol to a degree that would make dosing unsafe. The following actions are also considered to be non-compliant:

- ~~Repeated failure~~[1] ~~to submit~~Refusal to provide to toxicology sampling as requested.
- ~~Repeated failure~~[1] Refusal to ~~attend scheduled individual and/or group counseling sessions, or other clinical activities such as psychiatric or psychological appointments.~~follow individualized treatment plan including treatment services or other recommended services.
- ~~Failure~~ Lack of ~~to~~ managing~~e~~ medical concerns/conditions, including adherence to physician treatment and recovery services and prescription medications that may interfere with the effectiveness of ~~methadone~~Methadone and may present a physical risk to the individual.
- ~~Repeated failure~~[1] ~~to~~Lack of follow through on other treatment and recovery plan related referrals. [1] ***~~Repeated failure~~Administrative discharge should be considered on an individual basis and only after the OTP has taken steps to assist individuals ~~to comply with activities~~in following treatment plans.***

The commission of acts by the individual that jeopardize the safety and well-being of staff and/or other individuals, or negatively impact the therapeutic environment, is not acceptable and can result in immediate discharge. Such acts include, but are not limited to the following:

- Possession of a weapon on OTP property.
- Assaultive behavior against staff and/or other individuals.
- Threats (verbal or physical) against staff and/or other individuals.
- Diversion of controlled substances, including ~~methadone~~Methadone.
- Diversion and/or adulteration of toxicology samples.
- Possession of a controlled substance with intent to use and/or sell on agency property or within a one block radius of the clinic.
- Sexual harassment of staff and/or other individuals.
- Loitering on the clinic property or within a one-block radius of the clinic.

Administrative discontinuation of services can be carried out by two methods:
1) Immediate Termination – This involves the discontinuation of services at the time of one of the above safety related incidents or at the time an incident is brought to the attention of the OTP.

2) Enhanced Tapering Discontinuation – This involves an accelerated decrease of the ~~methadone~~Methadone dose (usually by 10 mg or 10% a day). The manner in which ~~methadone~~Methadone is discontinued is at the discretion of the OTP physician to ensure the safety and well-being of the individual.

Commented [DB7]: Check to see if they are tested prior or is it just when suspected or history of alcohol use

It may be necessary for the OTP to recommend those being ~~refer individuals who are being~~ administratively discharged to ~~the local access management system for evaluation for~~ another level of care using the concurrent review. Justification for ~~noncompliance~~ termination must be documented in the individual's chart.

Commented [NA8]: End of state policy

Clarification of Substance-Dependence Treatment and Recovery with Methadone in Individuals with Prior or Existing Pain Issues

All persons assessed for a substance use disorder must be assessed using the ASAM patient placement criteria and the current Diagnostic and Statistical Manual of Mental Disorders (DSM). In the case of Opioid Use Disorder (OUD), pseudo-addiction must also be ruled out. Tolerance and physical dependence are normal consequences of sustained use of opioid analgesics and are not synonymous with an OUD. In some cases, primary care and other doctors may misunderstand the scope of the OTP and refer individuals to the OTP for pain control. The "Michigan Guidelines for the Use of Controlled Substances for the Treatment of Pain," should be consulted to assist in determining when substance use disorder treatment is appropriate, as well as the publication, Responsible Opioid Prescribing: A Michigan Physician's Guide by Scott M. Fishman, MD. This publication was distributed to all controlled substance prescribers in Michigan by the Michigan Department of Health & Medicaid Managed Specialty Supports and Services Program FY20 Attachment PII.B.A Human Services, Bureau of Health Professions, in September of 2009. OTPs are not pain clinics, and cannot address the underlying medical condition causing the pain. The OTP and CA are encouraged to work with the local medical community to minimize inappropriate referrals to OTPs for pain.

Individuals receiving ~~methadone~~Methadone as treatment for an OUD may need pain medication in conjunction with this adjunct therapy. The use of non-opioid analgesics and other non-medication therapy is recommended whenever possible. Opioid analgesics as prescribed for pain by the individual's primary care physician (or dentist, podiatrist) can be used; they are not a reason to initiate detoxification to a drug-free state, nor does their use make the individual ineligible for using ~~methadone~~Methadone for the treatment of OUD. The ~~methadone~~Methadone used in treating OUD does not replace the need for pain medication. It is recommended that individuals inform their prescribing practitioners that they are on ~~methadone~~Methadone, as well as any other medications. On-going coordination (or documentation of efforts if prescribing practitioners do not respond) between the OTP physician and the prescribing practitioner is required for continued services at the OTP and for any off-site dosing including Sunday and holidays.

VII. EXHIBITS

b. Methadone Treatment Program CMHPSM/~~Client~~Individual/Provider Agreement
c. State of Michigan Substance Abuse Contract
d. CMHPSM Grievance and Appeals Policy
e. MEDICATION ASSISTED TREATMENT GUIDELINES for OPIOID USE DISORDERS; State of Michigan, Department of Health and Human Services (2014)
f. ATTACHMENT A: CMHPSM/~~Client~~Individual/Provider Agreement
g. ATTACHMENT B: CMHPSM Concurrent Review Form
h. ATTACHMENT C: CMHPSM Notice of Denial or Change of Services for Non-Medicaid Recipients
i. ATTACHMENT D: CMHPSM ~~Client~~Individual Information Release Authorization

j. ATTACHMENT E: CMHPSM Methadone Continuing Care Evaluation

VIII. REFERENCES

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ATTACHMENT A

COMMUNITY MENTAL HEALTH PARTNERSHIP OF SOUTHEAST MICHIGAN

Methadone Treatment Program
CMHPSM/~~Client~~Individual/Provider Agreement

I, _____agree this day _____,
To the following conditions in order to receive and/or continue receiving the CMHPSM-funded ~~methadone~~Methadone treatment benefit:

1. I agree to reduce my use of all illegal and non-prescribed drugs to the point of abstinence from all illegal and non-prescribed drugs.

2. I agree to reduce my alcohol intake to the point of abstinence from all alcohol.

3. I understand that ~~methadone~~Methadone is used for the treatment of addiction to opioid drugs and not for pain management.

4. **I agree to attend the ~~methadone~~Methadone clinic for dosing on a daily basis including Sundays and Holidays if criteria for take home medications are not met.**

5. I agree to participate with my provider to develop an individualized treatment/recovery plan, which may include group and individual treatment sessions. Once this plan is developed, I agree to comply with the goals and objectives of the treatment plan.

6. I agree to follow all treatment program rules and policies. If I do not, I may be placed on probation and/or be detoxed from the ~~methadone~~Methadone clinic.

7. **I understand that I am required to give the names, addresses and phone numbers of all my prescribing practitioners over the past year, including my doctors, dentists and all other health care providers.** I also understand I am to sign Authorizations to Release Information with my medical, dental and pharmacy providers in order to better coordinate my treatment. I am aware that if I refuse to meet these expectations, it could negatively impact my success with treatment, **and may be grounds for refusal of admission**.

8. I agree to produce a valid prescription or current medication bottle (s) with doctor's name on the label for any controlled substances I take (especially pain medications and medications for anxiety). I understand I may be expected to authorize communication between my primary clinic and my ~~methadone~~Methadone clinic in order to coordinate the best care for me.

9. I understand I may be asked to change my prescribed medications as part of my treatment plan for recovery.

10. I understand I am to submit **monthly** random **toxicology testing**. I agree to submit to all urine drug screens, with the understanding that not doing so is the same as a positive screen. I understand specimens that have been tampered with will be considered a positive screen.

11. I understand if I test positive for a controlled substance that I have not previously provided a valid prescription for, I agree to present a valid prescription or current medication bottle (s) with the doctor's name on the label for the controlled substance.

12. I understand that I can place myself at risk of discharge for the following reasons:

    a. Treatment goals not met within two (2) years

Commented [NA9]: We should probably delete this and much/all of the rest of "policy". Agreed?

Commented [DB10R9]: Is this still required and used?

Commented [DB11R9]: Does this form need to look like the rest of our forms ask Drew

b. Repeated or continued use of one or more other drugs/alcohol prohibited on the ~~client~~individual's treatment plan, or drug screens negative for ~~methadone~~Methadone metabolites
c. Failure to attend individual and/or group ~~counseling~~treatment sessions or **other clinical activities such as psychiatric or psychological** appointments
d. Repeated failure to follow through on other referrals in the treatment plan
e. Failure to manage medial conditions or concerns, including adherence to physician treatment and recommendations
f. Failure to submit to drug testing as requested
g. Failure to provide documentation of prescribed medications

13. I understand that if I continue to put myself at risk of discharge, I will be offered detoxification from ~~methadone~~Methadone and my treatment will be terminated.

14. I understand that I am expected to taper off ~~methadone~~Methadone by the end of two years or to have become rehabilitated to the point where I am able to assume payment for my treatment.

15. I agree to follow my treatment plan in order to get the most out of my time in treatment. I understand I may be offered a program of detoxification, stabilization and drug-free services for ongoing substance abuse treatment if I am discharged from the ~~methadone~~Methadone clinic.

16. **I understand that my treatment may be terminated for engaging in behavior that jeopardizes the safety and wellbeing of the therapeutic environment, staff, and/or any other individual receiving treatment, including but not limited to the following violations:**

a. Possession of a weapon on clinic property
b. Assaultive behavior against staff and/or other ~~client~~individuals
c. Verbal or physical threats against staff and/or other ~~client~~individuals; may include emails or other special media, such as Facebook.
d. Diversion of controlled substances, including ~~methadone~~Methadone
e. Diversion and/or adulteration of drug screen samples
f. Possession of controlled substance with intent to use/sell on ~~methadone~~Methadone clinic property
g. Sexual harassment of staff and/or other ~~client~~individuals
h. Loitering on clinic property or within one (1) block radius of clinic

I have read this agreement, have had it explained to me, and I understand it. I agree to comply with this CMHPSM/~~Client~~Individual/~~Client~~Individual Agreement.

~~Client~~Individual signature and date

CMHPSM staff signature and date

Attachment #4d – July 2022
From: Methadone Treatment Provider
To: CMHPSM

_____ has read and had the CMHPSM OTP ~~Client~~Individual Agreement explained to him/her and has agreed to meet the terms of this agreement by signing this document.

Please sign and date this document to ensure that you are aware that the ~~client~~individual has agreed.

_____

Clinician's signature and date

Please fax the clinician signed copy back to the CMHPSM or designated Access Department and place the signed original in the ~~client~~individual's file. Thank you

Attachment B

COMMUNITY MENTAL HEALTH PARTNERSHIP OF SOUTHEAST MICHIGAN
LIVINGSTON – WASHTENAW SUBSTANCE ABUSE COORDINATING AGENCY

Concurrent Review Form

Commented [NA12]: If we want to keep this attachment, we need CRCT

Commented [DB13R12]: My opinion would be to remove this portion however, I would like to know the background reason this is placed in this policy (maybe it is needed).

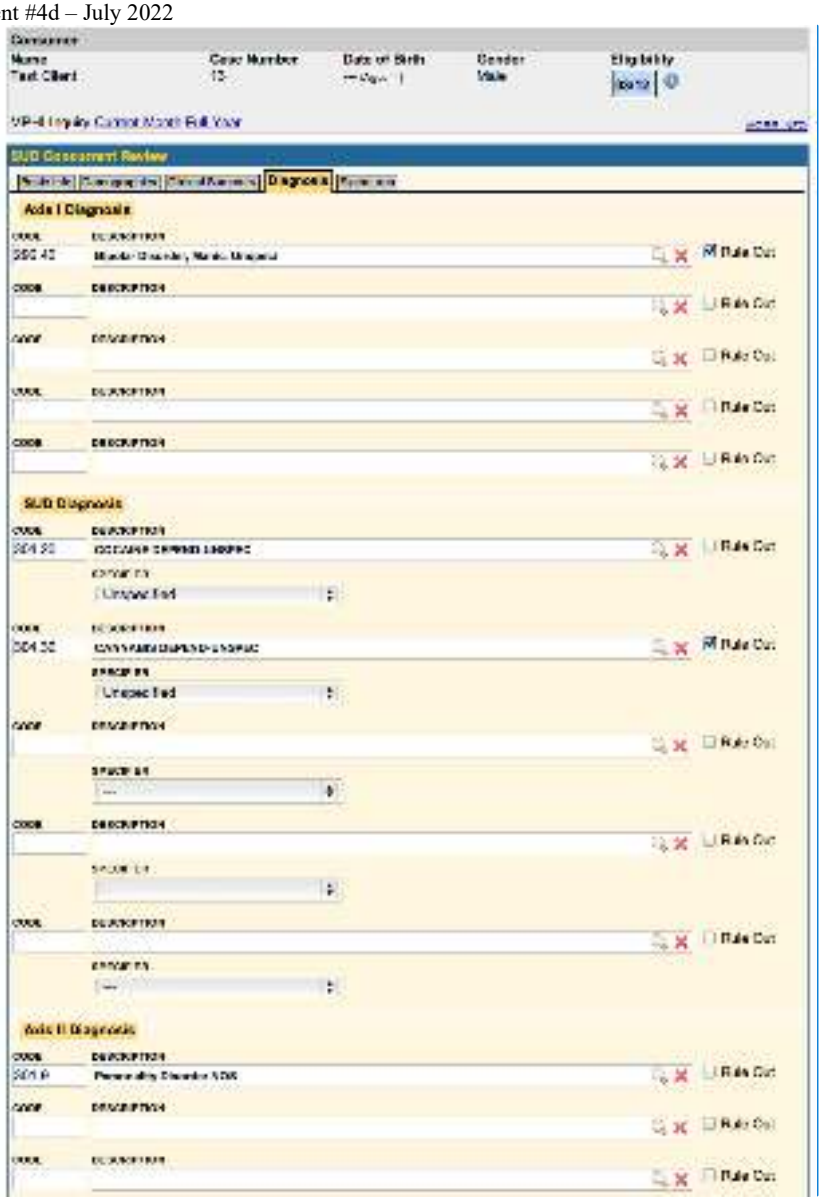
Commented [DB14R12]: Is attachment B addressed in the policy anywhere? Remove it from the policy

Attachment #4d – July 2022


Health and Other Conditions
Ability to hear
Hearing Aid Used
Adequate
No
Adequate
No
Pneumonia
Asthma
Upper Respiratory Infections
Gastroesophageal Reflux
Chronic Bowel Impaction
Seizure disorder or Epilepsy
Never present
Never present
Never present
Never present
Never present
Never present
Obesity
Not present
No
No
No


E.II
Consumer
Name
Case Number
Date of Birth
Gender
Eligibility
General Information
Level of Care
Stage of Change
Other Information
Goals
Drug Use in Last 30 Days
Primary
Secondary
Tertiary
Drug
Route of Administration
Age of First Use
Frequency of Use
Clinical
Clinical Summary

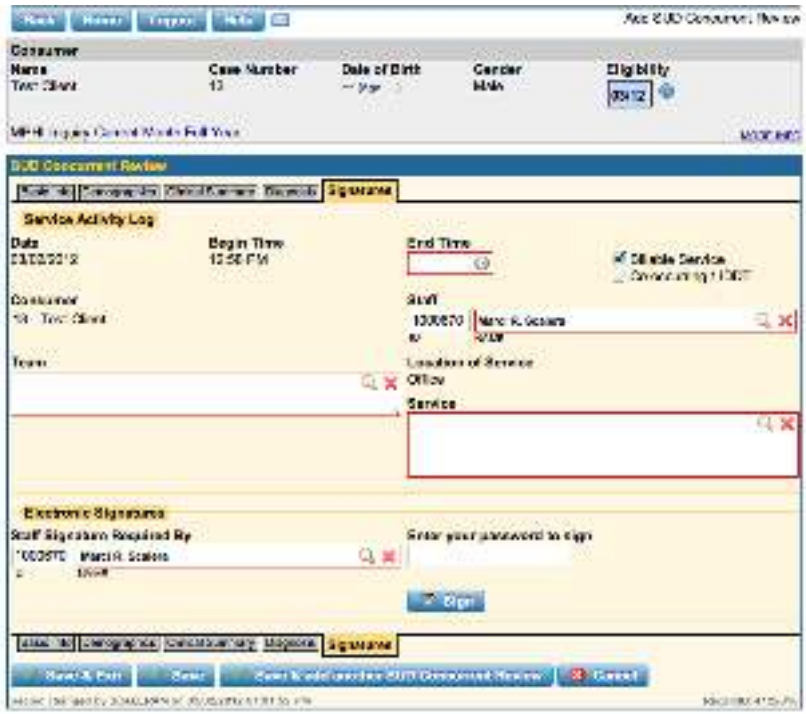
Attachment #4d – July 2022



Commented [DB15]: The diagnosis section appears to be outdated

Commented [DB16R15]: No it is not used further


Axis IV Diagnosis
Axis V Diagnosis
Current GAF
Date
Current GAS
Date
42
Diagnosis Summary
Diagnosis Information
Diagnosis Made By
Date
Diagnosis
Signature


Consumer
Name
Case Number
Date of Birth
Gender
Eligibility
SUD Concurrent Review
Signature
Service Activity Log
Date
Begin Time
End Time
Billable Service
Consumer
Staff
Team
Location of Service
Office
Service
Electronic Signature
Staff Signature Required By
Enter your password to sign
Sign
Signature
Cancel

Attachment C

Commented [NA17]: Keep?

Commented [DB18R17]: Probably can remove

Commented [DB19R17]: Ask CJ if this needs to be removed, we need to make a link for the Adverse Benefits Det.

Commented [DB20R17]: Link to our forms on our website

Community Mental Health Partnership of Southeast Michigan

NOTICE OF DENIAL OR CHANGE OF SERVICES FOR NON-MEDICAID RECIPIENTS

_____ _____

(Recipient Name and I.D. #) (Date)

Following a review of the services that you are currently receiving, it has been determined that the following service(s) must be denied or changed as follows:

Service(s)	Action to be Taken	Effective Date
_____	_____	_____
_____	_____	_____
_____	_____	_____

If you do not agree with this action you may:

- Speak with your worker or his/her supervisor. They will be happy to discuss this with you and try to resolve your concerns. They can also help you access any available conflict resolution mechanisms.
- Ask for a second opinion if your application for services has been denied, or if hospitalization has been denied, by signing, dating and returning the enclosed Request for Second Opinion form to CMHPSM within 30 days.
- Ask for a review by the Local Dispute Resolution Committee by contacting your local Grievance and Appeals Officer or your local Office of Recipient Rights at (734) 544-3000 within 90 days of the date of this Notice. In an emergency situation, an LDRC meeting may be held within 24 hours of receiving the necessary information.
- Once you receive a written decision from the Local Dispute Resolution Committee, if you are not satisfied with the outcome, you may then ask for a review by the Michigan Department of Health and Human Services Alternative Dispute Resolution Process.

If you would like further information or if you want help in pursuing your appeal options, please contact your local Grievance and Appeals Officer, Member Services, or your local Office of Recipient Rights at (734) 544-3000.

You can also contact the Regional Fair Hearings Officer at (734) 544-3000 for help with your appeal.

Attachment D

Commented [NA21]: Keep?
Commented [DB22R21]: Remove all attachments ?
Commented [DB23R21]: Remove

COMMUNITY MENTAL HEALTH PARTNERSHIP OF SOUTHEAST MICHIGAN

~~CLIENT~~INDIVIDUAL INFORMATION RELEASE AUTHORIZATION

I, _____Date of Birth: _____ am currently receiving Methadone Therapy and hereby authorize, Name of Clinic_____its director or designee, counselor, and/or case manager to release and obtain information contained in my ~~client~~individual records under the following conditions:

1. **Name of person(s) or organization to whom disclosure is to be made**:

   COMMUNITY MENTAL HEALTH PARTNERSHIP OF SOUTHEAST MICHIGAN

2. **Specific type of information to be disclosed**: The information pertaining to the diagnosis, participation, progress, treatment and prognosis of the above named ~~client~~individual during the course of treatment including HIV/AIDS/ARC, psychiatric/mental health and substance abuse information. This includes information via telephone, facsimile or U.S. Mail. **Other: _____**

3. **Purpose and need for the disclosure**: Medical evaluation for continuing Methadone Therapy and coordinating treatment, planning and follow up services:
   Other: _____

4. This consent is subject to revocation at any time except in those circumstances in which the program has taken certain actions on the understanding that the consent will continue unrevoked until the purpose for which the consent was given shall have been accomplished.

5. **Without expressed revocation, this consent expires for the following specified reasons:**

   DATE: _____ EVENT: _____
   CONDITION: _____

   If none is specified, release automatically expires upon the ~~client~~individual's discharge from the agency or organization to which the ~~client~~individual was referred for treatment, or within 1 year from the date of the ~~client~~individual's signature.

   I understand that my records cannot be disclosed without my written permission as stated in the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, unless otherwise provided for in the regulations. According to Reference MCL 333.5131 (5) (s), I acknowledge that my records contain or may contain HIV or AIDS information.

~~Client~~Individual **To Initial One:**
_____ I do not wish to continue Methadone Treatment and request **Detoxification** from Methadone
_____ I wish to continue Methadone Therapy with the **goal of becoming drug free**.
_____ I wish to continue Methadone Treatment and agree to the conditions of treatment.

~~Client~~Individual **comments**:
_____

_____ _____
~~Client~~Individual **signature (or parent/guardian, if applicable**) Date

_____ _____
Physician Signature Date

Attachment E

COMMUNITY MENTAL HEALTH PARTNERSHIP OF SOUTHEAST MICHIGAN

Methadone Continuing Care Evaluation

To be completed by treating physician

Date: _____
~~Client~~Individual Name: _____
Clinic Name: _____
DSM IV Diagnosis: _____ Code: _____
HIV Status: _____
Hepatitis Status: _____

To determine whether a patient should continue in Methadone treatment, the program physician in cooperation with the clinical staff must use the following ASAM Patient Placement criteria in evaluating the ~~client~~individual.

1. Acute narcotics dependence and/or potential relapse (check at least one):
_____ Continued Methadone maintenance is required to prevent relapse to illicit narcotic use.
_____ The patient needs ongoing medical monitoring and access to medical management.
_____ Patient continues to have adequate support systems to ensure commitment to continuing Methadone maintenance treatment.

Explain:
_____
_____

2. Biomedical Conditions and Complications (check at least one):
_____ There is a current or chronic illness and ~~opiate~~Opioid addiction problem that requires medical monitoring and management.
_____ There is a presence of or potential for:
episodic use of drugs other than narcotics; Positive HIV Status or AIDS; Chronic health conditions that could be medically compromised with discontinuation of Methadone maintenance treatment, including but not limited to liver disease or problems with the hepatic decompensation, Pancreatitis, Gastrointestinal, cardiovascular, and other systems disorders, Sexually transmitted diseases, Concurrent psychiatric illness requiring psychotropic medications; Tuberculosis, Hepatitis.
_____ Patient is pregnant and narcotic dependent.

Explain:
_____
_____

3. Emotional/Behavioral Conditions and Complications (check at least one):
_____ Patient's emotional/behavioral functioning may be jeopardized by discontinuation of Methadone maintenance treatment.
_____ Patient demonstrates the ability to benefit from Methadone treatment but may not have achieved significant life changes.
_____ Patient s making progress toward resolution of an emotional/behavioral problem, but has not sufficiently resolved problems to benefit from a transfer from Methadone maintenance to a less intensive level of care.
_____ Patient's emotional/behavioral disorder continues to distract the patient from focusing on treatment goals, however, the patient is responding to treatment, and it is anticipated that with additional intervention the patient will meet treatment objectives.
_____ Patient continues to exhibit risk behaviors endangering self or others but the situation is improving.
_____ Patient is being detained pending transfer to a more intensive treatment service.
_____ Patient has a diagnosed but stable emotional/behavioral or neurological disorder which requires monitoring, management, and/or psychotropic medication due to the patient's history of being distracted from recovery and/or treatment.

Explain:
_____
_____

4. Treatment Acceptance/Resistance (check at least one):

_____ Patient recognizes the severity of the drug problem, however, the patient exhibits little understanding of the detrimental effects of drug use, including alcohol, yet the patient is progressing in treatment.
_____ Patient recognizes the severity of the addiction and exhibits an understanding of his/her relationship with narcotics, however, the patient does not demonstrative behaviors that indicate the patient has assumed responsibility necessary to cope with the situation.
_____ Patient is becoming aware of responsibility for addressing the narcotic addiction, but still requires current level of treatment and psychotherapy to sustain person responsibility in treatment.
_____ Patient has accepted responsibility for addiction and has determined that ongoing Methadone treatment is the best strategy for preventing relapse to narcotics dependence.

Explain: _____
_____

5. Relapse Potential (check at least one):

_____ Due to continued relapse attributable to physiological cravings, the patient requires structured outpatient psychotherapy with Methadone to promote continued progress and recovery.
_____ Patient recognized relapse occurs, but has not developed or exhibited coping skills to interrupt, postpone or neutralize gratification, or to change impulse control behavior.
_____ Narcotic symptoms are stabilized, but have not been reduced to support successful functioning without structured outpatient treatment.
_____ Pharmacotherapy (Methadone) has been effective as an adjunct to psychotherapy and as a strategy used to prevent relapse, however, withdrawal from Methadone is likely to lead to recurrence of addiction symptoms and, possibly, relapse.

Explain: _____
_____

6. Recovery Environment (check at least one):

_____ Patient has not integrated and exhibited coping skills sufficient to survive stressful situations in the work environment, or has not developed vocational alternatives.
_____ Patient has not developed coping skills sufficient to successfully deal with a non-supportive family and social support environment or has not developed alternative living support systems.
_____ Patient has not integrated and exhibited the socialization skills essential to establishing a supportive family and social support environment.
_____ Patient has responded to treatment of psychosocial problems affecting patient's social and interpersonal life; however, the patient's ability to cope with psychosocial problems would be limited if the patient is transferred to a less intensive level of treatment.
_____ Patient's social and interpersonal life has not changed or deteriorated, however, the patient needs additional treatment to cope with his/her social and interpersonal life or to take steps to secure an alternative environment.
_____ Emotional and behavioral complications of addiction are present, however, the behavioral complications are manageable in a structured outpatient program. The behaviors include: 1) criminal activity involving illicit drugs, 2) victim of abuse or domestic violence, 3) inability to maintain a stable household, including the provision of food, shelter, supervision of children and health care, or 4) inability to secure or retain employment.

Explain: _____
_____

Has ~~client~~individual been consistent with clean urines? Yes No

If no, explain reason and plan:
_____
_____

Has ~~client~~individual been consistent with attending Individual and/ or Group Therapy sessions? Yes No

If no, explain reason and plan:
_____
_____

Does the ~~client~~individual have any medical conditions that are currently being treated? Yes No

If yes, explain: _____
_____

~~Client~~Individual's Mental Status:
_____
_____

Physician comments (include any ~~client~~individual treatment information that is not covered in this review that must be considered for re-evaluation of medical necessity for continuing Methadone Therapy):
_____
_____

_____ _____ _____
Print Physician Name Signature Date

Attach copy of last 6 months of Urine Drug Screens, Concurrent Review Form and Treatment Plan

~~CLIENT~~INDIVIDUAL: _____ CLINIC: _____ DATE: _____

TO BE COMPLETED BY REVIEWING PHYSICIAN CONSULTANT
Please initial

_____ ~~Client~~Individual meets medical necessity for continuation of Methadone Therapy.

_____ ~~Client~~Individual does not meet medical necessity for continuation of Methadone Therapy.
Alternative treatment is recommended.
Explain: _____

_____ ~~Client~~Individual should be place on probationary status and re-reviewed in _____ months.
Explain: _____

_____ Face to face evaluation is needed with the ~~client~~individual to gather further information. Schedule within _____

_____ Physician to physician review is recommended.

Comments:
_____
_____
_____

_____ _____ _____
Print Physician Name Signature Date

Date of Face to Face Evaluation (if applicable): _____ Time in: _____ Time out: _____

Comments:
_____
_____
_____

_____ _____ _____
Print Physician Name Signature Date

Date of Physician to Physician review: _____ Provider/~~client~~individual's physician: _____
Comments:
_____
_____

_____ _____ _____
Print Physician Name Signature Date

Please initial for final recommendation:

_____ ~~Client~~Individual meets medical necessity for continuation of Methadone Therapy.

_____ ~~Client~~Individual does not meet medical necessity for continuation of ~~Methadone~~ Therapy.
Alternative treatment is recommended.
Explain:
_____
_____

_____ ~~Client~~Individual should be place on probationary status and re-reviewed in _____ months.
Explain:
_____
_____

_____ _____ _____
Print Physician Name Signature Date

_____ _____ _____
Utilization Review Agency Date

Community Mental Health Partnership of Southeast Michigan/PIHP	*Policy* **Medication Assisted Treatment (MAT)/ Medication for Opioid Use Disorder (MOUD) – Buprenorphine and Naltrexone**
Department: SUD Services	**Regional Operations Committee Review Date 06/27/2022**
Implementation Date (1st of month following approval)	**Oversight Policy Board Approval Date**

I. PURPOSE

To have a uniform policy and procedure for all CMHPSM individuals requesting Buprenorphine or Naltrexone for Medication Assisted Treatment (MAT) or Medication for Opioid Use Disorder (MOUD) as a pharmacological support in Opioid Treatment Programs (OTPs) or Office Based Opioid Treatment (OBOT) locations.

II. REVISION HISTORY

DATE	MODIFICATION
June 2021	
December 2021	Information and Language
Will be OPB approval date	Information and Language

III. APPLICATION

This policy applies to any individual requesting MAT or MOUD to include Buprenorphine or Naltrexone as a pharmacological support; Opioid Treatment Program (OTP) Providers; and Utilization Review Staff.

IV. DEFINITIONS

Community Mental Health Partnership of Southeast Michigan (CMHPSM): The Regional Entity that serves as the PIHP for Lenawee, Livingston, Monroe and Washtenaw for mental health, developmental disabilities, and substance use disorder services.

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

Medication Assisted Treatment (MAT)/Medications for Opioid Use Disorder (MOUD) – These terms refer to medications used to treat Opioid Use Disorder (OUD). They are most commonly referred to as MAT, MOUD is a newer term being used to replace MAT in cases when OUD is the primary diagnosis. Naltrexone can also be used to for treatment of Alcohol Use Disorder (AUD).

Regional Entity: The entity established under section 204b of the Michigan Mental Health Code to provide specialty services and supports.

V. BACKGROUND

The Food and Drug Administration (FDA) approved Buprenorphine hydrochloride (Subutex®) and buprenorphine hydrochloride/naloxone hydrochloride (Suboxone®) on October 8, 2002 for the treatment of Opioid Use Disorder (OUD). There are other forms of these medications also approved by the FDA. Both buprenorphine and buprenorphine/naloxone can be administered in sublingual tablets or films (placed under the tongue) and gradually absorbed, or there are also injectable forms of these medications. Prior to their approval and subsequent scheduling as Schedule III medications, the only prescription medications approved for opioid substitution agents were Methadone and LAAM, both Schedule II medications. Schedule II medications must be prescribed to patients enrolled in OTPs. Because of the numerous federal and state regulations with respect to OTPs, the addition of Schedule III medications as adjunctive treatment greatly increases access to services for potential opioid use disorder treatment individuals because they can now receive medication for opioid use disorder through a qualified physician's office.

Buprenorphine is a partial agonist at the mu opioid receptor which allows for a decreased overall increase in dopamine release thus creating a ceiling effect of the addictive potential of the medication. Buprenorphine has a ceiling effect for toxicity because of its antagonist properties. Once a certain dose or receptor occupancy level is reached, additional dosing does not produce further toxicity. Studies have shown that buprenorphine plateaus at the equivalent of 40 to 60 milligrams of Methadone. Because of the maximum for toxicity, respiratory depression and/or death from overdose are less common than with opioid agonists, such as heroin, oxycodone, or Methadone. Concurrent use of buprenorphine with alcohol, benzodiazepines, or other respiratory depressants can still result in overdose. Naloxone (Narcan) is added to buprenorphine by the manufacturer to prevent diversion because, although the naloxone will have no effect when absorbed under the tongue, crushing and injecting the medication will result in sudden and intense withdrawal symptoms. The ceiling effect also restricts the medication's effectiveness in treating patients who have a need for high levels of opioid replacement medication.

Naloxone and Naltrexone are medications that also block the effects of morphine, heroin, and other opioids. As antagonists, they are especially useful as antidotes. Naltrexone has long-lasting effects, ranging from 1 to 3 days, depending on the dose. The injectable version of Naltrexone (Vivitrol*) lasts for 30 days. Naltrexone blocks the pleasurable effects of opioids and is useful in treating some highly motivated individuals. Naltrexone has also been found to be successful in preventing relapse following periods of abstinence. This medication can also be used for Alcohol Use Disorder.

Although behavioral and pharmacologic treatments can be extremely useful when employed alone, integrating both types of treatments will ultimately be the most effective approach. There are many effective behavioral treatments available for OUD. These can include residential and outpatient approaches. An important task is to match the best treatment approach to meet the particular needs of the individual.

VI. POLICY

Private physicians who have the Substance Abuse and Mental Health Services Administration (SAMHSA) waiver for prescribing buprenorphine/naloxone are limited to

managing 30 individuals on buprenorphine at any one time. An OTP physician who has the SAMHSA waiver may prescribe the medication for off-site use as if the physician were in private practice. The maximum number of active individuals would be 30 individuals. Qualified practitioners who undertake required training can treat up to 100 patients using buprenorphine for the treatment of OUD in the first year if they possess a waiver under 21 U.S.C. § 823(g)(2) (i.e., a DATA 2000 waiver) and meet certain conditions (SAMHSA.gov).

One of two conditions must be satisfied for qualified practitioners to treat 100 patients in their first year:

1. The physician holds a board certification in addiction medicine or addiction psychiatry by the American Board of Preventive Medicine or the American Board of Psychiatry and Neurology
2. The practitioner provides medication-assisted treatment (MAT) in a "qualified practice setting." A qualified practice setting is a practice setting that:
    - provides professional coverage for patient medical emergencies during hours when the practitioner's practice is closed;
    - provides access to case-management services for patients including referral and follow-up services for programs that provide, or financially support, the provision of services such as medical, behavioral, social, housing, employment, educational, or other related services;
    - uses health information technology systems such as electronic health records;
    - is registered for their State prescription drug monitoring program (PDMP) where operational and in accordance with Federal and State law; and
    - accepts third-party payment for costs in providing health services, including written billing, credit, and collection policies and procedures, or federal health benefits.

After one year at the 100-patient limit, qualifying practitioners who meet the above criteria can apply to increase their patient limit to 275. In addition, 42 CFR 8.655 defines circumstances in which qualifying practitioners may request a temporary increase to treat up to 275 patients to address emergency situations for six months (SAMHSA.gov). The waiver can be found here: https://buprenorphine.samhsa.gov/forms/select-practitioner-type.php

Program Requirements

1. The individual must have a Diagnostic Statistical Manual (DSM) impression of opioid use disorder as determined by the treating provider. All six dimensions of the current American Society of Addiction Medicine (ASAM) Patient Placement Criteria must be used. The individual must meet medical necessity criteria as determined by a physician who has a SAMHSA waiver to prescribe or dispense buprenorphine.

2. Buprenorphine/naloxone must be used as adjunct to opioid treatment throughout the continuum of care (OP, IOP, Residential, sub-acute detoxification, and Methadone adjunctive treatment as part of a detoxification regimen).

3. Toxicology screens must be done at intake and then on a random basis, at least weekly, for the first six months. For a new recipient to a program, the test results must be documented in the individual record prior to the initial dosing. After the first six months of negative screens testing must be done on a random frequency at least monthly. Screens must assay for opioids, cocaine, amphetamines, cannabinoids, benzodiazepines, and Methadone metabolites.

VIII. References

American Psychiatric Association. (2000). *The Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Text Revision, Washington, DC.

American Society of Addiction Medicine. (2001). *ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders*, Second Edition-Revised, ASAM UPC-2R, Chevy Chase, Maryland.
Become a Buprenorphine Waivered Practitioner; SAMHSA.gov; https://www.samhsa.gov/medication-assisted-treatment/become-buprenorphine-waivered-practitioner

Certification of Opioid Treatment Programs: United States Code of Federal Regulations, Title 42, Part 8, Washington, D.C. (2003).

Drug Addiction Treatment Act of 2000: PL106-310, Section 3502, United States House, 105th Congress, Washington, DC. (October 17, 2000).

Food and Drug Administration. (October 8, 2002). *Subutex and Suboxone Approved to Treat Opiate Dependence*, FDA Talk Paper, Washington, DC.

MDHHS Substance Use Disorder Services Policies, Behavioral Health and Developmental Disabilities Administration (BHDDA), OROSC. (2014) *Technical Advisory, Medication Assisted Treatment Guidelines for Opioid Use Disorders*
https://www.michigan.gov/documents/mdhhs/MAT_Guidelines_for_Opioid_Use_Disorders_524339_7.pdf

MDHHS Substance Use Disorder Services Policies, Behavioral Health and Developmental Disabilities Administration (BHDDA), OROSC. (2006) *Treatment Policy #3, Buprenorphine*
https://www.michigan.gov/documents/Treatment_Policy_03_Buprenorphine_145923_7.pdf

Opioid Drugs in Maintenance and Detoxification Treatment of Opiate Addiction; Addition of Buprenorphine and Buprenorphine Combination to List of Approved Opioid Treatment Medications: Federal Register, Volume 68, Number 99, pp 27937-27939, Interim final rule, United States Superintendent of Documents. (May 22, 2003).

Schuster, C and Seine, S. (October 8, 2002). *Interview*. University Psychiatric Clinic, Wayne State University, Detroit Michigan.

Community Mental Health Partnership of Southeast Michigan/PIHP	***Policy*** **Medication Assisted Treatment (MAT)/ Medication for Opioid Use Disorder (MOUD) ~~–~~ Buprenorphine and Naltrexone**
Department: **Author:** Nicole Adelman	**Local Policy Numbers (if used)**
Oversight Policy Board~~Regional Operations Committee~~ **Approval Date**	**Implementation Date**

I. PURPOSE

To have a uniform policy and procedure for all CMHPSM ~~client~~individuals requesting Buprenorphine or Naltrexone for Medication Assisted Treatment (MAT) or Medication for Opioid Use Disorder (MOUD) as a pharmacological support in Opioid Treatment Programs (OTPs) or Office Based Opioid Treatment (OBOT) locations.

II. REVISION HISTORY

DATE	REV. NO.	MODIFICATION
June 2021	original	
December 2021	1	Information and Language
April 18, 2022	2	Information and Language

III. APPLICATION

This policy applies to any ~~client~~individual ~~-~~requesting MAT or MOUD to include Buprenorphine or Naltrexone as a pharmacological support; Opioid Treatment Program (OTP)~~s~~ Providers; ~~OBOTs; ROSC Core Providers and~~ and Utilization Review Staff.

IV. DEFINITIONS

Community Mental Health Partnership of Southeast Michigan (CMHPSM): The Regional Entity that serves as the PIHP for Lenawee, Livingston, Monroe and Washtenaw for mental health, developmental disabilities, and substance use disorder services.

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

Medication Assisted Treatment (MAT)/Medications for Opioid Use Disorder (MOUD) – These terms refer to medications used to treat Opioid Use Disorder (OUD). They are most commonly referred to as MAT, ~~which is inclusive of Naltrexone being used for Alcohol Use Disorder (AUD).~~ MOUD is a newer term being used to replace MAT in cases when OUD is the primary diagnosis. Naltrexone can also be used to for treatment of Alcohol Use Disorder (AUD).

Regional Entity: The entity established under section 204b of the Michigan Mental Health Code to provide specialty services and supports.

V. BACKGROUND

The Food and Drug Administration (FDA) approved Buprenorphine hydrochloride (Subutex®) and buprenorphine hydrochloride/naloxone hydrochloride (Suboxone®) on October 8, 2002 for the treatment of Opioid Use Disorder (OUD). There are other forms of these medications also approved by the FDA. Both buprenorphine and buprenorphine/naloxone can beare administered in sublingual tablets or films (placed under the tongue) and gradually absorbed, or there are also injectable forms of these medications. Prior to their approval and subsequent scheduling as Schedule III medications, the only prescription medications approved for opioid substitution agents were methadoneMethadone and LAAM, both Schedule II medications. Schedule II medications must be prescribed to patients enrolled in OTPs. Because of the numerous federal and state regulations with respect to OTPs, the addition of Schedule III medications as adjunctive treatment greatly increases access to services for potential opioid use disorder treatment clientindividuals because they can now receive medication for opioid addiction treatmentuse disorder through a qualified physician's office.

Buprenorphine is a partial agonist at the mu opioid receptor which allows for a decreased overall increase in dopamine release thus creating a ceiling effect of the addictive potential of the medication. Buprenorphine has a ceiling effect for toxicity because of its antagonist properties. Once a certain dose or receptor occupancy level is reached, additional dosing does not produce further toxicity. Studies have shown that buprenorphine plateaus at the equivalent of 40 to 60 milligrams of methadoneMethadone. Because of the maximum for toxicity, respiratory depression and/or death from overdose are less common than with opioid opiate agonists, such as heroin, oxycodone, or methadoneMethadone. Concurrent use of buprenorphine with alcohol, benzodiazepines, or other respiratory depressants can still result in overdose. Naloxone (Narcan) is added to buprenorphine by the manufacturer to prevent diversion because, although the naloxone will have no effect when absorbed under the tongue, crushing and injecting the medication will result in sudden and intense withdrawal symptoms. The ceiling effect also restricts the medication's effectiveness in treating patients who have a need for high levels of opioid replacement medication. Studies are currently being done to determine the safety of buprenorphine/naloxone in pregnancy as well as breastfeeding.

Buprenorphine is a particularly attractive treatment for Opioid Use DisordersOUD because, compared with other medications, such as methadone, it causes weaker opiate opioid effects and is less likely to cause overdose problems. It is a partial agonist at the mu opioid receptor which allows for a decreased overall increase in dopamine release thus creating a ceiling effect of the addictive potential of the medication. Buprenorphine also produces a lower level of physical dependence, so patients who discontinue the medication generally have fewer withdrawal symptoms than do those who stop taking methadone. Because of these advantages, buprenorphine is appropriate for use in a wider variety of treatment settings than other currently available medications. Several other medications with potential for treating heroin overdose or addiction are currently under investigation by NIDA.

Naloxone and Nn~~n~~altrexone are medications that also block the effects of morphine, heroin, and other opioids. As antagonists, they are especially useful as antidotes. Naltrexone has long-lasting effects, ranging from 1 to 3 days, depending on the dose. The injectable version of Nn~~n~~altrexone (Vivitrol*) lasts for 30 days. Naltrexone blocks the pleasurable effects of ~~herein~~ opioids and is useful in treating some highly motivated individuals. Naltrexone has also been found to be successful in preventing relapse ~~by former opioid addicts released from prison on probation~~following periods of abstinence. This medication can also be used for Alcohol Use Disorder.

Although behavioral and pharmacologic treatments can be extremely useful when employed alone, ~~science has taught us that~~ integrating both types of treatments will ultimately be the most effective approach. There are many effective behavioral treatments available for ~~Opioid Use Disorders~~OUD. These can include residential and outpatient approaches. An important task is to match the best treatment approach to meet the particular needs of the ~~patient~~individual. ~~Moreover, several new behavioral therapies, such as contingency management therapy and cognitive-behavioral interventions, show particular promise as treatments for patients with Opioid Use Disorders~~OUD~~, especially when applied in concert with pharmacotherapies. Contingency management therapy uses a voucher-based system, where patients earn "points" based on negative drug tests, which they can exchange for items that encourage healthy living. Cognitive-behavioral interventions are designed to help modify the patient's expectations and behaviors related to drug use, and to increase skills in coping with various life stressors. Both behavioral and pharmacological treatments help to restore a degree of normalcy to brain function and behavior, with increased employment rates and lower risk of HIV and other diseases and criminal behavior.~~

VI. POLICY

~~**STANDARD**~~

~~PIHPs may choose to fund the cost of the buprenorphine/naloxone medication as adjunct therapy for opioid addiction in treatment services including residential, intensive outpatient, outpatient, and methadone programs. Allowable funding consists of federal block grant, state general funding, and local funding. Medicaid reinvestment savings may also be used if part of a Medicaid reinvestment plan submitted by the Pre-paid Inpatient Health Plan (PIHP) and approved by Centers for Medicare and Medicaid Services (CMS) and MDHHS/OROSC. PIHPs may use clients on a discretionary basis after covered services have been paid.~~

~~Clients with Medicaid coverage may have access to the pharmacy benefit for buprenorphine/naloxone. It must be preauthorized through the Medicaid pharmacy plan.~~

~~Opioid Treatment Programs (OTPs) providing services must conform to the Federal opioid treatment standards set forth under 42 C.F.R. Part 8, including off-site dosing when dispensing buprenorphine/naloxone. There is no limit to the number of clients to whom buprenorphine can be dispensed from an OTP.~~

Private physicians who have the Substance Abuse and Mental Health Services Administration (SAMHSA) waiver for prescribing buprenorphine/naloxone are limited to managing 30 ~~client~~individuals on buprenorphine at any one time. An OTP physician who has the SAMHSA waiver may prescribe the medication for off-site use as if the physician were in private practice. The maximum number of active ~~client~~individuals would be 30 ~~client~~individuals. Qualified practitioners who undertake required training can treat up to 100 patients using buprenorphine for the treatment of OUD in the first year if they possess a waiver under 21 U.S.C. § 823(g)(2) (i.e., a DATA 2000 waiver) and meet certain conditions (SAMHSA.gov).

One of two conditions must be satisfied for qualified practitioners to treat 100 patients in their first year:

1. The physician holds a board certification in addiction medicine or addiction psychiatry by the American Board of Preventive Medicine or the American Board of Psychiatry and Neurology
2. The practitioner provides medication-assisted treatment (MAT) in a "qualified practice setting." A qualified practice setting is a practice setting that:
    - provides professional coverage for patient medical emergencies during hours when the practitioner's practice is closed;
    - provides access to case-management services for patients including referral and follow-up services for programs that provide, or financially support, the provision of services such as medical, behavioral, social, housing, employment, educational, or other related services;
    - uses health information technology systems such as electronic health records;
    - is registered for their State prescription drug monitoring program (PDMP) where operational and in accordance with Federal and State law; and
    - accepts third-party payment for costs in providing health services, including written billing, credit, and collection policies and procedures, or federal health benefits.

After one year at the 100-patient limit, qualifying practitioners who meet the above criteria can apply to increase their patient limit to 275. In addition, 42 CFR 8.655 defines circumstances in which qualifying practitioners may request a temporary increase to treat up to 275 patients to address emergency situations for six months (SAMHSA.gov). The waiver can be found here: https://buprenorphine.samhsa.gov/forms/select-practitioner-type.php

Program Requirements

1. The ~~client~~individual ~~must have a Diagnostic Statistical Manual (DSM) impression of opioid dependency~~use disorder as determined by the treating provider~~Access Management System (AMS)~~. All six dimensions of the current American Society of Addiction Medicine (ASAM) Patient Placement Criteria must be used. The ~~client~~individual ~~must meet medical necessity criteria as determined by a physician who has a SAMHSA waiver to prescribe or dispense buprenorphine.

2. Buprenorphine/naloxone must be used as adjunct to opioid treatment throughout the continuum of care (OP, IOP, Residential, sub-acute detoxification, and ~~methadone~~Methadone adjunctive treatment as part of a detoxification regimen). ~~It cannot be used without counseling.~~

~~3.~~ Toxicology screens must be done at intake and then on a random basis, at least weekly, ~~frequency until three (3) consecutive screens are negative~~for the first six months. For a new recipient to a program, the test results must be documented in the individual record prior to the initial dosing. After the first six months of negative screens testing must be done ~~Thereafter, they must be done~~ on a ~~monthly,~~ random frequency at least monthly. Screens must assay for opioids, cocaine, amphetamines, cannabinoids, benzodiazepines, ~~, and Medicaid Managed Specialty Supports and Services Program FY20 Attachment PII.B.A methadone~~ and Methadone metabolites. ~~Screens must be random for days of the week and days since last screen was administered.~~

3.

~~4. As an adjunctive medication for the treatment of opioid addiction, the PIHP cannot pay for the buprenorphine/naloxone alone. The medication must be used in conjunction with counseling at a substance abuse treatment program under contract with the PIHP. The PIHP must develop a plan in which the substance abuse treatment program, a qualified physician, and a pharmacy are involved.~~

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~~Reporting Requirements~~
~~The data system has been modified to accommodate reporting for clients receiving buprenorphine/naloxone.~~

~~Data system:~~
~~• Admission and discharge Treatment Episode Data Set (TEDS) records must be submitted as is routine with other clients. In the client admission record, the field OPIOD TREATMENT PROGRAM (1= Methadone, 2= No, and 3= Buprenorphine) must be coded with "3" for all clients receiving buprenorphine/naloxone, regardless of service category.~~
~~• Buprenorphine/naloxone daily dosages and associated cost must be reported with HCPCS Code of H0033 as required in the 837 Professional Encounter record.~~

~~PROCEDURE:~~
Prescribing Policy
~~1. All physicians, including those at an OTP, must have a waiver from SAMHSA permitting them to prescribe or dispense buprenorphine/naloxone (e.g., Suboxone®).~~

~~2. Buprenorphine/naloxone (Suboxone®) must be used as an adjunctive treatment within an individualized treatment plan for opioid addiction. It is not appropriate as a stand-alone treatment procedure.~~

~~3. The target populations for buprenorphine/naloxone are the following:~~
~~• Clients who are being transferred from methadone as part of a detoxification regimen;~~
~~• Clients that have been opioid dependent less than one year, but for whom adjunctive therapy is deemed medically necessary; and~~
~~• Clients that are eligible for methadone adjunctive therapy within the 40-60 milligrams therapeutic range.~~

~~4. In accordance with FDA regulations, buprenorphine is not currently approved for pregnant women.~~
~~5. The combination medication buprenorphine/naloxone (Suboxone®) is the only medication approved for use under these guidelines. No "off-label" or experimental use of buprenorphine/naloxone is permitted under these policies.~~

VIII. References

American Psychiatric Association. (2000). *The Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Text Revision, Washington, DC.

American Society of Addiction Medicine. (2001). *ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders*, Second Edition-Revised, ASAM UPC-2R, Chevy Chase, Maryland.

Become a Buprenorphine Waivered Practitioner; SAMHSA.gov; https://www.samhsa.gov/medication-assisted-treatment/become-buprenorphine-waivered-practitioner

Certification of Opioid Treatment Programs: United States Code of Federal Regulations, Title 42, Part 8, Washington, D.C. (2003).

Drug Addiction Treatment Act of 2000: PL106-310, Section 3502, United States House, 105th Congress, Washington, DC. (October 17, 2000).

Food and Drug Administration. (October 8, 2002). *Subutex and Suboxone Approved to Treat Opiate Dependence*, FDA Talk Paper, Washington, DC.

MDHHS Substance Use Disorder Services Policies, Behavioral Health and Developmental Disabilities Administration (BHDDA), OROSC. (2014) *Technical Advisory, Medication Assisted Treatment Guidelines for Opioid Use Disorders* https://www.michigan.gov/documents/mdhhs/MAT_Guidelines_for_Opioid_Use_Disorders_524339_7.pdf

MDHHS Substance Use Disorder Services Policies, Behavioral Health and Developmental Disabilities Administration (BHDDA), OROSC. (2006) *Treatment Policy #3, Buprenorphine* https://www.michigan.gov/documents/Treatment_Policy_03_Buprenorphine_145923_7.pdf

Opioid Drugs in Maintenance and Detoxification Treatment of Opiate Addiction; Addition of Buprenorphine and Buprenorphine Combination to List of Approved Opioid Treatment Medications: Federal Register, Volume 68, Number 99, pp 27937-27939, Interim final rule, United States Superintendent of Documents. (May 22, 2003).

Schuster, C and Seine, S. (October 8, 2002). *Interview*. University Psychiatric Clinic, Wayne State University, Detroit Michigan.

Community Mental Health Partnership of Southeast Michigan/PIHP	*Policy and Procedure* *Substance Abuse Residential Room and Board SDA Policy*
Department: SUD Services	**Regional Operations Committee Review Date 06/27/2022**
Implementation Date (1st of month following approval)	**Oversight Policy Board Approval Date**

I. PURPOSE

To ensure State Disability Assistance (SDA) earmarked funds are appropriately distributed for eligible recipients.

II. POLICY

It is the policy of the CMHPSM to utilize State Disability Assistance (SDA) when available, to ensure the funding of room and board for individuals requiring a residential level of care within the Region. The individual must attest to the fact that they are SDA eligible through Michigan Department of Health and Human Services (MDHHS) prior to the provider billing for room and board using a CMHPSM designated form.

III. REVISION HISTORY

DATE	MODIFICATION
9/18/07	Original policy
6/2021	Update Language and process
1/24/2021	Language
Will be OPB approval date	Language

IV. APPLICATION

This policy applies to SDA eligible individuals, eligible residential providers; CMHPSM SUD Team and Finance Department

V. DEFINITIONS

Eligible provider: Provider of Residential Substance Abuse services located within Lenawee, Livingston, Monroe or Washtenaw counties

Eligible Individual: Individual who meets the financial eligibility criteria as determined by the Michigan Department of Health and Human Services, has completed the application process, and has been granted Supplemental Disability Assistance (SDA), or has met eligibility criteria as listed on the form below.

Residential Substance Use Disorder Treatment: Treatment in a residential setting that provides structured clinical services as determined by ASAM level of care.

VI. STANDARDS

All individuals receiving SDA funding for room and board will have the designated form submitted by the residential provider and will be reviewed by the PIHP.

According to MDHHS SDA website:
To receive SDA, a person must be disabled, caring for a disabled person, or age 65 or older.

A person is disabled for SDA purposes if they:

- receives other specified disability-related benefits or services (e.g., Retirement, Survivors and Disability Insurance (RSDI) or Supplemental Security Income (SSI) due to disability or blindness, etc.), or
- resides in a qualified Special Living Arrangement facility (e.g., Home for the Aged, County Infirmary, Adult Foster Care Home or Substance Abuse Treatment Center), or
- is certified (a review process initiated by the MDHHS Specialist) as unable to work due to mental or physical disability for at least 90 days from the onset of the disability.

VII. PROCEDURE

1. PIHP will have a written agreement with providers to provide SDA funds.
2. Eligible Residential Provider determines whether individual currently has been approved for SDA. If not, refers individual to MDHHS for application if individual is in need and meets preliminary criteria.
3. If individual has not yet been approved by MDHHS but meets criteria on designated form below and is confirmed to be receiving residential services, individual will be considered eligible.
4. Provider will submit on a monthly invoice billing that at a minimum includes individuals initials, Date of Birth, Admission Date, Discharge Date (if applicable), number of days billed, SDA charges per day, and total charges. Documentation of SDA eligibility using the designated form must accompany the invoice.
5. PIHP will verify residential treatment status and will authorize for residential treatment when the PIHP expects to reimburse the provider for the treatment.

VIII. REFERENCES

General Administrative Requirements: Code of Federal regulations, Title 45, Part 160, US Government, (2013)
https://www.govinfo.gov/content/pkg/CFR-2020-title45-vol2/pdf/CFR-2020-title45-vol2-part160.pdf

Reference:	Check if applies:	Standard Numbers:
42 CFR Parts 400 et al. (Balanced Budget Act)	X	
45 CFR Parts 160 & 164 (HIPPA)	X	
42 CFR Part 2 (Substance Abuse)	X	
Michigan Mental Health Code Act 258 of 1974		
JCAHO- Behavioral Health Standards		

MDHHS Medicaid Contract		
MDHHS Substance Abuse Contract	X	
Michigan Medicaid Provider Manual		
MDHHS SDA website	X	

This form is to be used as a screening tool to help determine if an individual may qualify for SDA funding for a portion of your residential treatment services through CMHPSM. Please complete the following information:

1. I am 18 years of age or older. ☐True ☐False
2. I am a Michigan resident. ☐True ☐False
3. I am U.S. citizen or have an acceptable alien status. ☐True ☐False
4. I am not receiving any type of cash assistance from another state. ☐True ☐False
5. Please list cash assets: (*do not include property owned such as cars, homes, land, etc.):*

- Amount of cash on hand: _____
- Bank account balances: _____
- Any other type of cash assets such as Investments, Retirement plans, Trusts, etc.: _____

Total Cash Assets: _____

- My total cash assets are $3,000 or less. ☐ True ☐False

I verify that the above statements are true.

_____
PRINT Individual Name

_____ _____
Individual Signature Date

If this screening has determined you may be eligible for residential SDA funding, you are encouraged to contact your local Michigan Department of Health & Human Services office/MI Bridges website to apply for full SDA benefits. The state of Michigan has more eligibility guidelines that must be met.

Provider Use Only

Screening positive for SDA eligibility? ☐Yes ☐No
Individual participating or admitted for residential services? ☐Yes ☐No

Staff will verify that this individual meets the ASAM criteria for residential level of care.

_____
PRINT Staff Name

_____ _____
Staff Signature Date

~~WCHO~~ Community Mental Health Partnership of Southeast Michigan/PIHP	***Policy and Procedure*** ***Substance Abuse Residential Room and Board SDA Policy***
Department: Substance Abuse **Author: Marci Scalera**	**Local Policy Number (if used)**
Approval Date **9/18/07**	**Implementation Date** **10/18/07**
~~Archive Information~~	
~~Date:~~	
~~Reason:~~	

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I. PURPOSE

To ensure State Disability Assistance (SDA) earmarked funds are appropriately distributed for eligible recipients.

II. POLICY

It is the policy of the CMHPSM ~~WCHO~~ to utilize State Disability Assistance (SDA) when available, to ensure the ~~for~~ funding of room and board for ~~clients~~individuals requiring a residential level of care within the ~~Substance Abuse Coordinating Agency~~ Region. The ~~client~~individual must attest to the fact that they are ~~will be determined to be~~ SDA eligible through Michigan Department of Health and Human Services (MDHHS) prior to the provider billing for room and board ~~services~~ using a CMHPSM designated form.~~.~~

Commented [DB1]: Nicole will reach out to Mecomb Co. to inquire if they have to gain approval through MDHHS first

III. REVISION HISTORY

DATE	REV. NO.	MODIFICATION
9/18/07		Original policy
6/2021		Update Language and process
1/24/2021		Language
4/18/2022		Language

~~III.~~IV. APPLICATION

This policy applies to SDA eligible ~~clients~~individuals, eligible residential providers; ~~Health Services Access~~CMHPSM SUD Team and Finance Department

~~IV.~~V. DEFINITIONS

Eligible provider: Provider of Residential Substance Abuse services located within Lenawee, Livingston, Monroe or Washtenaw cCounties

Eligible clientIndividual: ClientIndividual who meets the financial eligibility criteria as determined by the Michigan Department of Health and Human Services, and has completed the application process, and has been granted Supplemental Disability Assistance (SDA), or has met eligibility criteria as listed on the form below.

Residential Substance UAbuse Disorder Treatment: Short-term (less than 30 days) and Long-term (greater than 30 days)Treatment in a residential setting that provides 3 or more structured clinical services daily as determined by ASAM level of care., 24-hour supervision

V.VI. STANDARDS

All clientsindividuals receiving SDA funding for room and board will have the designated form submitted by the residential provider and will be reviewed by Health Services Accessthe PIHP. to ensure they meet ASAM criteria forare receiving Residential servicesLevel of Care, regardless of treatment funding source.

According to MDHHS SDA website:
To receive SDA, a person must be disabled, caring for a disabled person, or age 65 or older.

A person is disabled for SDA purposes if hethey:

- receives other specified disability-related benefits or services (e.g., Retirement, Survivors and Disability Insurance (RSDI) or Supplemental Security Income (SSI) due to disability or blindness, etc.), or
- resides in a qualified Special Living Arrangement facility (e.g., Home for the Aged, County Infirmary, Adult Foster Care Home or Substance Abuse Treatment Center), or
- is certified (a review process initiated by the MDHHS Specialist) as unable to work due to mental or physical disability for at least 90 days from the onset of the disability.

VII. PROCEDURE

1. PIHP will have a written agreement with providers to provide SDA funds.
2. Eligible Residential Provider determines whether clientindividual currently has been approved for SDA. If not, refers clientindividual to DHHSMDHHS for application if clientindividual is in need and meets preliminary criteria.
1. For Non-CMHPSM funded clients, submits completed clinical assessment to PIHP, and requests determination to be in need of residential services.
3. If individual has not yet been approved by MDHHS but meets criteria on designated form below and is confirmed to be receiving residential services, individual will be considered eligible.
4. Provider will submit on a monthly invoice or Financial Status Report (FSR) billing that at a minimum includes client individuals initials, Date of Birth, number, SDA authorization number, AdmitAdmission Date, Discharge Date (if applicable), number of f prior days billed, number of days this billing, SDA charges per day, and total charges. Documentation of SDA eligibility using the designated form must accompany the invoice/FSR.

5. PIHP will verify residential treatment status and will authorize for residential treatment when the PIHP expects to reimburse the provider for the treatment. ~~Reviews Clinical Assessment and verifies residential treatment status for Non-Funded SDA Clients~~

~~Enters information onto a "CLIENT SCREENING CALL" screen in CRCT~~
~~Selects under 'Insurance Information' "Coordinating Agency Resources" and "SDA, SSI, SSDI"~~
~~Under Services Needed, selects "Other" and Specify (if "Other") "*ROOM AND BOARD*"~~
~~Under Disposition, denote Immediate action taken*: "meets criteria for residential"*~~

~~Agency submits monthly invoice including eligibility criteria form, provider must determine prior to billing if individual is eligible for SDA, and confirm residential treatment services.~~

~~PIHP rindividuals~~

~~VI.~~VIII. EXHIBITS

~~See attachment "A" below~~

IX. REFERENCES

General Administrative Requirements: Code of Federal regulations, Title 45, Part 160, US Government, (2013) https://www.govinfo.gov/content/pkg/CFR-2020-title45-vol2/pdf/CFR-2020-title45-vol2-part160.pdf

Reference:	Check if applies:	Standard Numbers:
42 CFR Parts 400 et al. (Balanced Budget Act)	X	
45 CFR Parts 160 & 164 (HIPPA)	X	
42 CFR Part 2 (Substance Abuse)	X	
Michigan Mental Health Code Act 258 of 1974		
JCAHO- Behavioral Health Standards		
MDHHS~~DCH~~ Medicaid Contract		
MDHHS~~CH~~ Substance Abuse Contract	X	~~2007, Attachment A; General Services Section 1.c~~
Michigan Medicaid Provider Manual		
MDHHS SDA website	X	

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Commented [NA2]: This is not happening. Is this still required? Right now, DF sends an invoice and assessment, it's confirmed and Finance pays the invoice; nothing is happening in CRCT.
Commented [DB3R2]: We aren't billing this through CRCT approved removal
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Commented [DB4]: https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-C/part-160
Commented [DB5]: http://www.legislature.mi.gov/(S(jkpd1bknqzfzvdwejl4feoak))/mileg.aspx?page=getObject&objectName=mcl-330-1508
Commented [NA6]: Didn't see in contract
Commented [DB7R6]: Check Again

PROCEDURES

WHO	DOES WHAT
Eligible Residential Provider	2. Determines whether client currently has been approved for SDA. If not, refers client to DHS for application if client is in need and meets preliminary criteria. 3. For Non-WCHO funded clients, Submits completed clinical assessment to Health Services Access, and requests determination to be in need of residential services. 4. Submit on a monthly Financial Status Report (FSR) billing that at a minimum includes client number, SDA authorization number, Admit Date, Discharge Date, number of prior days billed, number of days this billing, SDA charges per day, and total charges. Documentation of SDA eligibility must accompany the FSR.
Health Services Access	1. Reviews Clinical Assessment and verifies residential treatment status based on ASAM Level of Care Criteria for Non-Funded SDA Clients 2. Enters information onto a "CLIENT SCREENING CALL" screen in the Encompass System 3. Selects under 'Insurance Information' "Coordinating Agency Resources" and "SDA, SSI, SSDI" 4. Under Services Needed, selects "Other" and Specify (if "Other") "*ROOM AND BOARD*" 5. Under Disposition, denote Immediate action taken*: "meets criteria for residential"*
Finance Department	1. Processes FSR 2. Ensures appropriate funding stream is applied for room and board for SDA clients who are WCHO funded through GF funds 3.1. Reimburses provider for Non-funded SDA clients who are approved by Health Services Access

1.

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~~ATTACHMENT A~~

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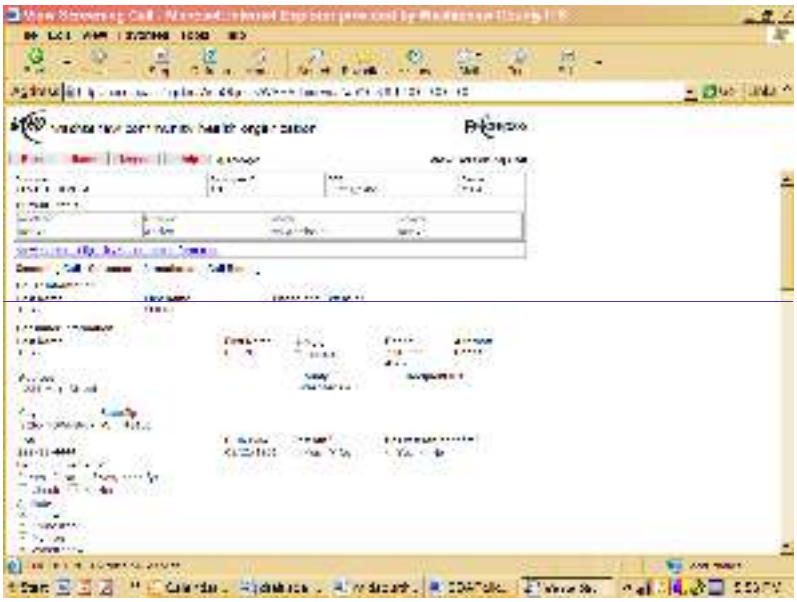

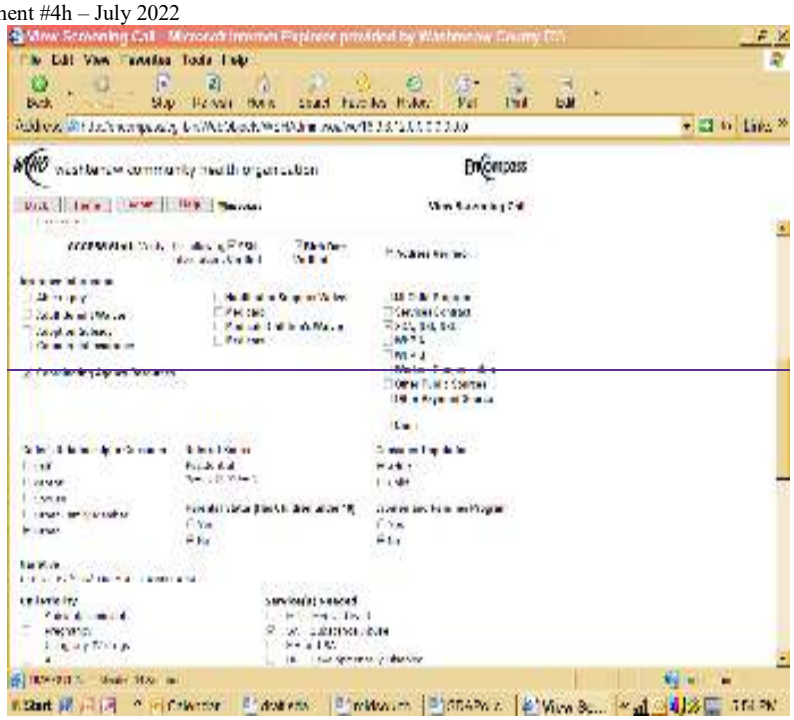

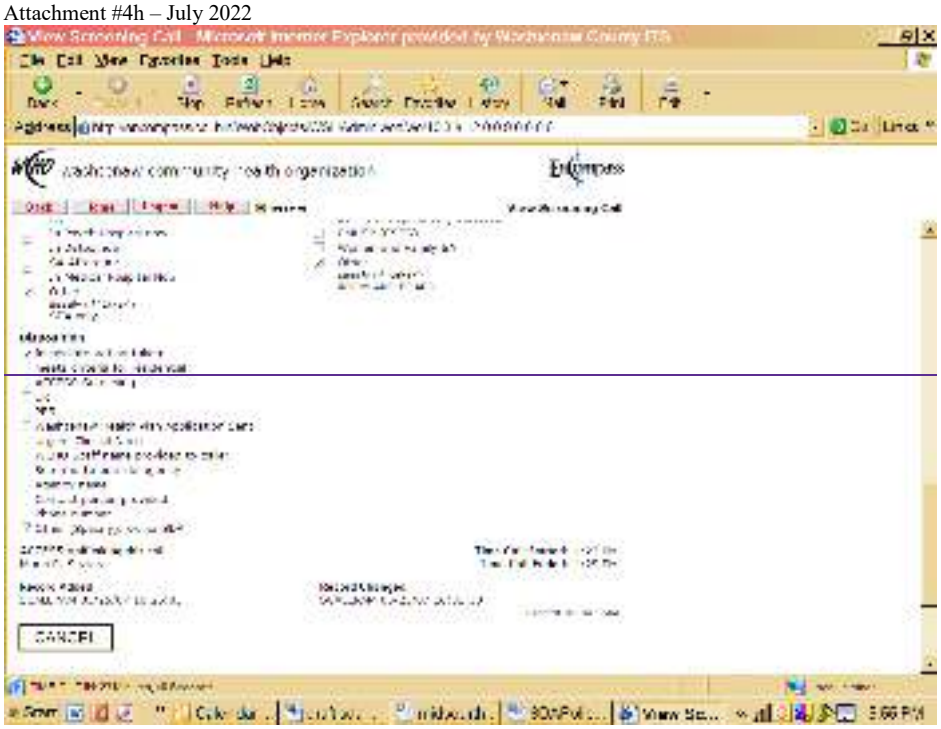
CANCEL

Exhibit B **WCHO Author Policy Flow Checklist**

Author must ensure all steps, in order, of this process are completed.

- [x] Policy Author notifies the PIHP point person of need for new/change in policy
  - Notes expected completion date
  - Obtains official policy template from PIHP policy format specialist, action form and checklist if needed.
- [x] Policy Drafting
  - Obtain all standards
  - Obtain stake holder input
- [X] Completed draft to PIHP management team
  - Review and provide feedback
- [X] Incorporate Mgt. Team Recommendations
- [ ] Send to PIHP Policy Format Specialist
  - Formats and corrects all spelling/grammar errors
  - Places policy in OOC electronic file.
  - PIHP Management Assistant puts policy in board packet and notifies author of date to attend board meeting
- [ ] Present Policy to the Organizational Operations Committee
- [ ] Incorporate board changes and send to PIHP Point Person
  - PIHP management assistant documents in minutes and forwards to WCHO management assistant for full board packet
  - Full board approves and WCHO management assistant notifies PIHP point person
  - PIHP point person sends to PIHP Policy Format Specialist
  - PIHP Policy Format Specialist formats policy and saves to policy manual and sends to PIHP point person, WCHO/regional website specialist and to provider website specialist
  - PIHP point person Sends policy to all staff

This is an optional form to assist you through the policy development process. Please do not submit this form with the policy at each step of the process

CMHPSM State Disability Assistance (SDA)

This form is to be used as a screening tool to help determine if an individual may qualify for SDA funding for a portion of your residential treatment services through CMHPSM. Please complete the following information:

1. I am 18 years of age or older. ☐True ☐False
2. I am a Michigan resident. ☐True ☐False
3. I am U.S. citizen or have an acceptable alien status. ☐True ☐False
4. I am not receiving any type of cash assistance from another state. ☐True ☐False
5. Please list cash assets: (*do not include property owned such as cars, homes, land, etc.):*
   - Amount of cash on hand: _____
   - Bank account balances: _____
   - Any other type of cash assets such as Investments, Retirement plans, Trusts, etc.: _____
     Total Cash Assets: _____
   - My total cash assets are $3,000 or less. ☐ True ☐False

I verify that the above statements are true.

_____
PRINT Client Name

_____ _____
Client Signature Date

If this screening has determined you may be eligible for residential SDA funding, you are encouraged to contact your local Michigan Department of Health & Human Services office/MI Bridges website to apply for full SDA benefits. The state of Michigan has more eligibility guidelines that must be met.

Staff Use Only

Screening positive for SDA eligibility? ☐*Yes ☐No

*If 'Yes' for SDA is true, complete SDA form in FOCUS under the "Funding Sources and Insurance Policies" link.

_____
PRINT Staff Name

_____ _____
Staff Signature Date

Commented [DB9]: Take out client and place it as individual, update it to say attestation form

Commented [DB10R9]: Staff use only is for the Provider staff, make a statement that says staff verifies that this individual meets the ASAM criteria for residential level of care

Commented [DB11R9]: Individual participating or admitted for residential services place another Yes no box were the focus is

COMMUNITY MENTAL HEALTH PARTNERSHIP OF SOUTHEAST MICHIGAN
REGULAR BOARD MEETING MINUTES
July 13, 2022

Members Present: Judy Ackley (remote), Roxanne Garber, Bob King, Sandra Libstorff, Jim Neumann, Randy Richardville, Mary Serio, Sharon Slaton, Holly Terrill (remote)

Members Absent: Molly Welch Marahar, Alfreda Rooks, Katie Scott, Ralph Tillotson

Staff Present: Kathryn Szewczuk, Stephannie Weary, James Colaianne, CJ Witherow, Matt Berg, Lisa Jennings, Trish Cortes, Nicole Adelman, Connie Conklin

Guests Present:

I. Call to Order
Meeting called to order at 6:04 p.m. by Board Chair S. Slaton.

II. Roll Call
- Quorum confirmed.

III. Consideration to Adopt the Agenda as Presented
Motion by R. Garber, supported by B. King, to approve the agenda
Motion carried

IV. Consideration to Approve the Minutes of the 5-11-2022 Regular Meeting and Waive the Reading Thereof
Motion by M. Serio, supported by R. Garber, to approve the minutes of the 5-11-2022 regular meeting and waive the reading thereof
Motion carried

V. Audience Participation
None

VI. Old Business
a. Board Information: June Finance Report – FY2022 as of May 31st
   - M. Berg presented.
   - S. Slaton requested that the funds related to the current status of the historical deficit be included in the future Financial Summary documents.

b. Board Action: Board Governance Policy Manual Revision
Motion by M. Serio, supported by R. Garber, to approve the updated Board Governance Policy Manual
Motion carried
Roll Call Vote
Yes: Garber, King, Libstorff, Neumann, Richardville, Serio, Slaton
No:
Non-Voting: Ackley, Terrill
Absent: Welch Marahar, Rooks, Scott, Tillotson

VII. New Business

a. Board Action: FY2022 Q3-4 Provider Stability Funding
Motion by R. Garber, supported by B. King, to approve the proposed allocation of funding to the CMHSPs to assist the regional provider network in delivering essential face-to-face services
Motion carried
Roll Call Vote
Yes: Garber, King, Libstorff, Neumann, Richardville, Serio, Slaton
No:
Non-Voting: Ackley, Terrill
Absent: Welch Marahar, Rooks, Scott, Tillotson

b. Board Action: Contracts
Motion by B. King, supported by J. Neumann, to authorize the CEO to execute the contract amendments as presented
Motion carried
Roll Call Vote
Yes: Garber, King, Libstorff, Neumann, Richardville, Serio, Slaton
No:
Non-Voting: Ackley, Terrill
Absent: Welch Marahar, Rooks, Scott, Tillotson

c. Board Action: Susan Fortney Proclamation
Motion by S. Libstorff, supported by J. Neumann, to authorize the CMHPSM Board Chair to sign a formal proclamation acknowledging the four years of service by Susan Fortney to the PIHP region as a CMHPSM Regional Board member
Motion carried

d. Board Information: CEO Authority Update
- After a regional procurement process, Roslund, Prestage & Company was retained for FY2023 audit services and a contract will be brought forward with the FY2023 contract list in September.
- Washtenaw County requires a contracted related to PA2 funds, which the CEO signed.

VIII. Reports to the CMHPSM Board

a. No report from the SUD Oversight Policy Board
b. Board Information: CEO Report to the Board
- The 3rd employee engagement survey was released this week. The survey is conducted every 18 months. Staff has until the end of the month to complete the survey.
- Legislation: it's not expected that either the senate or house bills will move this summer.
- Rates: There have been some FY23 rate projections. The Public Health Emergency (PHE) is not projected to end before the end FY23, which comes with an increase of eligibles. With the increase of eligibles, the state is expecting to lower rates to offset the eligibles increase. The state has committed to adjusting the rates if the PHE ends sooner than expected.
- The draft FY23 budget will be presented at the August board meeting.
- There will be a 10-15 anti-stigma training for board members at the August meeting if there is room on the agenda.

IX. Adjournment

Motion by J. Neumann, supported by B. King, to adjourn the meeting
Motion carried

Meeting adjourned at 6:58 p.m.

_____
Sandra Libstorff, CMHPSM Board Secretary

CEO Report

Community Mental Health Partnership of Southeast Michigan

Submitted to the CMHPSM Board of Directors

July 6, 2022 for the July 13, 2022 Meeting

CMHPSM Update

- The CMHPSM had all-staff meetings on May 9, May 23, June 13 and June 27. We are scheduled to meet on July 11 and potentially July 25.
- The CMHPSM leadership team is continuing to meet on a weekly basis.
- The CMHPSM increased our employee business mileage reimbursement amount beginning on July 1 to $0.625 per mile to align with the updated IRS guidance.
- We will be releasing our third employee engagement survey on July 11, 2022. This survey has been released every 18 months beginning in June 2019. We are adding some additional questions to the survey based upon suggestions from the Employee Engagement Committee. Results should be available to the CMHPSM Regional Board in August.

COVID-19 Update

- The CMHPSM office continues to be closed to the public outside of public Board meetings. We implemented a March 28, 2022 return to the yellow reduced capacity phase. The most recent version of the re-opening plan is continually shared with staff as it is updated. The leadership team is continuing to review statewide and county guidance related to best practices.
- We will continue to monitor recommendations around the projected return to full office capacity in the future.

Re-Opening Plan Phase as of July 6, 2022:

Phase:	**Essential Only Capacity**	**Limited Capacity**	**Reduced Capacity**	**Full Capacity**
Office:	**Office Closed**	**Limited Office Attendance and Office Closed to Public (Except for Board Meetings)**	**50% Capacity – 75% Capacity and Office Closed to Public (Except for Board Meetings)**	**100% Capacity – Office Open to Public**
Projected Date Range for Phase:			3/28/2022 – 7/31/2022	8/1/2022
Current Phase:			**X**	

CMHPSM Staffing Update

- The CMHPSM has recently filled four open positions:
  - Callie Finzel joined us in June in a newly created Operations Specialist position.
  - Jonathon Huhn also joined our team in June as our second SUD Treatment and Utilization Specialist.
  - Heather Schubbe joined our team as a regional SIS Assessor in July.
  - Stacy Pijanowski is the new CMHPSM Regional Administrative Assistant joining us in July.

- The CMHPSM currently has two open positions that we are accepting applications for:
  - Accountant
  - Information Management Coordinator

- More information and links to job descriptions and application information can be found here: https://www.cmhpsm.org/interested-in-employment

Regional Update

- The CMHPSM continues to update our general COVID-19 resources and information on our website: https://www.cmhpsm.org/covid19
- We have also established a webpage for provider information related to service delivery changes during this pandemic: https://www.cmhpsm.org/covid19provider
- Individuals receiving Behavioral Health and/or substance use disorder services can access targeted information at the following webpage: https://www.cmhpsm.org/covid19consumers
- Our regional committees continue to meet using remote meeting technology, the Regional Operations Committee will work with our committees to determine best practices moving forward related to in-person versus remote regional committee meetings.
- The Regional Operations Committee continues to meet on at least a weekly basis. The remote meetings are allowing our region to share best practices while obtaining a regional picture of our COVID-19 pandemic response.

Statewide Update

- PIHP CEO meetings are being held remotely on a monthly basis. The PIHP CEOs last met on July 5, 2022. Discussions around the BHDDA reorganization occurred with representatives from the new MDHHS department.
- The PIHP CEO / MDHHS operations meeting with MDHHS behavioral health leadership staff was held on May 5, 2022 and June 2, 2022. We are scheduled to meet Thursday July 7, 2022 with MDHHS staff. Included in the meetings are updates on the various emergency waivers and MDHHS COVID funding that impact our service delivery systems, funding, and requirements. I provide a summary of those meetings to our regional directors at our Regional Operations Committee meetings each month.
- Latest information on Michigan legislation will be shared at our Board meeting.

Future Update

- FY2022 rate revision information and FY2023 rate planning information was received and shared with the CMHSPs. We will begin projections related to the FY2023 regional budget in preparation for our August and September budget focused Regional Board meetings.
- We're planning to deliver a quick stigma training to the Board at our August meeting. We have a staff person that will be conducting the 10-15 minute training.

Respectfully Submitted,

James Colaianne, MPA