Question from 12/1/20 Bidder Meeting:

Q: What is the range of current reimbursement for assessment, group, and therapy services?

A: The following is the current range for assessment, group, and therapy services. Please note that some rates reflect different amount of time/length of service and/or specialty services:

Assessment	$63 - $120
Individual Therapy	$63 - $80
Group Therapy	$27 - $36

Additional Questions and Answers Submitted 12/4/20

Q: Under "Minimum Contractor Requirements", Section B states the applicant must "have, or obtain prior to contracting, the Office of Recovery Oriented System of Care ASAM approval for each level of service proposed to be offered." Can you please clarify what this means? We are licensed by LARA under "Outpatient" and "SARF", and were told that once we've treated 100 patients with MAT, the MAT license category will immediately be added to our licensure (as we've already passed the pre-survey).

A: Agencies contract for treatment services with PIHPs must demonstrate that the services provided meet ASAM Criteria for specific levels of care and receive approval from MDHHS. This can be completed if selected as a provider. See attached sample application.

Q: Is there a specific number of Medicare/third party approved therapists MCCMH is looking for here?

A: We do not require a specific number but expect programs to be able serve clients dually enrolled in Medicaid and Medicare.

Q: Under Section III "Requested Services and Expectations", it notes an expectation for group treatment. Our plan from the start of establishing our SUD program was to incorporate group therapy once our patient numbers increased. Now that we feel we have enough patients to begin group therapy, COVID is preventing us from doing so safely. With that being said, we plan to incorporate group therapy services into treatment once COVID is no longer a huge issue. We have recently found that we have the capability to do group visits via our electronic medical record functionality, however, we think it makes the most sense to start group treatment in person, and then supplement with a virtual therapy option thereafter. Is this reasonable given the current COVID climate?

A: Please describe your plan for group services, noting any issues during COVID.

Q: Under "Content of Proposal" Section C, Organizational Description, Number 3 requests resumes for the Executive Director and Clinical Director. Is this referring to the SUD Clinic Program Director and the SUD Clinic Medical Director?

A: MCOSA is looking for the resumes of the person overseeing the program and the clinical person supervising clinical staff/therapists, peer, etc.

The Michigan Department of Health and Human Services (MDHHS) is required to designate the ASAM level of care for all licensed outpatient treatment programs. In order to make this determination, the following questionnaire is required to be filled out for each licensed program seeking to provide publicly funded services. The information provided and submitted with this questionnaire will allow MDHHS to assign an ASAM level for the program.

Program/Facility Name:

Facility Address:

City/State/Zip:

License Number:

Treatment Capacity:
(If Applicable)

Please indicate the ASAM Level being applied for (select only one):

- ☐ 0.5 Early Intervention
- ☐ 1.0 Outpatient Services
- ☐ 2.1 Intensive Outpatient Services
- ☐ 2.5 Partial Hospitalization Services

Please indicate the population served by the program:

☐ Adolescent ☐ Adult

Please indicate which Pre-paid Inpatient Health Plan(s) the program is currently contracted with (or planning to contract with for new programs)to provide services: (check all that apply)

- ☐ Community Mental Health Partnership of Southeast Michigan
- ☐ Detroit Wayne Mental Health Authority
- ☐ Lakeshore Regional Entity
- ☐ Macomb County Community Mental Health Services
- ☐ Mid-State Health Network
- ☐ Northcare Network
- ☐ Northern Michigan Regional Entity
- ☐ Oakland County Community Mental Health Authority
- ☐ Region 10 Pre-paid Inpatient Health Plan
- ☐ Southwest Michigan Behavioral Health

SERVICE DELIVERY and SETTING

Please indicate the type of setting where services are provided.

- ☐ Behavioral health clinic/office-based program
- ☐ Primary care office/clinic
- ☐ Integrated care clinic (combined physical and behavioral health)
- ☐ Work sites
- ☐ School
- ☐ Community based
- ☐ Individuals home

On average, over the past 90 days, what percentage of clients with a substance use disorder were served **(Level 0.5 programs can skip this)**: (Total must equal 100%)

a. Without a co-occurring mental health disorder – %
b. Combined with a co-occurring mental health disorder – %

SUPPORT SYSTEMS

Please select “yes” or “no” for each of the following questions designated for your level:

Level 0.5

1) Does your program provide referral and linking to ongoing treatment?
    a. Y/N
2) Does your program provide referral for medical, psychological, and/or psychiatric services (including assessment)?
    a. Y/N
3) Does your program provide referral for community social services?
    a. Y/N

Level 1

1) Are emergency services available 24/7 outside normal program hours?
    a. Y/N
2) Does your program have direct affiliations with other levels of care and/or close coordination for referrals to other services?
    a. Y/N

Level 2.1

1) Does your program have the ability to conduct and/or arrange for laboratory/toxicology tests or other needed procedures?
    a. Y/N
2) Does your program offer psychiatric and other medical consultation within 24 hours over telephone and within 72 hours in person?
    a. Y/N
3) Are emergency services available 24/7 through telephone outside normal program hours?
    a. Y/N
4) Does your program have direct affiliation with more and less intensive levels of care?
    a. Y/N

Level 2.5

1) Does your program have the ability to conduct and/or arrange for laboratory/toxicology tests or other needed procedures?
    a. Y/N
2) Does your program offer psychiatric and other medical consultation within 8 hours over telephone and within 48 hours in person?
    a. Y/N
3) Are emergency services available 24/7 through telephone outside normal program hours?
    a. Y/N
4) Does your program have direct affiliation with more and less intensive levels of care?
    a. Y/N

STAFF

Please select “yes” or “no” for each of the following questions designated for your level:

Level 0.5

1) Do you employ trained personnel who are knowledgeable about substance use and addiction?
    a. Y/N
2) Is counseling/therapy provided by appropriately licensed and credentialed professionals (not required yet possible)?
    a. Y/N

Level 1

1) Do you employ credentialed/licensed treatment professionals to assess and treat substance-related, mental, and addictive disorders?
    a. Y/N
2) Is there a generalist physician(s) and/or physician assistant(s) available?
    a. Y/N

Level 2.1/2.5

1) Is your program staffed by an interdisciplinary team of appropriately credentialed addiction treatment professionals?
    a. Y/N
2) Is there a generalist physician(s) and/or physician assistant(s) available?
    a. Y/N
3) Does most—if not, all—staff have sufficient cross-training to understand signs and symptoms of mental disorders, also being able to explain the uses of psychotropic medications and their interactions with substance use and other addictive disorders?
    a. Y/N

4) Please indicate program staff conducting each service.

    Check all that apply on the following table:

License or Certification /	Screening and/or Assessment	Individual Counseling Sessions	Group Counseling Sessions	Didactic/ Educational Sessions	COD Treatment Services	Medical RX
MD/DO	☐	☐	☐	☐	☐	☐
LP/LLP/TLLP	☐	☐	☐	☐	☐	☐
LMFT/LLMFT	☐	☐	☐	☐	☐	☐
LPC/LLPC	☐	☐	☐	☐	☐	☐
RN,NP,LPN	☐	☐	☐	☐	☐	☐
PA	☐	☐	☐	☐	☐	☐
LMSW/LLMS	☐	☐	☐	☐	☐	☐
LBSW/LLBSW	☐	☐	☐	☐	☐	☐
Occupational Therapist	☐	☐	☐	☐	☐	☐
Recreational Therapist	☐	☐	☐	☐	☐	☐
CADC-	☐	☐	☐	☐	☐	☐
CAADC	☐	☐	☐	☐	☐	☐
CCJP-R	☐	☐	☐	☐	☐	☐
CCDP	☐	☐	☐	☐	☐	☐
CCDP-D	☐	☐	☐	☐	☐	☐
CCS-M	☐	☐	☐	☐	☐	☐
CCS-R	☐	☐	☐	☐	☐	☐
DP-S	☐	☐	☐	☐	☐	☐
DP-C	☐	☐	☐	☐	☐	☐
Recovery	☐	☐	☐	☐	☐	☐
Specifically trained staff	☐	☐	☐	☐	☐	☐

Specifically trained staff explanation:

THERAPIES

Please describe the following in reference to the program:

1) Focus of program activities for the level of care requested in this application:

2) Recovery support services:

Please select "yes" or "no" for each of the following questions:

3) Individual therapy/counseling/psychotherapy provided?
☐Yes ☐No

4) Group therapy provided?
☐Yes ☐No

5) Family therapy provided?
☐Yes ☐No
   a. If provided is there involvement of family members, guardians and significant others in the assessment, treatment and continuing care of the client?
   ☐Yes ☐No

6) Educational/didactic services provided?
☐Yes ☐No

7) Occupational therapy?
☐Yes ☐No

8) Recreational therapy available?
☐Yes ☐No

9) Medication management (SUD) available?
☐Yes ☐No

10) Medication management (mental health) available?
☐Yes ☐No

11) Monitoring of medication adherence (for behavioral health and physical health)?
☐Yes ☐No

12) Use of laboratory and toxicology services (on-site/consultation/referral)?
☐Yes ☐No

13) For **Levels 2.1 and 2.5** please submit a weekly schedule of services with the individual, group, educational and/or other treatment services labeled to verify the minimum amount of hours of skilled treatment services for the level are available.

ASSESSMENT/ TREATMENT PLAN REVIEW

Indicate if the program's assessment & treatment plan review processes include the following?

Level 0.5

1) Screening to rule in or out substance related addictive disorders?
   ☐Yes ☐No

Levels 1, 2.1, 2.5

1) Assessment of ASAM dimensional risk and severity of need performed prior to and throughout the process of delivering services?
   ☐Yes ☐No
2) Physical examination by (MD/DO, PA, NP) available for conditions as warranted based on physician approved protocols?
   ☐Yes ☐No
3) Individualized treatment plan, developed in collaboration with client and reflects client's personal goals?
   ☐Yes ☐No
4) Treatment plan reviews are conducted at specified times, as noted in the plan or with a frequency as determined by appropriately credentialed staff?
   ☐Yes ☐No
5) Documentation of mental health problems and relationship to substance use disorder?
   ☐Yes ☐No
6) Documentation of progress and treatment changes?
   ☐Yes ☐No
7) Ongoing recovery/continuing care planning?
   ☐Yes ☐No

I CERTIFY THAT THE INFORMATION PROVIDED REGARDING THE OPERATION OF THIS PROGRAM IS ACCURATE, TRUE, AND COMPLETE IN ALL MATERIAL ASPECTS. (Electronic signatures are acceptable)

AUTHORIZED INDIVIDUAL	TITLE	SIGNATURE	DATE

ENTER THE CONTACT INFORMATION OF THE PERSON THAT CAN BE REACHED FOR FOLLOW-UP IF NEEDED.

NAME	TITLE	EMAIL	TELEPHONE

Please submit the completed, signed form and any attachments to QMPMeasures@michigan.gov