

LAKESHORE REGIONAL ENTITY
Substance Use Disorder Residential Treatment and Recovery Residences

This service must be provided consistent with requirements outlined in the MDHHS Medicaid Provider Manual as updated. The manual is available at:

<http://www.mdch.state.mi.us/dch-medicaid/manuals/MedicaidProviderManual.pdf>

1. Definition or Description of Service

- a. Residential Treatment is defined as an intensive therapeutic service which includes overnight stay and planned therapeutic, rehabilitative and didactic counseling to address cognitive and behavioral impairments for the purpose of enabling the beneficiary to participate and benefit from less intensive treatment.
- b. This service is based on the American Society of Addiction Medicine, 3rd Edition (ASAM), October 2013. Residential Treatment (Level 3 Programs) offer organized treatment services that feature a planned and structured regimen of care in a 24-hour residential setting. Treatment services adhere to defined policies, procedures, and clinical protocols. They are housed in, or affiliated with, permanent facilities where patients can reside safely. (One of the purposes of these programs is to demonstrate aspects of a positive recovery environment.) They are staffed 24-hours a day. Mutual/self-help group meetings, while not clinical services, are usually available on-site.
- c. All Level 3 programs serve individuals who, because of specific functional limitations, need safe and stable living environments and 24-hour care. This is needed to develop the recovery skills necessary so that patients do not immediately relapse or continue to use in an imminently dangerous manner upon transfer to a less intensive level of care. Such services are community-based rather than hospital-based services, although they might be housed in a hospital. The living environments may be housed in the same facility as the treatment services, or they may be in separate facilities that are affiliated with the treatment provider. In the latter situation, the relationship between the living environment and the treatment provider must be sufficiently close to allow specific aspects of the individual's treatment plan to be addressed in both facilities.
- d. Sublevels of Residential Treatment (Range of Intensities)
 - i. Level 3.1 – Clinically Managed Low-Intensity Residential Services
 - (1) Level 3.1 programs offer at least 5 hours per week of low-intensity treatment of substance-related disorders (or as specified by state licensure requirements). Treatment is characterized by services such as individual, group, and family therapy; medication management; and psychoeducation. These services facilitate the application of recovery skills, relapse prevention, and emotional coping strategies. They promote personal responsibility and reintegration of the individual into the network systems of work, education, and family life. Mutual/self-help meetings are available on-site, or easily accessible in the local community.
 - (2) When the clinical services and recovery residence (or similar supports) components are provided together, Level 3.1 programs may not be necessary for individuals who need time and structure to practice and integrate their recovery and coping skills.
 - (3) The residential component of Level 3.1 programs also can be combined with intensive (Level 2.1) outpatient services for individuals whose living situations or recovery environments are incompatible with their recovery goals, if they otherwise meet the dimensional admission criteria for intensive outpatient care.
 - (4) The functional limitations found in populations typically treated at Level 3.1 include problems in the application of recovery skills, self-efficacy, or lack of connection to the community systems of work, education, or family life. In a

setting that provides 24-hour structure and support, residents have an opportunity to develop and practice their interpersonal and group living skills, strengthen their recovery skills, reintegrate into the community and family, and begin or resume employment or academic pursuits.

- (5) Level 3.1 programs also can meet the needs of individuals who may not yet acknowledge that they have a substance use or other addictive problem. Such individuals may be living in a recovery environment that is too toxic to permit treatment on an outpatient basis. They therefore may need to be removed from an unsupportive living environment in order to minimize their continued alcohol, other drug use, and/or addictive behavior. Because these individuals are at an early stage of readiness to change ("pre-contemplation" in Prochaska and DiClemente's stages of change model), they may need monitoring and motivating strategies to prevent deterioration, engage them in treatment and facilitate their progress through the stages of change to recovery. They are appropriately placed in a Level 3.1 supportive environment while receiving "discovery, dropout prevention" services, as opposed to "recovery, relapse prevention" services. "Discovery, dropout prevention" services are aimed at patients who have not yet determined that they have an addiction problem or who are currently not interested in addressing it, and for whom "recovery" services would be unsuitable. An important focus of treatment is thus engagement and attracting people into continuing treatment. (Because continued use of substances in a "discovery" population likely will be more common than in a "recovery" population, consideration should be given to the problems inherent in housing the two populations together.)
 - (6) Intoxication and withdrawal require separate consideration. Intoxication or withdrawal in an individual who is placed in a Level 3.1 program usually represents an isolated relapse associated with problems in applying recovery skills (Dimension 5). If the intoxication or withdrawal is associated with limitations in problem recognition or understanding (Dimension 4), the individual is appropriately placed in a Level 3.1 program only if Level 1 or 2 motivational and engagement services are being provided concurrently.
 - (7) Treatment at Level 3.1 sometimes is warranted as a substitute for or supplement to deficits in the patient's recovery environment, such as a chaotic home situation; drug-using family or significant others, caretakers, or siblings; or a lack of daily structured activity (such as school or work). In other cases, an extended period in Level 3.1 treatment is needed to sustain and further therapeutic gains made at more intensive levels of care because of the patient's functional deficits (including developmental immaturity, co-occurring conditions, greater than average susceptibility to peer influence or significant others, or lack of impulse control). Many patients evidence a combination of these vulnerabilities.
 - (8) Level 3.1 is not intended to describe or include sober houses, boarding houses, or group homes where treatment services are not provided.
- ii. Level 3.3 – Clinically Managed Population-Specific High-Intensity Residential Services
- (1) These services provide a structured recovery environment in combination with high-intensity clinical service provided in a manner to meet the functional limitations of patients to support recovery from substance-related disorders. For the typical patient in a Level 3.3 program, the effects of substance use or other addictive disorder or a co-occurring disorder resulting in cognitive impairment on the individual's life are so significant, and the resulting level of impairment so great, that outpatient motivational and/or relapse prevention strategies are not

- feasible or effective. Similarly, the patient's cognitive limitations make it unlikely that he or she could benefit from other levels of residential care.
- (2) The functional limitations seen in individuals who are appropriately placed at Level 3.3 are primarily cognitive and can be either temporary or permanent. They may result in problems in interpersonal relationships, emotional coping skills or comprehension. For example, temporary limitations may be seen in the individual who suffers from an organic brain syndrome as a result of his/her substance use and who requires treatment that is slower paced, more concrete, and more repetitive until his or her cognitive impairment subsides.
 - (3) When assessment indicates that such an individual no longer is cognitively impaired, he or she can be transferred to another level of care (such as a Level 3.5 program) or a less intensive level of care (such as a Level 1, 2.1, 2.5, or 3.1 program), based on a reassessment of his or her severity of illness and rehabilitative needs. (Transfer to a Level 3.7 or more intensive level of care would not be considered except in the presence of unstable or acute medical or psychiatric problems that require medical and nursing care.)
 - (4) By contrast, the individual who suffers from chronic brain syndrome, or the older adult who has age and substance-related cognitive limitations, or the individual who has experienced a traumatic brain injury, or the patient with developmental disabilities would continue to receive treatment in a Level 3.3 program. For such an individual, the effects of the addictive disorder or co-occurring condition are so significant, and the level of his or her impairment so great, that outpatient or other levels of residential care would not be feasible or effective.
 - (5) Some individuals have such severe limitations in interpersonal and coping skills that the treatment process is one of habilitation rather than rehabilitation. Treatment of such individuals is directed toward overcoming their lack of awareness of, or ambivalence about, the effects of substance-related problems or addiction on their lives, as well as enhancing their readiness to change. Treatment also is focused on preventing relapse, continued problems, and/or continued use, and promoting the eventual reintegration of the individual into the community. In every case, the individual should be involved in planning continuing care to support recovery and improve his or her functioning.
 - (6) Level 3.3 programs generally are considered to deliver high-intensity services, which may be provided in a deliberately repetitive fashion to address the special needs of individuals for whom a Level 3.3 program is considered medically necessary. Such individuals often are elderly, cognitively impaired, or developmentally delayed, or are those for who the chronicity and intensity of the primary disease process requires a program that allows sufficient time to integrate the lessons and experiences of treatment into their daily lives. Typically, they need a slower pace of treatment because of mental health problems or reduced cognitive functioning (Dimension 3), or because of the chronicity of their illness (Dimensions 4 and 5). They also may be homeless, although homelessness is not, in itself, a sufficient indication for admission to a Level 3.3 program.
 - (7) Where treatment staff have been specially trained and adequate nursing supervision is available, Level 3.3 programs are able to address the needs of patients with certain medical problems as well. These include patients whose biomedical conditions otherwise would meet medical necessity criteria for placement in a nursing home or other medically staffed facility. For such persons, their general medical condition (Dimension 2 comorbidity) provides the justification for admission to a Level 3.3 program.

- (8) Reintegration of patients in a Level 3.3 program into the community requires case management activities directed toward networking patients into community-based ancillary or “wraparound” services such as housing, vocational services, or transportation assistance so that they are able to attend mutual/self-help meetings or vocational activities after discharge.
 - (9) Note: Adolescent-specific considerations are not included in Level 3.3 programming because the types of programs described in Level 3.5 encompass the range of settings in which adolescent treatment is provided, and the distinction between Level 3.3 and Level 3.5 does not have sufficient specificity in adolescent treatment to merit the added complexity of adolescent-specific considerations.
- iii. Level 3.5 – Clinically Managed High-Intensity Residential Services
- (1) Level 3.5 programs are designed to serve individuals who, because of specific functional limitations, need safe and stable living environments in order to develop and/or demonstrate sufficient recovery skills so that they do not immediately relapse or continue to use in an imminently dangerous manner upon transfer to a less intensive level of care, Level 3.5 assists individuals whose addiction is currently so out of control that they need a 24-hour supportive treatment environment to initiate or continue a recovery process that has failed to progress. Their multidimensional needs are of such severity that they cannot safely be treated in less intensive levels of care.
 - (2) Many patients treated in Level 3.5 have significant social and psychological problems. For these patients, Level 3.5 programs are characterized by their reliance on the treatment community as a therapeutic agent. The goals of treatment in these programs are to promote abstinence from substance use, arrest other addictive and antisocial behaviors, and effect change in participants' lifestyles, attitudes, and values. This philosophy views substance-related and other addictive problems as disorders of the whole person that are reflected in problems with conduct, attitudes, moods, values, and emotional management. Frequent defining characteristics of these patients are found in their emotional, behavioral, and cognitive conditions (Dimension 3) and their living environments (Dimension 6).
 - (3) Individuals who are placed in a Level 3.5 program typically have multiple limitations, which may include substance use and addictive disorders, criminal activity, psychological problems, impaired functioning, and disaffiliation from mainstream values. Their mental disorders may involve serious and chronic mental disorders (such as schizophrenia, bipolar disorders, and major depression) and personality disorders (such as borderline, narcissistic, and antisocial personality disorders).
 - (4) Such individuals generally can be characterized as having chaotic, non-supportive, and often abusive interpersonal relationships; extensive treatment or criminal justice histories; limited work histories and educational experiences; and antisocial value systems. These limitations require comprehensive, multifaceted treatment that can address all of the patient's interrelated problems. For such patients, standard rehabilitation methods are inadequate.
 - (5) These are patients who have never developed adequate coping skills and for whom the mere cessation of alcohol and/or other drug use or addictive behavior does not result in reemergence of previous coping skills. These patients stand in contrast to those who have developed adequate coping skills, usually before the onset of their addiction, and for whom addiction has impeded the application of those skills. Effective treatment approaches for some are primarily habilitative

rather than rehabilitative in focus, addressing the patient's educational and vocational limitations, as well as his or her socially dysfunctional behavior, until the patient can be stabilized and is appropriately transferred to a less intensive level of care.

- (6) Patients may present with the sequelae of physical, sexual, or emotional trauma. Chronic use of psychoactive substances also may have impaired their judgment, at least temporarily, leaving them vulnerable to relapse, continued problems, or continued use outside of a structured environment.
- (7) Other functional limitations in patients appropriately placed at this level of care include a constellation of past criminal or antisocial behaviors, with a risk of continued criminal behavior, an extensive history of treatment and/or criminal justice involvement, limited education, little or no work history, limited vocational skills, poor social skills, inadequate anger management skills, extreme impulsivity, emotional immaturity, and/or an antisocial value system.
- (8) For such patients, treatment is directed toward ameliorating their limitations through targeted interventions. For example, treatment may be focused on reducing the risk of relapse, reinforcing prosocial behaviors, and assisting with healthy reintegration into the community. This treatment is accomplished by providing specialty modalities and skills training while the patient is in a safe and structured environment, thus providing an opportunity for continued improvement. Because treatment plans are individualized, fixed lengths of stay are inappropriate. The intensity and duration of clinical and habilitative or rehabilitative services, rather than medical services, are the defining characteristics of Level 3.5 programs.
- (9) Some patients may meet DSM diagnostic criteria for a co-occurring personality disorder (such as antisocial personality disorder) or another mental disorder (such as attention deficit hyperactivity disorder). Other patients may not meet diagnostic criteria and exhibit subthreshold Dimension 3 problems. Examples include impulsivity, deficient anger management skills, hostile and violent acting out, antagonism to limits and authority, hyperactivity, and distractibility. When treatment of these limitations cannot be implemented safely and successfully on an outpatient basis, placement in a Level 3.5 program should be considered.
- (10) Dimension 6 problems that may lead to placement in a Level 3.5 program include a living environment in which substance use, crime, and unemployment are endemic. These social influences may represent a sense of hopelessness or an acceptance of deviance as normative (in such an environment, the threat of incarceration is not a source of motivation because it is a common occurrence). Recovery may be perceived by the patient as providing a lesser return for effort (for example, the patient may not associate recovery from an addiction with outcomes such as vocational and housing opportunities). Some patients may have had no experience in a living environment that is conducive to healthy psychosocial development. Their entire social network may be composed of others who are involved in addictive disorders and/or criminal behaviors.
- (11) Patients may be appropriately placed in a Level 3.5 program as direct admissions or as transfers from a Level 3.7 or Level 4 program when their problems in Dimensions 1, 2, and 3 no longer warrant the availability of 24-hour medical or nursing interventions, but problems in Dimensions 4, 5, and 6 are sufficiently severe to exclude outpatient treatment as a viable option. Patients also may be transferred to a Level 3.5 program from less intensive levels of care.
- (12) When offered to patients who are being transferred from a Level 3.7 program, the services of a Level 3.5 program may be provided by a separate treatment

program in the patient's home area. But Level 3.5 may also be provided by continued care in the program at which they received their Level 3.7 treatment, thus providing continuity of care.

- (13) The duration of treatment always depends on an individual's progress in acquiring basic living skills. How long a person stays in a 24-hour treatment setting depends on his or her ability to apply and demonstrate coping and recovery skills, such that he or she doesn't immediately relapse or continue to use in an imminently dangerous manner upon transfer to a less intensive level of care.
- (14) It is not intended in the ASAM criteria that all, or even the majority of social and psychological problems will be resolved in the Level 3.5 treatment stay. Such complex and often lifelong challenges will need an ongoing treatment process to enhance wellness and recovery. Thus, the treatment in Level 3.5 is best viewed as just one part of a person's treatment and recovery process seamlessly integrated into a flexible continuum of services. Treatment may begin in an outpatient setting, but require transfer to Level 3.5 if an individual is not progressing and faces imminent danger if not in a supportive 24-hour treatment setting.
- (15) An individual may need direct admission to Level 3.5 because the assessment indicates that the patient's multidimensional assessment is of such severity and functioning that outpatient treatment is not safe or feasible. Admission to Level 3.5 is indicated to further assess severity and function and treat priorities so there is not a continuation or recurrence of imminently dangerous addiction signs and symptoms. The focus of Level 3.5 is on stabilization of dangerous addiction signs and symptoms, initiation or restoration of a recovery process, and preparation for ongoing recovery in the broad continuum of care of the ASAM criteria. At the point that the patient is not likely to immediately relapse or continue to use in an imminently dangerous manner, transfer to another level of care to continue the recovery process is indicated.
- (16) Although the therapeutic community is widely identified as an example of a Level 3.5 program, other types of programs also fall within Level 3.5. For example, a Level 3.5 program may represent a "step down" for patients of a Level 3.7 program if their complications in Dimensions 1, 2, or 3 no longer require subacute medical services. However, the patient's problems in Dimensions 4, 5, and 6 warrant 24-hour structure and clinical services to facilitate initial recovery. (One way of conceptualizing this level of service is as a Level 3.7 program without the intensive medical and nursing component.)
- (17) Where treatment staff have been specially trained and adequate nursing supervision is available, Level 3.5 programs are able to address the needs of individuals who have relatively severe biomedical problems (Dimension 2). For example, some patients may require daily medical monitoring or administration of prescription medications. A number of Level 3.5 programs offer a full range of medical services.

iv. Level 3.7 – Medically Monitored Intensive Inpatient Services

- (1) Level 3.7 programs provide a planned and structured regimen of 24-hour professionally directed evaluation, observation, medical monitoring, and addiction treatment in an inpatient setting. They feature permanent facilities, including inpatient beds, and function under a defined set of policies, procedures, and clinical protocols. They are appropriate for patients whose subacute biomedical and emotional, behavioral, or cognitive problems are so severe that they require inpatient treatment, but who do not need the full resources of an acute care general hospital or a medically managed inpatient treatment program.

- (2) The services of a Level 3.7 program are designed to meet the needs of patients who have functional limitations in Dimensions 1, 2, and/ or 3. For example, a patient may present with moderate to severe Dimension 1 problems, such as withdrawal risk. Dimension 2 problems could include such comorbid medical problems as poorly controlled asthma, hypertension, or diabetes, or a co-occurring chronic pain disorder that interferes with the patient's ability to engage in a recovery program. Dimension 3 problems would include either a diagnosable comorbid mental disorder or symptoms of such a disorder that are subthreshold and not severe enough to meet diagnostic criteria, but that do interfere with or distract from recovery efforts (for example, anxiety or hypomanic behavior), and thus require the availability of 24-hour nursing and medical interventions.
 - (3) Because physical and mental health problems exist on a continuum of severity, problems that exist in Dimensions 2 or 3 may fall short of reaching the threshold to meet diagnostic criteria, but still require treatment in a Level 3.7 program. For example, a patient's high level of anxiety distracts him or her from recovery efforts, but falls short of the DSM criteria required to meet the diagnosis for an anxiety disorder.
 - (4) Requirements for admission to a Level 3.7 program indicate that at least one of the two specifications must be in Dimensions 1, 2, or 3. Individuals whose major problems are in Dimensions 4, 5, or 6 are better served by admission to a clinically managed residential program, or by combining an intensive outpatient program or partial hospitalization with a housing or domiciliary/supportive living component.
 - (5) The care provided in Level 3.7 programs is delivered by an interdisciplinary staff of appropriately credentialed treatment professionals, including addiction-credentialed physicians. The primary focus of treatment is specific to substance-related disorders. The skills of the interdisciplinary team and the availability of support services also can accommodate withdrawal management and/or intensive inpatient treatment of addiction, and/or integrated treatment of co-occurring subacute biomedical and/or emotional, behavioral, or cognitive conditions.
 - (6) Individuals who have a greater severity of illness in Dimension 1 (withdrawal), Dimension 2 (biomedical conditions), or Dimension 3 (emotional, behavioral, or cognitive complications) require use of more intensive staffing patterns and support services. For example, patients undergoing medical withdrawal management or with co-occurring medical conditions typically require more intensive medical and nursing care than do other patients in a Level 3.7 program.
- e. Recovery Residences are generally described as supportive living environments for individuals recovering from alcohol or other drug dependence that typically offer an alcohol- and drug-free environment, peer encouragement and accountability, support for continuing participation in treatment or ongoing recovery services and other forms of necessary assistance. Recovery Residences are expected to adhere to the standards as published by the National Alliance of Recovery Residences (www.naronline.org) for Levels I, II or III. In Michigan, Level IV programs will be licensed as residential treatment programs.

 National Alliance for Recovery Residences	Level I Peer-Run	Level II Monitored	Level III Supervised	Level IV Service Provider
Administration	<ul style="list-style-type: none"> • Democratically run • Manual or Policy and Procedures 	<ul style="list-style-type: none"> • House manager or senior resident • Policy and Procedures 	<ul style="list-style-type: none"> • Organizational hierarchy • Administrative oversight for service providers 	<ul style="list-style-type: none"> • Overseen organizational hierarchy • Clinical and administrative

			<ul style="list-style-type: none"> • Policy and Procedures • Licensing varies from state to state 	<p>supervision</p> <ul style="list-style-type: none"> • Policy and Procedures • Licensing varies from state to state
Services	<ul style="list-style-type: none"> • Drug Screening • House meetings • Self-help meetings encouraged 	<ul style="list-style-type: none"> • House rules provide structure • Peer run groups • Drug Screening • House meetings • Involvement in self-help and/or treatment services 	<ul style="list-style-type: none"> • Life skill development emphasis • Clinical services utilized in outside community • Service hours provided in house 	<ul style="list-style-type: none"> • Clinical services and programming are provided in house • Life skill development
Residence	<ul style="list-style-type: none"> • Generally single family residences 	<ul style="list-style-type: none"> • Primarily single family residences • Possibly apartments or other dwelling types 	<ul style="list-style-type: none"> • Varies – all types of residential settings 	<ul style="list-style-type: none"> • All types – often a step down phase within care continuum of a treatment center • May be a more institutional in environment
Staff	<ul style="list-style-type: none"> • No paid positions within the residence • Perhaps an overseeing officer 	<ul style="list-style-type: none"> • At least 1 compensated position 	<ul style="list-style-type: none"> • Facility manager • Certified staff or case managers 	<ul style="list-style-type: none"> • Credentialed staff

(Source: <http://narronline.org/wp-content/uploads/2013/09/NARR-Standards-20110920.pdf>)

2. Practice Principles

- a. Residential treatment is to be utilized according to ASAM standards, which is specific as to levels of care for specific clinical needs.
 - i. In general, residential treatment is intended as a setting in which clinical stabilization may occur during which a patient-specific recovery plan is to be developed. Given the nature of addiction, specific early attention is to be given to the need for a safe and sober living environment upon discharge and should include consideration of a recovery residence when clinically warranted and appropriate.
 - ii. Patients who have not been exposed to prior episodes of treatment may require a complete course of education about substance use disorders, while those who have had prior episodes of care and have retained their previous understanding should be able to put a greater emphasis on the refinement of their recovery plan and provision of services focused on stabilization.
 - iii. Individuals seeking treatment may request access to residential treatment on the basis of their familiarity with the term and a lack of familiarity with treatment alternatives better suited to their needs. It is important for a person’s request for treatment to be evaluated in light of their needs using LRE medical necessity criteria which may or may not support the meeting of their initial or specific service request. SUD case management (Family Engagement, Women’s Case Management, or Recovery Management) may be appropriate alternatives, as these teams are able to offer similar supports to residential care without the client leaving their home environment. If a client can be adequately supported by a SUD case management team, engagement with a team may be required prior to authorization of residential treatment.

- iv. Education and therapeutic interventions are key deliverables and must be organized to increase the patient's capacity to execute their recovery plan.
 - v. Programs are expected to provide individualized treatment; that is, they should provide reasonable modifications to their standard services package in order to support the unique recovery plan requirements of each patient supported by the LRE.
 - vi. The course of residential treatment, including length of stay, must be developed and delivered according to a patient's specific needs. It may be possible to generally predict the length of stay persons with similar needs may require, however the length of stay must never be standardized or fixed.
 - vii. Residential treatment is not to be used as a substitute for community-based housing or to be extended in duration merely due to a lack of readily available housing. Similarly, a person with a substance use disorder is not necessarily appropriate for residential treatment merely because they are homeless.
- b. Recovery Residences are intended for persons who have become stabilized and have entered a recovery process. The structure of a recovery residence is intended to assist individuals who need an additional level of structure and support in order to establish (or re-establish) a recovery environment and plan for needed ongoing recovery supports (economic, social, etc.).
- i. Recovery residences are housing with a purpose. While a person may stay with a recovery residence for as long as the operator and resident agree it is helpful or useful, the LRE's interest is in providing 'jump-start' funding. The LRE's aim is to bridge the period of time between a need for admission and the individual's ability to fund their own stay.
 - ii. It is expected that LRE funds will be needed for no more than 60 or 90 days during which time an individual may be expected to obtain gainful employment or arrange for support that will allow continued residency for as long as desired/offered. Persons who cannot be reasonably expected to establish a means of support for themselves in a recovery residence should pursue another alternative.
 - iii. LRE-funded SUD treatment and case management services may be provided whether or not the recovery residence services are being funded by the LRE.

3. Service Requirements

- a. Services provided to program clients must comply with the provisions of Michigan's Medicaid Manual, which incorporates the Healthy Michigan Plan and is available at <http://www.mdch.state.mi.us/dch-medicaid/manuals/MedicaidProviderManual.pdf>.
- b. ASAM Criteria:
 - i. Level 3.1
 - (1) SUD (moderate to severe) diagnosis
 - (2) Co-occurring mental health conditions must be stable
 - (3) Co-occurring physical conditions must be stable
 - (4) No withdrawal symptoms
 - (5) Needs a structured environment
 - (6) At risk of MI, SUD, COD relapse in a non-supervised setting
 - (7) Current living environment is not supportive of recovery
 - (8) Living environment is unsafe/dangerous
 - (9) Has limited coping skills
 - (10) Is socially isolated or has few stable relationships
 - ii. Level 3.3
 - (1) SUD (moderate to severe) diagnosis
 - (2) None or minimal withdrawal symptoms
 - (3) Existing medical conditions do not require medical monitoring

- (4) Functional deficits are primarily cognitive which are either temporary or permanent
- (5) Mental status, emotional stability, and cognitive functioning are sufficiently stable to permit participation in interventions and can benefit from treatment
- (6) Low readiness is the expectation due to cognitive limitation, chronicity of the disorder, and limited understanding
- (7) There is imminent danger of continued SUD and/or MI problems with significant consequences
- (8) Needs 24-hour monitoring and a structured environment
- (9) Current living environment is not supportive of recovery
- (10) Living environment is unsafe/dangerous
- (11) Is at risk for victimization

iii. Level 3.5

- (1) SUD (moderate to severe) diagnosis
- (2) None or minimal withdrawal symptoms
- (3) Existing medical conditions do not require medical monitoring or medical monitoring can be contracted
- (4) Functional deficits include impaired functioning, disaffiliation from mainstream values, criminal or antisocial behaviors and/or psychological problems
- (5) Mental status, emotional stability, and cognitive functioning are sufficiently stable (or stabilizing) to permit participation in interventions and can benefit from treatment
- (6) Little awareness of SUD/MI issues
- (7) Passive or active opposition to addressing SUD/MI issues
- (8) Blames other or events for SUD/MI issues
- (9) Low readiness is the expectation
- (10) Imminent danger of continued SUD/MI issues with significant consequence
- (11) Has little ability to interrupt the relapse process and control impulses, poses risk to self or others
- (12) Social network includes persons who use alcohol/drugs
- (13) Environment characterized by criminal behavior, victimization or other antisocial norms
- (14) Needs 24-hour monitoring and structure

iv. Level 3.7 (May also be referred to as Intensive Stabilization)

- (1) SUD (mild to severe) diagnosis
- (2) None or minimal withdrawal symptoms
- (3) Existing medical conditions may require medical monitoring
- (4) Functional deficits may include impaired functioning, disaffiliation from mainstream values, criminal or antisocial behaviors and/or psychological problems
- (5) This service can serve both mental health and substance use disorders as a short-term alternative to inpatient (detoxification/psychiatric) services for individuals experiencing an acute crisis when clinically indicated.
- (6) The goal of the program is to alleviate the individual's crisis by providing a safe, structured environment in order to address all immediate needs relevant to the state of the crisis. The focus of the intense stabilization program is to promote recovery among individuals with SUD, co-occurring disorders (MI and SUD) and/or severe mental illness.
- (7) Mental status, emotional stability, and cognitive functioning are sufficiently stable (or stabilizing) to permit participation in interventions and can benefit from treatment

- (8) Passive or active opposition to addressing SUD/MI issues
- (9) Imminent danger of continued SUD/MI issues with significant consequence
- (10) Psychiatric consultation is available. Services must include evaluations for psychotropic medication (by qualified medical professionals) when need is identified. Provider must assume responsibility to provide for psychotropic needs when identified and psychiatric evaluation is complete. Provider will remain responsible for psychotropic medication needs for 30 days after discharge unless a subsequent service provider assumes this responsibility earlier.
- (11) Provider is expected to treat individuals who are enrolled in a medication assisted treatment program (Methadone/Suboxone). Provider should coordinate the individual's care with the medication assisted treatment provider as necessary.
- (12) Has little ability and/or desire to interrupt the relapse process and control impulses, poses acute risk to self or others without immediate intervention
- (13) Needs 24-hour monitoring and structure

4. Service Requirements

- a. Medicaid/Healthy Michigan Service Requirements – Services provided to residential treatment program clients must comply with all current provisions of Michigan's Medicaid Manual, which incorporates the Healthy Michigan Plan and is available at <http://www.michigan.gov/mdhhs/0,5885,7-339--87572--,00.html>.
- b. Provider Expectations – Providers are expected to provide:

Level of Care	Minimum Daily Core Services	Minimum Weekly Core Services	Minimum Weekly Life Skills/Self Care
ASAM 3.1	At least 3 hours of clinical services per day.	At least 3 hours/day of clinical services every day of the week.	At least 5 hours/week.
ASAM 3.3	At least 3 hours/day of clinical services 6 days per week. At least 2 hours the 7th day.	At least 20 hours per week.	At least 13 hours/week.
ASAM 3.5	At least 2 hours/day of clinical services 6 days per week. At least 1 hour the 7th day.	At least 13 hours per week.	At least 20 hours/week.
ASAM 3.7	At least 5 hours/day of clinical services 6 days per week. At least 3 hours the 7th day.		At least 13 hours/week.

In situations where required services cannot be provided to the individual served in the necessary frequency or quantity, a justification must be documented in the clinical record.

- c. Covered Services - The following services must be available in a residential setting regardless of the LOC and based on individual client need:

Type	Residential Services Description
Basic Care	Room, board, supervision, self-administration of medications monitoring, toxicology screening, transportation facilitating to and from treatment; and treatment environment is structured, safe, and recovery-oriented.
<u>Core Service:</u> Treatment Basics	Assessment; Episode of Care Plan (addressing treatment, recovery, discharge and transition across episode); coordination and referral; medical evaluation and attempt to link to services; connection to next provider and medical services; preparation for 'next step'.

<u>Core Service:</u> Therapeutic Interventions	Individual, group, and family psychotherapy services appropriate for the individual's needs, and crisis intervention. Services provided by an appropriately licensed, credentialed, and supervised professional working within their scope of practice.
<u>Core Service:</u> Interactive Education/Counseling	Interaction and teaching with client(s) and staff to process skills and information adapted to the individual client needs. This includes alternative therapies, individual, group and family counseling, anger management, coping skills, recovery skills, relapse triggers, and crisis intervention. Examples: disease of addiction, mental health, and substance use disorder.
Life Skills/Self-Care	Social activities that promote healthy community integration/reintegration; development of community supports, parenting, employment, job readiness, how to use public transportation, hygiene, nutrition, laundry, education.
Milieu/Environment (building recovery capital)	Peer support; recreation/exercise; leisure activities; family visits; treatment coordination; support groups; drug/alcohol free campus.

- d. General – Clients entering any level of residential care will have recovery and functional needs that will continue to require intervention once residential services are no longer appropriate. Therefore, residential care should be viewed as a part of an episode of care within a continuum of services that will contribute toward recovery for the client. Residential care should not be presented to clients as being a complete episode of care. To facilitate the client moving along the treatment continuum, it is expected that the provider, as part of treatment planning, begins to prepare the client for the next stage of the recovery process as soon after admission as possible. This will help to facilitate a smooth transition to the next LOC, as appropriate, and make sure that the client is aware that services will continue once the residential stay is over. To make the transition to the next LOC, the residential care provider may assist the client in choosing an appropriate service based on needs and location scheduling appointments, arranging for a meeting with the new service provider, arranging transportation, and ensuring all required paperwork is completed and forwarded to the new service provider in a timely manner. These activities are provided, as examples of activities that could take place if it were determined there would be a benefit to the client. There could potentially be many other activities or arrangements that may be needed, or the client may require very little assistance. To the best of their ability, it is expected that the residential provider will arrange for any needed assistance to ensure a seamless transfer to the next LOC.
- e. Continuing Stay Criteria – Re-authorization or continued treatment should be based on ASAM 3rd Edition Continued Service Criteria, medical necessity, and a reasonable expectation of benefit from continued care. Continuing stay can be denied in situations where the client has decided not to participate in his/her treatment. This is evidenced by continued non-compliance with treatment activities, other behavior that is deemed to violate the rules and regulations of the program providing the services, or a demonstrated lack of benefit from treatment received, after documented attempts to meet the needs of the client, by adjusting the services, were made. Progress notes must support lack of benefit, and that other appropriate services have been offered, before a client can be terminated from a treatment episode.
- f. Requirements:
- i. Provide co-occurring capable services in a welcoming environment.
 - ii. Provide integrated screening, data collection/reporting, assessment, and treatment planning.
 - iii. Provide services and/or interventions that are stage-matched with ongoing evaluation to meet changing needs and abilities, including referrals to alternative services as needed.
 - iv. Clinical staff must have specialized training in behavior management techniques. These trainings will be at a minimum: Trauma Informed Care, Motivational

Interviewing, Stages of Change, and basic DBT. These trainings will need to be completed within 6 months of hire.

- v. The program must have daily therapeutic programming of at least five hours per day, seven days a week.
 - vi. Treatment planning and treatment is individualized and individual specific.
 - vii. Individuals must receive at least one individual counseling session per week, but more frequently if clinically indicated.
 - viii. Physician monitoring and nursing care are provided on site in level 3.7 program
 - ix. A physical examination, performed by a physician within 24 hours of admission or a review by a facility physician of a physical examination conducted no more than 90 days prior to admission.
 - x. Psychiatric services are available through consultation or referral. Services must include evaluations for psychotropic medication (by qualified medical professionals) within 30 days of an identified need. Provider will need to assume responsibility to provide for psychotropic needs within 30 days of admission.
 - xi. Medical care should be coordinated through the individual's primary care physician.
 - xii. Individuals will have their aftercare coordinated through appropriate referral/step down to more/less intensive levels of care and other needed services.
 - xiii. Therapy groups may have no more than 14 individuals within each group.
 - xiv. Didactic groups may have no more than 28 individuals within each group.
 - xv. Case notes for all group services will record the number of individuals in the group.
 - xvi. Provider is expected to treat individuals who are enrolled in a medication assisted treatment program (Methadone/Suboxone/Vivitrol). Provider should coordinate the individual's care with the medication assisted treatment provider as necessary.
- g. Communicable Disease (Screening and Testing):
- i. All individuals must be screened at assessment for risk of TB, STD, HIV, and Hepatitis in a manner that is consistent with the MDHHS Best Practice.
 - ii. If the screen identifies high-risk behavior, the individual must be referred for testing.
 - iii. Referral for testing is required for the following populations:
 - (1) Hepatitis C for all individuals with history of IDU.
 - (2) STD and HIV testing for all pregnant women.
 - iv. Mandatory TB testing for all individuals entering residential treatment within 48 hours of admission.
 - v. Referral agreements with Communicable Disease testing sites.
 - vi. Method for ensuring that the agency to which the individual has been referred has the capacity to accept the referral.
 - vii. Protocol for linking infected individuals with appropriate treatment/support resources.
 - viii. Protocol for recording the screening, referral, and linking activities in the individual's file.
 - ix. Completion of the Communicable Disease reporting requirements as specified by the Office of Recovery Oriented Systems of Care (OROSC).
- h. Health Education and Risk Reduction:
- i. All individuals who are identified as having high risk behaviors must receive Health Education and Risk Reduction services delivered by a qualified provider.
 - ii. Health Education and Risk Reduction services must be documented in the individual's file.
 - iii. Staff Capability:
 - (1) A Training Plan to provide program staff with Level I Training as described in the APG, delivered by a qualified provider.
 - (2) A Training Plan to provide treatment staff with Level II Training as described in the APG, delivered by a qualified provider.

- (3) Documented evidence of the implementation of the Training Plan.
- i. Fetal Alcohol Spectrum Disorder (FASD):
 - i. FASD prevention information must be provided to men and women in all substance use disorder treatment programs.
 - ii. For any treatment program that serves individuals with children, it is required that the program complete the FASD Pre-Screen for children they interact with during the treatment episode. In the event a child has a positive pre-screen, a referral must be made to a Fetal Alcohol Diagnostic Clinic.
 - j. Performance Requirements:
 - i. Ninety-five percent (95%) of persons requesting a screening for eligibility must be seen within 14 days from the request for service.
 - ii. Ninety-five percent (95%) of persons determined to be eligible for ongoing LRE services must be seen within 14 days of the date of determination.

5. Credentialing Requirements

- a. Residential Treatment Programs
 - i. Programs must hold a current license for residential treatment services from Michigan's office of [Licensing and Regulatory Affairs](#).
 - ii. Professional staff must have a Master's degree in an approved field of behavioral health and meet the qualifications of a "Substance Abuse Treatment Practitioner" (SATS) per the [Michigan PIHP/CMHSP Provider Qualifications Chart](#).
 - iii. Michigan PIHP/CMHSP Provider Qualifications per Medicaid Services & HCPCS/CPT Codes (https://www.michigan.gov/documents/mdch/PIHP-MHSP_Provider_Qualifications_219874_7.pdf)
 - iv. Master's level professional staff must also be credentialed by the [Michigan Certification Board for Addiction Professionals](#) as a CAADC, CADC, CCJP, or CCDP-D (or have a development plan for one of these credentials).
 - v. Staff who provide didactic (teaching) interventions within an Intensive Outpatient Program must have a Bachelor's degree and [Michigan Certification Board for Addiction Professionals](#) credential (or have a development plan).
 - vi. Staff must be supervised by a Master's prepared Clinical Supervisor with a MCBAP certified clinical supervisor certification (or development plan). Please refer to the [Michigan PIHP/CMHSP Provider Qualifications Chart](#) and [MCBAP](#) for a detailed listing of certification options and requirements, including student intern requirements.
 - vii. Recovery Supports – The individual completed Recovery Coach Training in compliance with MDHHS requirements and is supervised by a Master's prepared clinical supervisor.
 - viii. As these standards are now being uniformly applied across the LRE region, providers with specific challenges in meeting these requirements with legacy staff should contact their contracting entity to discuss options for compliance.
 - ix. Accreditation – Agencies providing residential treatment services must be accredited by one of the following accrediting bodies: The Joint Commission (TJC formerly JCAHO); Commission on Accreditation of Rehabilitation Facilities (CARF); the American Osteopathic Association (AOA); Council on Accreditation of Services for Families and Children (COA); National Committee on Quality Assurance (NCQA), or Accreditation Association for Ambulatory Health Care (AAAHC).
- b. Recovery Residences must:
 - i. Obtain and hold a current state license to provide prevention services
 - ii. Demonstrate overt compliance with applicable zoning rules
 - iii. Have membership in good standing of a state or local recovery residence coalition that conducts peer monitoring against NARR standards

- iv. Meet LRE contract compliance and eligibility standards for funding participation

6. Training Requirements

- a. See Attachment I: Training Requirements for specific training requirements and frequency of trainings.
- b. Provider will ensure and document that each staff is trained on the individual's plan of services prior to delivery of service.

7. Eligibility Criteria

a. Admission

- i. Admission to Residential Treatment must be based on medical necessity criteria. The current edition of the ICD 10 is used to determine an initial diagnostic impression of a substance use disorder (also known as provisional diagnosis). The diagnosis will be confirmed by the provider's assessment process.
- ii. Individualized determination of need/level of care determination – ASAM 3rd Edition is used to determine substance use disorder treatment placement/admission and/or continued stay needs, and are based on a LOC determination using the six assessment dimensions of the current ASAM 3rd Edition below:
 - (1) Withdrawal potential.
 - (2) Medical conditions and complications.
 - (3) Emotional, behavioral, or cognitive conditions and complications.
 - (4) Readiness to change – as determined by the Stages of Change Model.
 - (5) Relapse, continued use or continued problem potential.
 - (6) Recovery/living environment.
- iii. Treatment must be individualized based on a biopsychosocial assessment, diagnosis, and client characteristics that include, but are not limited to, age, gender, culture, and development.

b. Continuing Stay/Discharge:

- i. Authorization decisions on length of stay (including continued stay), change in level of care, and discharge must be based on the ASAM 3rd Edition. As a client's needs change, the frequency, and/or duration, of services may be increased or decreased as medically necessary. Client participation in referral, continuing care, and recovery planning must occur prior to a move to another level of care for continued treatment.

c. Discharge:

- i. Provider must complete the substance use disorder discharge treatment form in the authorization system within 2 business days.
- ii. All discharges summaries must be mailed or faxed to CMHSP within 10 business days of the individual's discharge.

8. Access Requirements

- a. Priority Populations – Provider will prioritize services for the following populations (below). Admission time line standards will be met as stated in the contract. For pregnant women, if Provider cannot provide services within 24 hours, the individual will be referred back to the CMHSP and then referred to an alternative service provider.
 - i. Pregnant Women-Injecting Drug Users – if the opiate use is significant, please refer to MAT services. If opiate use is not significant, detox can be commenced.
 - ii. Pregnant Women
 - iii. Injecting Drug Users who have injected drugs in the past 30 days
 - iv. Parents whose children have been removed from the home under the Child Protection Laws of this State or are in danger of being removed from the home because of the parents' substance abuse.

- v. All others
- b. Medicare – Individuals with Medicare insurance coverage will be referred to a Medicare Provider.

9. Authorization Procedures

- a. Individuals will generally be authorized for up to 22 days of treatment, initially. Additional days may be authorized when authorization requirements continue to be met, if there is evidence of progress in achieving treatment plan goals, and reauthorization is necessary to resolve cognitive and behavioral impairments which prevent the beneficiary from benefiting from less intensive treatment.
- b. If the request for additional days of care is denied, the provider can request reconsideration through the UM Department Manager.
- c. All services authorized will be based on ASAM criteria, medical necessity, and the validation of eligibility.
- d. All authorizations will reflect the required timelines and the requirements established by MDHHS.