Final Minutes

State Drug Treatment Court Advisory Committee Meeting
9:30 a.m. • Tuesday, March 26, 2013
Legislative Council Conference Room • 3rd Floor Boji Tower
124 W. Allegan • Lansing, MI

Members Present:
Judge William Rush, Chair
Stephanie Drury
Judge William Ervin
Judge Allen Garbrecht
Judge Michael Haley
Janette Kolodge
Andrew Konwiak
Robert Nida
Dr. Jessica Parks
Mark Risk
Jeffrey Sauter
Mark Witte

Members Excused:
Judge Amy Ronayne Krause, Vice Chair
Christopher Luty
Judge Brian MacKenzie
Stacy Salon

I. Call to Order
The Chair called the meeting to order at 9:35 a.m.

II. Roll Call
The Chair asked the clerk to take the roll. A quorum was present and absent members were excused.

III. Committee Appointments
Juvenile Graduate Recommendation: The Chair noted that Ms. Kolodge has brought forward an individual who is interested in being appointed to the Committee to fill the vacant juvenile graduate representative position. A statement from Jesse Billings was provided to the members. **Ms. Kolodge moved, supported by Judge Ervin, that the Committee make a recommendation to the Senate Majority Leader and Speaker of the House that Mr. Jesse Billings be appointed to the State Drug Treatment Court Advisory Committee as the juvenile graduate representative. There was no further discussion. The motion was unanimously approved.** The Chair noted that a recommendation letter will be prepared and sent to leadership.

Veterans' Treatment Court Judicial Representative Recommendation: Judge MacKenzie was not present and could not report back on his inquiries regarding candidates for the vacant Veterans' Treatment Court judicial position. Ms. Kolodge may have a person that has been recommended by the Oakland County Court Administrator, but she needs to seek permission from the individual before bringing their name forward for consideration.

IV. 2011 State Drug Treatment Court Advisory Committee Annual Report
The Chair directed the members' attention to the proposed 2011 State Drug Treatment Court Advisory Committee Annual Report and asked if there were any concerns with the report. **Judge Ervin moved, supported by Judge Garbrecht, to approve the 2011 State Drug Treatment Court Advisory Committee Annual Report as proposed. There was no further discussion. The motion was unanimously approved.**

V. Approval of Minutes of January 22, 2013 Meeting
The Chair asked members to review the minutes of the January 22, 2013 meeting. No changes or additions were recommended. The Chair asked for a motion to approve the minutes as proposed. **Mr. Witte moved, supported by Ms. Drury, to approve the proposed minutes of the January 22, 2013 State Drug Treatment Court Advisory Committee meeting. The motion was unanimously approved.**

VI. Subcommittee Updates

Defense Attorney Participation Subcommittee: Mr. Risk had no update to report.

Funding Alternative Subcommittee: Judge Hoffman was not present at today's meeting. No update was given.

Juvenile Issues Subcommittee: Mr. Nida had no update to report.

Legislative Subcommittee: Judge Hoffman was not present at today's meeting. No update was given.

Medical Marijuana: Mr. Sauter reported that they are still waiting for the Supreme Court to decide if they are going to grant leave in a case (People v. Koon) that deals with the issue of driving under the influence of medical marijuana and whether prosecution is done under the medical marijuana law or the motor vehicle code. A discussion of a potential due process problem followed. Mr. Sauter noted that the Supreme Court ruled that prosecution has to be based on testing of active THC. The Chair also noted that there is legislation pending dealing with the creation of provisioning centers.

Cross-Assignment Subcommittee: Judge Haley had no news to report and asked Dr. Parks to provide an update. She shared that the drug court transfer form has been approved by SCAO and is now being used. With the release of the form, Judge Haley noted that there is nothing more the subcommittee needs to do at this point.

Recidivism Subcommittee: Dr. Parks reported that the legislative report is being posted today on SCAO's website. She summarized that the recidivism numbers are similar to last year and look good. She added that the juvenile court numbers are slightly better than last year. A discussion of juvenile drug court participant trends and risk factors followed.

Vision Subcommittee: Judge Bowler was not present at today's meeting. No update was given.

VII. Ad Hoc Committees

Veteran Treatment Courts

Judge MacKenzie was not present at today's meeting. Dr. Parks reported that the diversion bills that recently passed do not pertain to veterans treatment courts and wondered if the committee may want to address that issue. The subcommittee will investigate the matter and report back to the committee. The members then revisited the subject of finding a veterans treatment court representative candidate and pondered the qualifications required by statute that the individual be a circuit or district court judge who has presided over a veterans treatment court. After further discussion the Chair asked the subcommittee to bring forward a recommended nomination that the Committee can consider.

Report of the Ad Hoc Committee on the Affordable Care Act Impact on Drug Courts

Members of the Ad Hoc Committee arranged for a meeting at the MADCP conference on 3/13/2013 to discuss the current state of known developments of Michigan's implementation of the Affordable Care Act (ACA), with specific attention to the matter of which services are going to be covered through its Essential Health Benefit (EHB) provisions. In addition to the Honorable Harvey Hoffman, attendees included the Honorable Mark Feyen (Ottawa Co.) and Honorable Donald Allen (Ingham Co.), as well as staff from the State Court Administrator's Office and drug courts and agencies.

The essence of the presentation given by Mr. Mark Witte was to acquaint individuals in attendance with the key elements of the ACA and the responsibility that has been given to each state to determine the benefit array that will be required of the insurance plans offered on state-based health care exchanges and through the Medicaid program for states that choose to expand their Medicaid programs to include individuals who have incomes between 138% and 400% of the Federal Poverty Level (FPL). In the ensuing dialogue, those present who spoke indicated support for dialogue with Gov. Snyder's office to specifically determine the level of benefits that will be available to those who are uninsured and/or without access to behavioral health benefits under the ACA.

Subsequently, in a meeting with the Department of Community Health, Mr. Witte obtained a document from staff of the Bureau of Substance Abuse and Addiction Services (BSAAS) that cross-walked the current benefits of the "benchmark" plan Michigan has selected for EHB purposes with the benefits available through state/federal BSAAS funds as well as through the state's current Medicaid plan. The cross-walk revealed a large gap between the current state/federal BSAAS benefit array and that which exists in the Medicaid plan, and an even larger gap with the benchmark plan. That document is attached to this report.

A meeting has been requested and arranged with Lt. Governor Calley to discuss this information, and a report of that activity will be made at a future meeting of the State Drug Treatment Court Advisory Committee.

After Mr. Witte made his report, Mr. Risk asked to be appointed to the ad hoc committee. The Chair granted his request.

VIII. Funding Update

Dr. Parks reported that an additional $5 million has been requested for problem-solving courts in FY 2014—$2 million for mental health courts and $3 million for establishing regional DWI courts, funding veterans treatment courts, and increasing drug court funding. Although there is support for the additional funds, there is uncertainty in the budget process so all new spending is not being placed in the budget at this time. Dr. Parks also reported that they have learned Byrne-Jag funding will be cut due to the federal sequester.

IX. Report on 2-Year Delay of Sentence for Drug Court Participants

The issue of recommending that a 2-year delay of sentence for drug court participants be implemented was discussed. Mr. Sauter noted the potential opposition to this change and shared that with all of the diversion statutes, as a prosecutor, he really does not see a need to change the delayed sentencing statute. The Committee will continue to review the issue.

X. Public Comment

The Chair asked for public comment. There was none.

Committee Member Comments

Dr. Parks alerted the members to House Bill 4238 which allows a diversion for an individual with a mental illness. She summarized what the bill would do if passed and will send a copy of the bill to the members of the Committee.

XI. Next Meeting Date

The Chair announced that the next meeting is tentatively scheduled for **Tuesday, May 28, 2013,** at **9:30 a.m.**

XII. Adjournment

The Chair called for a motion to adjourn. **Judge Haley moved, supported by Mr. Risk, to adjourn the meeting. There were no objections. The motion was unanimously approved and the meeting was adjourned at 10:42 a.m.**

(Approved at the May 28, 2013 State Drug Treatment Court Advisory Committee Meeting.)

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Comparison of Covered Benchmark and Medicaid Services

Covered Service Comparison*

Covered Service	MI Benchmark Plan	Current Medicaid
Detoxification		
• Inpatient	**X**	
• Outpatient/ambulatory	**X**	**X**
• Residential		**X**
• Medically managed residential		**X**
• Non-medical/social		**X**
Inpatient treatment	**X**	
Partial hospitalization	**X**	
Outpatient treatment		
• Intensive (IOP)	**X**	**X**
• Individual	**X**	**X**
• Group	**X**	**X**
• Family		**X**
• Crisis Intervention		**X**
• Referral/linking/coordinating (CSM)		**X**
• Peer recovery and recovery support		**X**
• Early intervention		**X**
Residential treatment		**X**
Methadone treatment		**X**

*This comparison is based on the review of the Certificate of Coverage available from Priority Health on the plan selected by the state of Michigan and the services listed in the Medicaid Provider Manual dated January 1, 2013.

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Comparison of Covered Benchmark and SUD Services

Covered Service Comparison with Proposed SUD Benefits Package*

NC = Not Covered **P = Partial Coverage** **C = Coverage**

Proposed Benefit and Related Services**	Funding Sources					
	Medicaid		MI Benchmark Plan		Block Grant/ General Fund	
	SUD Only	COD	SUD Only	COD	SUD Only	COD
Preventive and Wellness Services and Chronic Disease Management						
• Screening	NC	NC	**P**	**P**	C	C
• Caretaker Education and Support Services	NC	P	**NC**	**NC**	P	P
• Health Coaching	NC	P	**NC**	**NC**	P	P
• Health and Wellness Promotions and Educational Programming	NC	P	**P**	**P**	C	C
• Interventions Aimed at Facilitating Compliance	NC	P	**NC**	**NC**	C	C
• Care Coordination	P	P	**NC**	**NC**	C	C
• Relapse Prevention	NC	NC	**NC**	**NC**	C	C
Assessment						
• Health Assessments	C	C	**P**	**P**	C	C
• Service Planning	C	C	**P**	**P**	C	C
• Specialized Evaluations	P	P	**P**	**P**	NC	NC
• Psychiatric Diagnostic Evaluation	C	C	**C**	**C**	C	C
• Diagnostic Assessments	P	P	**P**	**P**	P	P
Outpatient, Including Intensive Outpatient						
• Therapy	C	C	**C**	**C**	C	C
• General and Specialized Outpatient Medical and Monitoring Services	NC	P	**P**	**P**	C	C
• Early Intervention Services	P	P	**NC**	**NC**	C	C
• Consultation	P	P	**P**	**P**	P	P
• Evidence-Based Complementary/ Adjunct Medicine/Health Services	NC	NC	**NC**	**NC**	P	P
• Medication Management	P	C	**P**	**P**	P	P
• Assertive Community Treatment	NC	P	**NC**	**NC**	C	C
• Partial Hospitalization	NC	P	**C**	**C**	NC	NC
• Intensive Case Management	NC	P	**NC**	**NC**	C	C
• Medication Assisted Treatment	P	P	**NC**	**NC**	C	C
Residential/Inpatient Treatment						
• Residential Placement	C	C	**NC**	**NC**	C	C
• Inpatient Substance Use Disorder Care	NC	NC	**C**	**C**	NC	NC
Recovery and Rehabilitative Support Services						
• Case Management	P	P	**NC**	**NC**	C	C
• Transitional and Recovery Housing	NC	NC	**NC**	**NC**	P	P
• Supported Employment	NC	P	**NC**	**NC**	NC	NC
• Transportation Assistance	P	P	**NC**	**NC**	P	P

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Proposed Benefit and Related Services**	Funding Sources					
	Medicaid		MI Benchmark Plan		Block Grant/ General Fund	
	SUD Only	COD	SUD Only	COD	SUD Only	COD
• 24/7 Crisis/Assistance Hotline Services	P	P	**NC**	**NC**	NC	NC
• Clubhouse Psychosocial Rehabilitation	NC	P	**NC**	**NC**	P	P
• Peer Provided Recovery Support Services	P	P	**NC**	**NC**	C	C
• Recovery Community Support Center Services	NC	P	**NC**	**NC**	C	C
• Community Support Programs	NC	P	**NC**	**NC**	C	C
Emergency Services						
• Crisis Intervention Services	NC	P	**NC**	**NC**	P	P
• Intensive Crisis Stabilization	NC	P	**NC**	**NC**	P	P
• Crisis Residential	NC	P	**NC**	**NC**	P	P
• Crisis Observation Care	NC	P	**NC**	**NC**	P	P
• Detoxification Services	C	C	**P**	**P**	C	C
Pharmacotherapy						
• Approved Formulary of Medication	P	P	**P**	**P**	C	C
Laboratory Services						
• Drug Screens	C	C	**P**	**P**	C	C
• Medication-Related Tests	P	P	**P**	**P**	P	P
• General Health Screenings and Immunizations	P	P	**C**	**C**	P	P
Maternal, Newborn and Pediatric Services						
• Pre-and Peri-Natal Screening and Brief Interventions	C	C	**C**	**C**	C	C
• Health Education	NC	P	**P**	**P**	C	C
• Home Visiting Programs	NC	P	**NC**	**NC**	C	C
• Specifically Focused Early Intervention Services	NC	P	**NC**	**NC**	P	P
• Caretaker Coaching	NC	P	**NC**	**NC**	P	P
• Therapeutic Mentoring	NC	P	**NC**	**NC**	P	P
• Skill Building	NC	P	**NC**	**NC**	P	P
• Intensive Home-Based Treatment	NC	P	**NC**	**NC**	P	P

*This comparison is based on the review of the Certificate of Coverage available from Priority Health on the plan selected by the state of Michigan, the services listed in the Medicaid Provider Manual dated January 1, 2013 and the services covered by block grant and general fund for FY 2013.

**The proposed benefits and related services are based on the recommendations from the Recovery Oriented System of Care Transformation Steering Committee after a review of the recommendations from the Essential Health Benefit Package from the Coalition for Whole Health.

Comparison of Benchmark and Medicaid SUD Service Descriptions

Priority Health HMO – The selected Benchmark plan for Michigan

Covered Services*
Substance abuse services, including counseling, medical testing, diagnostic evaluation and detoxification are covered in a variety of settings. Patients may be treated in an inpatient or outpatient setting, depending on the particular condition. Services will generally be provided in the least restrictive place that will allow for the best results for any particular condition. Priority Health follows the American Society of Addiction Medicine (ASAM) Patient Placement Criteria. Outpatient substance abuse services do not require referral from a PCP. Inpatient substance abuse services (including partial hospitalization) require prior approval from the Behavioral Health Department, except in a medical emergency.

Covered treatment includes:

(a) Inpatient Detoxification. These are detoxification services that are provided in an inpatient hospital or sub-acute unit.
(b) Medically Monitored Intensive Inpatient Treatment. Following full or partial recovery from acute detoxification symptoms, this type of care is provided at an inpatient facility or sub-acute unit.
(c) Partial Hospitalization. This is an intensive, non-residential level of service provided in a structured setting, similar in intensity to inpatient treatment. Generally treatment is more than four hours but generally less than eight hours daily.
(d) Intensive Outpatient Programs. These are outpatient services provided by a variety of health professionals at a frequency of up to four hours daily, and up to five days per week.
(e) Outpatient Treatment. This is the least intensive level of service. It is provided in an office setting generally from 45-50 minutes (for individuals) to 90 minutes (for group therapies) per day.
(f) Outpatient/Ambulatory Detoxification. These detoxification services may be provided on an outpatient basis within a structured program when the consequences of withdrawal are non-life-threatening.

Coverage Limitations
Prescription Drug Coverage is only available when you are confined as an inpatient unless you have a prescription drug Rider to this Certificate.

Non-Covered Services

(a) The costs of residential treatment programs without medical monitoring, institutional care, non-licensed programs, half-way houses or assisted living settings.
(b) Non-skilled care received in a home or facility on a temporary or permanent basis. Examples of such care include room and board, health care aids, and personal care designed to help you in activities of daily living or to keep you from continuing unhealthy activities.
(c) Services for caffeine abuse or addiction.
(d) Experimental/investigational or unproven treatments and services.

**Information obtained from the Priority Health HMO 2012 Certificate of Coverage for Michigan*

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Medicaid Covered Services

Covered Service Categories*

Outpatient Services

Outpatient treatment is a non-residential treatment service that can take place in an office-based location with clinicians educated/trained in providing professionally directed alcohol and other drug treatment or a community-based location with appropriately educated/trained staff. The treatment occurs in regularly scheduled sessions, usually totaling fewer than nine contact hours per week but, when medically necessary, can total over 20 hours in a week. Individual, family or group treatment services may be provided individually or in combination. Treatment must be individualized based on a bio-psycho-social assessment, diagnostic impression and beneficiary characteristics, including age, gender, culture, and development. Authorized decisions on length of stay, including continued stay, change in level of care, and discharge, must be based on the American Society of Addiction Medicine (ASAM) Patient Placement Criteria. Beneficiary participation in referral and continuing care planning must occur prior to discharge and should be based on the needs of the beneficiary in order to support sustained recovery. Once the above criteria have been satisfied and the beneficiary has demonstrated a willingness to participate in treatment, the following services can be provided in the outpatient setting:

- **Individual Assessment –** A face-to-face service for the purpose of identifying functional, treatment, and recovery needs and a basis for formulating the Individualized Treatment Plan.
- **Individual Treatment Planning –** The beneficiary must be directly involved with developing the plan that must include Recovery Support Preparation/Relapse Prevention Activities.
- **Individual Therapy –** Face-to-face counseling services with the beneficiary.
- **Group Therapy –** Face-to-face counseling with three or more beneficiaries, and can include didactic lectures, therapeutic interventions/counseling, and other group related activities.
- **Family Therapy –** Face-to-face counseling with the beneficiary and the significant other and/or traditional or non-traditional family members.
- **Crisis Intervention –** A service for the purpose of addressing problems/issues that may arise during treatment and could result in the beneficiary requiring a higher level of care if intervention is not provided.
- **Referral/Linking/Coordinating/Management of Services –** For the purpose of ensuring follow-through with identified providers, providing additional support in the community if primary services are to be provided in an office setting, addressing other needs identified as part of the assessment and/or establishing the beneficiary with another provider and/or level of care. This service may be provided individually or in conjunction with other services based on the needs of the beneficiary (frequently referred to as substance use disorder case management).
- **Peer Recovery and Recovery Support –** To support and promote recovery and prevent relapse through supportive services that result in the knowledge and skills necessary for an individual's recovery. Peer recovery programs are designed and delivered primarily by individuals in recovery (Recovery Coach) and offer social, emotional, and/or educational supportive services to help prevent relapse and promote recovery.
- **Compliance Monitoring –** For the purpose of identifying abstinence or relapse when it is a part of the treatment plan or an identified part of the treatment program (excludes laboratory drug testing).

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- **Early Intervention –** Includes stage-based interventions for individuals with substance use disorders and individuals who may not meet the threshold of abuse or dependence but are experiencing functional/social impairment as a result of use.
- **Detoxification/Withdrawal Monitoring –** For the purpose of preventing/alleviating medical complications as they relate to no longer using a substance.
- **Substance Abuse Treatment Services –** Services that are required to include assessment, treatment planning, stage-based interventions, referral linking and monitoring, recovery support preparation, recovery support services, and treatment based on medical necessity. They may include individual, group and family treatment.

Approved Pharmacological Supports (Methadone)
Covered services for Methadone and pharmacological supports and laboratory services, as required by DPT/CSAT regulations and the Administrative Rules for Substance Use Disorder Service Programs in Michigan, include:

- Methadone medication
- Nursing services
- Physical examination
- Physician encounters (monthly)
- Laboratory tests (including health screening tests as part of the initial physical exam, pregnancy test at admission, and required toxicology tests)
- TB skin test (as ordered by physician)

Medical Maintenance Phase
When the maximum therapeutic benefit of counseling has been achieved, it may be appropriate for the individual to enter the medical maintenance (methadone only) phase of treatment and recovery; that is if it has been determined that ongoing use of the medication is medically necessary and appropriate for the individual.

Sub-Acute Detoxification
Sub-acute detoxification is defined as supervised care for the purpose of managing the effects of withdrawal from alcohol and/or other drugs as part of a planned sequence of addiction treatment. Detoxification is limited to the stabilization of the medical effects of the withdrawal and to the referral to necessary ongoing treatment and/or support services. Licensure as a sub-acute detoxification program is required. Sub-acute detoxification is part of a continuum of care for substance use disorders and does not constitute the end goal in the treatment process. The detoxification process consists of three essential components: evaluation, stabilization, and fostering client readiness for, and entry into, treatment. A detoxification process that does not incorporate all three components is considered incomplete and inadequate. Detoxification can take place in both residential and outpatient settings, and at various levels of intensity within these settings. Client placement to setting and to level of intensity must be based on ASAM Patient Placement Criteria and individualized determination of client need. The following combinations of sub-acute detoxification settings and levels of intensity correspond to the LOC determination based on the ASAM Patient Placement Criteria.

- Outpatient Setting.
- Ambulatory Detoxification without extended on-site monitoring corresponding to ASAM Level I-D, or ambulatory detoxification with extended on-site monitoring (ASAM Level II-D).
- Outpatient setting sub-acute detoxification must be provided under the supervision of a Substance Abuse Treatment Specialist. Services must have arrangements for access to licensed

medical personnel as needed. ASAM Level II-D ambulatory detoxification services must be monitored by appropriately credentialed and licensed nurses.

- Residential Setting
- Clinically Managed Residential Detoxification - Non-Medical or Social Detoxification Setting: Emphasizes peer and social support for persons who warrant 24-hour support (ASAM Level III.2-D). These services must be provided under the supervision of a Substance Abuse Treatment Specialist. Services must have arrangements for access to licensed medical personnel as needed.
- Medically Managed Residential Detoxification - Freestanding Detoxification Center: These services must be staffed 24-hours-per-day, seven-days-per-week by a licensed physician or by the designated representative of a licensed physician (ASAM Level III.7-D). This service is limited to stabilization of the medical effects of the withdrawal, and referral to necessary ongoing treatment and/or support services. This service, when clinically indicated, is an alternative to acute medical care provided by licensed health care professionals in a hospital setting. Authorization requirements:
- Symptom alleviation is not sufficient for purposes of admission. There must be documentation of current beneficiary status that provides evidence the admission is likely to directly assist the beneficiary in the adoption and pursuit of a plan for further appropriate treatment and recovery.

Residential Treatment

Residential Treatment is defined as intensive therapeutic service which includes overnight stay and planned therapeutic, rehabilitative or didactic counseling to address cognitive and behavioral impairments for the purpose of enabling the beneficiary to participate and benefit from less intensive treatment. This intensive therapeutic service is limited to those beneficiaries who, because of specific cognitive and behavioral impairments, need a safe and stable environment in order to benefit from treatment.

Excluded Services

- Room and board;
- All other services not addressed within Covered or Allowable Services; and
- The PIHPs are not responsible to pay for the following:
    - Acute detoxification.
    - Laboratory services related to substance abuse (with the exception of lab services required for Methadone).
    - Medications used in the treatment/management of addictive disorders.
    - Emergency medical care.
    - Emergency transportation.
    - Substance abuse prevention and treatment that occurs routinely in the context of providing primary health care.
    - Routine transportation to substance abuse treatment services which is the responsibility of the local DHS.

**Information obtained from the Medicaid Provider Manual dated January 1, 2013*