

ILLINOIS DEPARTMENT
OF HUMAN SERVICES

*Division of Substance Use
Prevention and Recovery*

2020

FISCAL YEAR

CONTRACTUAL POLICY MANUAL

The information contained within this manual is applicable to any organization with a contract to provide substance use disorder intervention and treatment services as authorized by the Illinois Department of Human Services (IDHS), Division of Substance Use Prevention and Recovery (SUPR).

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INTRODUCTION

The information contained within this manual is applicable to all SUPR funded organizations with a contract to provide substance use disorder prevention, intervention, and treatment services as authorized by the Illinois Department of Human Services (IDHS), Division of Substance Use Prevention and Recovery (SUPR). Each contract specifies funding deliverables and the policy and procedures contained within this manual are based upon rules and/or contract conditions in effect for Fiscal Year 2020. Where applicable, the specific source of the mandate is referenced. The term SUPR “funded organizations” as referenced in this manual means licensed/Medicaid certified organizations with funding for intervention or treatment services, licensed and/or Medicaid certified organizations with funding for non-licensable services or organizations with funding for specified activities or services.

Full compliance with and a thorough understanding of Department rules and procedures are expected of all funded organizations. Most reporting and billing errors that cause delay of payment and incorrect analysis of data can be prevented by correct utilization of reporting software and adherence to procedures established in this manual.

SUPR has an established Help Desk e-mail and fax number for all organizations to utilize when there are questions regarding contracts and/or funding requirements. This e-mail address is DoIT.SUPRHELP@ILLINOIS.GOV and the fax number is 217-558-4546.

GENERAL REQUIREMENTS

Unless otherwise indicated, all funded organizations must comply with the following requirements:

Financial Management

All organizations shall have a written procedure for financial management that meets the standards for fund control as specified in 2 CFR 200.302 (Financial Management). The written procedure must also identify the requirements that must be in effect in to qualify and request an advance payment of contract funds as allowed in 2 CFR 200.305. The organization’s contract manager should be contacted if additional information is needed to meet this requirement.

Annual On-Line Certification Plan Survey

Organizations are required to complete a FY 2020 Annual On-Line Certification Plan Survey. This plan certifies receipt and understanding of all Federal and state regulations applied to the contract award and any other terms and conditions in the FY 2020 contract and exhibits, the SUPR Attachment C and all applicable service requirements. All certifications are subject to on-site verification by SUPR staff.

Relocation or Closure of Any Funded Service

Organizations must receive approval in writing from SUPR at least 90 calendar days prior to the relocation or closure of any funded service. SUPR may exercise its right to disapprove any movement of funded services or locations and may request the return of payments related to such service closures or relocations.

Overdose Prevention, Patient and Staff Training

All funded treatment organizations must certify, on the FY 2020 On-Line Annual Certification Plan Survey, that all professional and support staff have received opioid overdose education and training that includes how to recognize an overdose and instruction on how to administer naloxone, a life-saving medication used to reverse a suspected opioid drug overdose. Organizations must also certify that naloxone is readily accessible to all staff members at each treatment facility and that such training is a part of any

new employee orientation. Additional information and training resources can be accessed at <http://www.dhs.state.il.us/page.aspx?item=116652>.

Drug Overdose Prevention Programs (DOPP) with access to naloxone can be located at <http://www.dhs.state.il.us/page.aspx?item=58142>, Illinois PDO and STR Naloxone Grant Recipient Grant Contact Information (pdf). Organizations are also encouraged to voluntarily enroll as a DOPP to provide increased access to training and information for local residents, municipalities and friends and families of those with an OUD. Voluntary enrollment information is available at <http://www.dhs.state.il.us/page.aspx?item=58142>.

Additionally, effective January 1, 2017, Public Act 99-0553 requires that all SUPR licensed substance use disorder (SUD) treatment organizations provide educational information to patients identified as having or seeking treatment for an opioid use disorder (OUD) that includes the use of medication for an OUD, recognition of and response to an opioid overdose, and use and administration of naloxone. This must be a documented objective in such patient's treatment and continuing recovery plan.

Contract Adjustment

All organizations that receive notification for a budget revision within the IDHS Community Service Agreement (CSA) must complete this revision and submit their revised budget for approval within 45 calendar days of notification. If the revision is not received by IDHS/SUPR within this time frame, the Division reserves the right to void the adjustment.

Authorized Organization Representative

The organization shall designate one individual as the authority for the management, control and use of funding contained in SUPR contract(s). This individual should be the same person for every contract and will be the point of contact for all communication relative to those contracts. The Authorized Organization Representative is also responsible for sharing and communicating information sent from SUPR with all applicable staff on a timely basis in order to ensure they have access to SUPR policy changes, training opportunities and other news alerts. The organization shall notify SUPR, in writing, within ten calendar days, when there is a change in this designation.

Charitable Choice

Any organization that identifies as religious or charitable must have current registration within the Illinois Attorney General Charitable Trust Database. In order to register, the organization must have written policies and procedures related to federal choice requirements specified in 42CFR Part 54. Information and the form required for registration can be obtained at:

<http://www.ag.state.il.us/charities/index.html>

<http://www.ag.state.il.us/charities/co-3form.pdf>

<http://charitableviewer.ilattorneygeneral.net/>

ELIGIBILITY - ORGANIZATION AND PATIENT

Organization Eligibility

To use contract dollars as a payer source for substance use disorder intervention and treatment services, eligibility begins with funding via a fully executed contractual agreement with IDHS/SUPR that specifies the types of services that are reimbursable and the rates for these respective services.

To maintain eligibility, organizations must deliver intervention and treatment services in accordance with IDHS rules that specify:

- The minimum standards necessary to deliver quality care (Part 2060);
- The minimum standards necessary for administration of funding (Grant Accountability and Transparency Act (GATA), Parts 509, 511 and 2030) as well as any other specific contractual obligations, if applicable.

Violations may result in a financial penalty or a disbursement adjustment and are considered in determining the continuation of contractual agreements.

Family Income Eligibility Criteria

To be eligible for reimbursement utilizing contract dollars as specified in a valid contract with IDHS/SUPR, the following family income eligibility criteria is utilized to determine the appropriateness of contract funding to pay for intervention or treatment services. If the patient meets the income criteria and can supply documented proof of such, 100% of the uniform or negotiated rate will be reimbursed.

FAMILY INCOME ELIGIBILITY CRITERIA CONTRACT FUNDING

FY 2020 FAMILY INCOME ELIGIBILITY

| Number of Dependents | Annual Income |
|----------------------|---------------|
| 1 | \$24,980 |
| 2 | \$33,820 |
| 3 | \$42,660 |
| 4 | \$51,500 |
| 5 | \$60,340 |
| 6 | \$69,180 |
| 7 | \$78,020 |
| 8 | \$86,860 |

For each additional person, add \$8,840.

- **Dependents are defined as the number of dependents living in the patient’s immediate household as well as any for whom financial responsibility exists.**
- **Annual income is defined as all projected annual gross income per calendar year.**

The FY 2020 Family Income Eligibility Criteria is double the minimum amounts contained in the most recent poverty guidelines published by the Department of Health and Human Services (HHS) in the Federal Register, Vol. 84, No. 22/Friday, February 1, 2019/ Notices. The Income Eligibility Criteria contained in this manual is in effect for all of FY 2020. **Organizations must establish policies and procedures to ensure income eligibility is updated when new information concerning the patient’s income status becomes available. At a minimum, patient income must be re-verified on an annual basis.**

Income Eligibility Waiver Criteria

Income eligibility may be waived on a case-by-case basis based upon hardship guidelines approved by the organization’s governing board that shall, at a minimum, allow for service to be provided to:

1. a dependent adult whose spouse or other responsible party is unwilling to assume financial responsibility for the cost of treatment, and the dependent adult would, as a result, be denied access to treatment services; or
2. a dependent minor who is not covered by the Department of Healthcare and Family Services Medical Programs and/or whose parent(s) or legal guardian is unwilling to assume financial responsibility for the cost of treatment or intervention, and the dependent minor would, as a result, be denied access to treatment or intervention services; or
3. a pregnant woman who is not covered by the Department of Healthcare and Family Services Medical Programs and has no insurance benefit that covers the cost of treatment; or
4. a member of a family unit whose combined debt for prior medical expenses (not covered by insurance) exceeds 7.5% of the total gross family income, and the individual would be denied access to treatment due to the unwillingness or inability of the family to assume further debt; or
5. a patient with an extenuating circumstance that meets any additional hardship guidelines adopted by the provider’s governing body; or
6. an individual for whom the fee is the sole inhibitor to accept treatment; or
7. other approved governing body criteria.

Documentation corroborating the use of the waiver criteria shall be kept in the patient record or a separate financial record.

Documentation of Income

The patient must supply documentation of income, which is required to be kept in the patient record or a separate financial record. Acceptable examples of proof of income are a copy of the most recently filed Federal Income Tax Return or any other document indicating current status of family income (i.e., paycheck stubs, W-2 forms, unemployment cards, and Medicare or Medicaid cards). When unable to secure income verification from the patient, the organization must document in the patient record or a separate financial record what attempts were made to secure such information and the reason for the absence of such information.

Documentation from the patient supporting his or her claim shall be kept in the patient record or a separate financial record. Providers are not required to submit such documentation to SUPR, but this

information is subject to review. Failure to maintain this documentation will result in disallowance of payments and recoupment.

Co-Payment

Assessment of a co-payment is optional for an intervention or treatment service that will be reimbursed with contract funds. If an organization elects to assess co-payments, a sliding fee scale and an associated policy and procedure must be developed and reviewed and approved annually by all owners or controlling parties of the organization. Collection of the co-payment is the responsibility of the organization. Inability to collect cannot be used as justification for discharge or denial of any intervention or treatment service, including any requested documentation of such services.

REIMBURSEMENT POLICY

A covered service is that for which payment can be made using contract funds by the Department. Covered services, as specified in this section, must be medically necessary, as applicable, and delivered in accordance with all provisions specified in 77 Ill. Adm. Code, Part 2060 and/or service requirements specified herein.

Each organization shall have established policy regarding eligibility, billing and collection. This policy shall ensure that third-party payment benefits, including Medicaid or other state or federal funds, are identified and accessed first before billing contract funding.

As part of the admission process, organizations are required to ensure that the patient has applied for any applicable entitlement benefit or, if eligible, health insurance under the Affordable Care Act, if such patient is not already enrolled or insured. Organizations are also expected to refer patients to other appropriately licensed organizations for medically necessary services the organization does not deliver or when the organization's services are not covered by the patient's Medicaid Managed Care (MCO) or insurance coverage. As such, funds contained in SUPR contracts shall be used for covered services for income eligible patients when all other applicable entitlement or third-party payment has been depleted. When this occurs, funds can be used as follows:

1. For services for any patient who has exhausted or not yet purchased third party insurance coverage OR for any annual insurance deductible.
2. For the amount of any applicable Medicaid spend-down and/or for services that are not Medicaid reimbursable.
3. For any patient covered by Medicare who receives services from a Division licensed organization that is not enrolled as a Medicare provider.

Covered Services

Admission and Discharge Assessment (One Each Per Episode of Care)

Level 1

Level 2

Level 3.1 (Residential Extended Care)

Level 3.7 (Medically Monitored Withdrawal Management)

Level 3.2 (Clinically Managed Withdrawal Management)

Level 3.5 (Day Treatment)

Level 3.5 (Room and Board Only)

Level 3.5 (Residential Rehabilitation)

Psychiatric Evaluation (Payable Per Encounter – One Per Day)

Case Management, Early Intervention, Community Intervention (Maximum Allowable Referenced in Exhibit I)

Recovery Home - Adult

Recovery Home - Adolescent

Medication Assisted Treatment (Methadone for Opioid Use Disorder (OUD))

FY 2020 REIMBURSEMENT RATES

The rates established to reimburse or calculate earnings represent what the Department has determined it will pay for each service. However, the applicable rate may not always cover the actual cost of the service. When this occurs, it is expected that organizations can demonstrate how the remainder of the cost will be collected to ensure fiscal solvency. Additionally, organizations who serve patients who are not contract eligible, cannot charge such patients **LESS than the Department uniform or negotiated rate for that service.**

Reimbursement rates for FY 2020 are as follows:

| Service | Minimum Unit of Service | Code | Rate |
|---|-------------------------|------|--|
| Admission and Discharge Assessment | Quarter Hour | AAS | \$68.96 – Per Hour \$17.24 – Per Quarter Hour |
| Level 1 (Individual) | Quarter Hour | OP | \$65.60 – Per Hour \$16.40 – Per Quarter Hour |
| Level 1 (Group) | Quarter Hour | OP | \$24.84 – Per Hour \$ 6.21 – Per Quarter Hour |
| Level 2 (Individual) | Quarter Hour | OR | \$65.60 – Per Hour \$16.40 – Per Quarter Hour |
| Level 2 (Group) | Quarter Hour | OR | \$24.84 – Per Hour \$ 6.21 – Per Quarter Hour |
| Level 3.1 | Daily | HH | \$70.56 – Daily |
| Level 3.2 or 3.7 (Withdrawal Management) | Daily | DX | Daily Provider/Site Specific |
| Level 3.5 | Daily | RR | Daily Provider/Site Specific |
| Recovery Home - Adult | Daily | RH | \$54.82 |
| Recovery Home - Adolescent | Daily | RH | \$139.21 – Daily |
| Case Management | Quarter Hour | CM | \$50.80 – Per Hour \$12.70 – Per Quarter Hour |
| Psychiatric Evaluation | Per Encounter/Per Day | | \$85.88 – Per Encounter/Per Day |
| Medication Assisted Treatment (Methadone for Opioid Use Disorder) | Weekly | OP | \$73.92 – Weekly |
| Early Intervention (Individual) | Quarter Hour | EI | \$65.60 – Per Hour \$16.40 – Per Quarter Hour |
| Early Intervention (Group) | Quarter Hour | EI | \$24.84 – Per Hour \$ 6.21 – Per Quarter Hour |
| Community Intervention | Quarter Hour | CIH | \$49.60 – Per Hour \$12.40 – Per Quarter Hour |
| Child Domiciliary Support | Daily | CRD | \$53.00 – Daily |
| Toxicology | Per Test | TOX | \$ 9.90 – Per Test |

REIMBURSEMENT/DISBURSEMENT SPECIFICATIONS

Reimbursement/Disbursement

It is not the Department's practice, or within its ability, to authorize or encourage the delivery of services beyond what the amount of funding contained in the contract can support. Services reported as contract services (using DARTS code DC) at any time during the fiscal year are considered paid for by the amount of funding contained in the contract. Services that you do not want considered in this manner SHOULD NOT BE REPORTED TO DARTS. Organizations are cautioned against the delivery of unfunded services as this practice may severely affect the delivery of quality clinical care and the organization's fiscal solvency.

Group Counseling

Level 1 and 2 services delivered as group counseling shall be reimbursed only for 16 patients per **counseling** group (Medicaid or Contract).

Billings Linked to Level of Care

Billings should match the Level of Care for the patient. Outpatient care cannot be billed on the same day as Residential care. Case management, psychiatric evaluation, and medication monitoring may be billed on the same day for any patient in any Level of Care in accordance with stated contract conditions, eligibility, limits, or exceptions.

Level 3 Care - Patient Day - No more than one patient day shall be reimbursed for any recipient in a 24-hour period.

Day of Discharge or Transfer - Level 3 - Billing for the day of discharge or transfer is allowable if services are delivered on that day. However, in accordance with the billing provisions specified above, only services in one Level of Care may be billed per patient per day. For any patient **transferred** to another level of care **within the same organization**, only one type of billing for services rendered that day will be allowed. Additionally, when this occurs within the same organization, the Level of Care in which the patient spent most of the time on the day of discharge should be billed. (A patient's day begins at 6:00 a.m. and continues for 24 hours.) Similarly, when a patient is **discharged** by one organization and transferred to another organization for the same or a different level of care, only one organization may bill the **Department of Healthcare and Family Services Medical Programs** for service delivered on that day, if applicable. However, if the Department of Healthcare and Family Services Medical Programs were not billed, the referring and receiving organizations may both bill contract for any services rendered on the day of discharge.

Psychiatric Evaluation

Such services are limited to the provision of a psychiatric evaluation to determine whether the patient's primary condition is attributable to the effects of alcohol or drugs or to a diagnosed psychiatric or psychological disorder. Reimbursable psychiatric evaluations may be delivered to treatment patients where need for such service is documented in the patient's individualized treatment plan. Psychiatric evaluation shall be reimbursed at the established rate on a per encounter basis (one per day). This service must be delivered by the organization's psychiatrist.

Medication Monitoring

Psychotropic medication monitoring is billed at the individual counseling rate for treatment patients. Psychotropic medication monitoring includes a review of the efficacy, dosage and side effects of any

psychotropic medication used by the patient. Medication monitoring may be conducted by the agency's physician, physician extender or psychiatrist and billed at the individual counseling rate.

Co-Dependence/Collaterals

A **co-dependent** is a family member or significant other of an individual with a substance use disorder. Department funding can be used for assessment of these individuals and for Level 1 services if the assessment resulted in a diagnosis of **co-dependent** (DSM-5 - Z65.9).

A **collateral** is an individual who receives minimal service because of participation in someone else's related treatment. These services are reported and billed as a treatment service for the patient. If a collateral is seen alone, it should be billed as an individual session. If any combination of patients and/or collaterals is seen together, each participant should be billed separately under the patient's unique identification number at the group rate. As a guideline, such service should average one contact per week. If need is demonstrated to exceed this average, these types of individuals should be treated as co-dependents.

Case Management

Case Management means a coordinated approach to the delivery of health and medical treatment, substance use disorder treatment, mental health treatment, and social services, linking patients with appropriate services to address specific needs and achieve stated goals. In general, case management assists patients with other disorders and conditions that require multiple services over extended periods of time and who face difficulty in gaining access to those services.

Case management services are individualized for patients in treatment. They reflect needs identified in the assessment process and those developed within the treatment plan. Case management that meets the following criteria and is specified below as an eligible service can be reimbursed for a patient in any level of care:

- The service is based upon an identified need, has an identified expected outcome documented in the assessment or the treatment plan.
- The services are documented and integrated in the progress notes. Documentation must show date, time and duration and include a brief description of the service provided. The note must be signed by the person providing the service.

Examples of Case Management Activities

- ♦ Assistance with health needs.
- ♦ Assistance with transportation but not actual transportation of patients.
- ♦ Assistance with childcare.
- ♦ Assistance with family situations, living conditions, school or work situations.
- ♦ Inter/intra provider record review.
- ♦ Internal and/or external multi-disciplinary clinical staffing.
- ♦ Telephone calls, letters and other attempts to engage family members or significant others in the patient's treatment.
- ♦ Telephone calls, letters, home visits to patients to keep them engaged in treatment.
- ♦ Assistance with budgeting, meal planning and housekeeping.
- ♦ Letters, telephone calls, meetings with employers on behalf of a patient.
- ♦ Assist patients and their families in obtaining Medicaid, Social Security, cash grants, WIC, Link Cards and other entitlements that they may need.

- ♦ Assist patients and their families in obtaining medical, dental, mental health, educational, recreational, vocational, and social services as specified in the treatment plan.

Early Intervention

Early Intervention means services, authorized by a treatment license, that are sub-clinical and pre-diagnostic and that are designed to screen, identify, and address risk factors that may be related to problems associated with substance use disorders and to assist individuals in recognizing harmful consequences. Early intervention services facilitate emotional and social stability and involve referrals for treatment, as needed.

Examples of risk factors are as follows:

- Repeated absences, suspensions or terminations from work or school environments.
- Gang Involvement.
- Criminal Justice Involvement.
- Absence from family or home, homelessness, or for youth, running away or placement in alternative living environments or schools.
- Substance use disorders with a family member or significant other.
- Extreme or prolonged exposure to severe stressor, e.g., loss of home through flood or fire, death of significant other.

Early Intervention services can be provided in an individual or group setting but must be documented in a client record by time, date and duration.

Community Intervention

Community Intervention is service that occurs within the community rather than in a treatment setting. These services focus on the community and its residents and include crisis intervention, case finding to identify individuals in need of service including in-reach and outreach to targeted populations or individuals not admitted to treatment. Outreach is the encouragement, engagement or re-engagement of at-risk individual(s) into treatment through community institutions such as churches, schools and medical facilities (as defined by the community) or through Illinois Department of Human Services consultation. In-reach is the education of community institutions or state agencies and social services staff regarding the screening and referral of at-risk individuals to treatment programs for a clinical assessment.

Anticipated outcomes of community intervention include an increased awareness, “community ownership” and connectedness between the service system and community institutions. Service visibility will increase. Access to services will increase for all populations but particularly for those earlier in their “problem use” as the public becomes more aware of substance use disorder symptoms and treatment resources. Examples of community intervention activities are as follows:

- Crisis Intervention consisting of brief contacts to determine appropriate interventions and/or services.
- In-reach activities such as meetings with local IDHS or DCFS office staff to discuss screenings and referrals.
- Outreach activities designed to educate community stakeholders and increase referrals for treatment.
- Consultations with referral sources.
- Training, if specific funding for participation in or the delivery of this type of activity is contained within the contract.
- Client/Patient Transportation for case management or treatment activity identified through assessment or in the treatment plan.

- Language interpreter services authorized by a linkage agreement and approved in the Annual On-Line Certification Plan Survey.

Case Management, Early Intervention and Community Intervention Billing Allowance

The Department will establish an allocation base amount for each of these services. These base amounts will be supported by edits in the DARTS software. Allocation base amounts will be applicable to global funding established for general treatment, DCFS referrals, gambling disorder treatment and STR services. The initial base amounts established for these globals for state fiscal year 2020 are:

- General treatment global:..... 20% of the award amount
- DCFS global: 40% of the award amount
- Gambling Disorder global:..... 35% of the award amount

Any variation from the base amount must be requested in writing to the Division and confirmed in writing from the Division. Requests and questions should be forwarded to the applicable Division contract manager.

Telehealth

Telehealth can be a valuable tool in the delivery of substance use disorder services by reducing barriers to needed care through a cost-effective alternative to traditional face to face services. The Division supports telehealth when needed services would otherwise not be available because of:

- Physical disabilities
- Mental disabilities
- Transportation problems
- Social barriers
- Unavailability of specialized care
- Unavailability of an appropriate level of care

Telehealth can be reimbursed using contract funds. However, these services are not reimbursable through Medicaid (with the exception of psychiatric evaluations) or through contract funds for any patient with Medicaid coverage. Prior to delivery, the organization's Medical Director must approve policies and procedures that assure telehealth services are provided in a safe, confidential, and effective manner. These policies and procedures must describe the types of services provided and how the organization will address issues related to patient safety and security, confidentiality, use of technology, staff training/supervision, and legal issues. Organizations are encouraged to review the Telehealth Capacity Assessment provided by the National Frontier and Rural Telehealth Education Center (NFARtec) at <http://www.nfartec.org/telehealth-capacity-assessment-tool/> and TIP 60: Using Technology-Based Therapeutic Tools in Behavior Health Services <https://store.samhsa.gov/product/TIP-60-Using-Technology-Based-Therapeutic-Tools-in-Behavioral-Health-Services/SMA15-4924>.

Telehealth may be utilized and reimbursed for assessments, early intervention, outpatient, and intensive outpatient services when the following criteria are met:

- Telehealth is an assessed need and included in treatment planning.
- All continued stay reviews must remain in person.
- Progress notes document when telehealth is used.
- Individuals mandated for assessment, intervention, or treatment services require written approval from the referring source.

Reimbursement/Disbursement Specifications

- Telehealth is provided between prearranged secured locations. The use of home computers, mobile devices or land line telephones is not allowed.
- Clients, patients, and collaterals must attend regular face-to-face sessions when the need for telehealth no longer exists.
- Unforeseen barriers occur that keep the patient/client from participating in a scheduled face-to-face session and delay of the session would be problematic. Use of telehealth in this case is episode specific and justification is documented in a progress note. (If this type of behavior becomes a pattern, the problem needs to be assessed as a real barrier or assessed as a change in treatment strategy.)

Billing requirements for telehealth are as follows:

- Gambling Disorder, DCFS, collateral, and medication monitoring services are reimbursable.
- Allowable program codes are 44 (Level 2), 43 (Level 1), and 42 (Level 0.5).
- Individual and group services may be provided using procedure codes IOI, IOG, OPI, OPG, EIG, and EII. Dedicated funds tagging is allowable.
- Activity code 08 must be used to indicate a telehealth service.

Billing for Opioid Use Disorder (OUD) Treatment Services

Any patient receiving OUD treatment must have an open demographic record in DARTS. Billable services are then calculated in DARTS based upon submissions to the Pharmacy Log. If the patient does not have an open demographic record in DARTS, services will not calculate.

OUD treatment services are covered by a weekly case rate. The case rate covers dispensing as well as any other service required by State and Federal regulations. Assessment, physical examinations, case management, toxicology, psychiatric evaluations, medication monitoring and substance use disorder treatment can be billed in addition to the case rate.

FUNDING SPECIFICATIONS

Exhibit 1

Exhibit 1 contains instructions and information for obtaining the applicable billing unit/program numbers and addresses that indicate all funded services and their associated locations. Standardized rates for each applicable service are specified in this manual. Provider specific rates for residential services will be mailed to each organization at the start of each fiscal year and thereafter if revisions are made.

Organizations are asked to review and verify all unit/program numbers, addresses and rates at the start of each fiscal year and report any discrepancies to the applicable Division contract manager in order to reduce the incidence of data rejection.

SUBAWARDS

Medical/Laboratory Services Purchases

Support service purchases, such as medical/laboratory services, do not require a subaward. The purchase agreement should address any protocol and/or Administrative Rule requirements/criterion stated within the Division contract and/or this manual related to the service(s) purchased.

Clinical Services Purchases

The requirements for any request to subaward treatment activities funded by the Division are referenced herein. Should the request for a subaward be approved and the organization executes a subaward with another entity to perform treatment or ancillary support, or recovery services identified as deliverables within the Uniform Grant Agreement, the principal vendor must have a signed state fiscal year specific subaward agreement with the entity providing such services. The subaward agreement must be signed and approved by the Division prior to the initiation of any services. Failure to obtain such approval may result in a disallowance of payment as result of voucher reviews, reconciliations, and or post-payment audit reviews.

Subaward Elements

The proposed subaward will be reviewed using at a minimum the items outlined below. Additional information beyond that listed can/may be requested by staff to make a thorough review of the potential subaward. The review of the proposed subaward and any approvals shall address and provide assurance of the following items:

1. Subaward's name, address, phone number, fax number, and email; copies of the applicable Division license for all service sites to be utilized;
2. Copy of all licenses and certifications held by staff, who are performing the treatment, recovery support, or intervention services;
3. Language and copies (attached by Addenda) of the applicable Department Community Services Boiler Plate, Uniform Grant Agreement, and Attachment C, which specify requirements under which the vendor must adhere to as well;
4. Listing of services to be provided;
5. Applicable rates for services to be provided;
6. Location/site where services are to be provided;
7. Applicable Administrative Rules;
8. Applicable federal requirements;
9. Services documentation requirement;
10. Billing requirements/ processes for the subaward;
11. Payment processes and agreements;
12. Post-payment audits/monitoring requirements and liability;
13. Renewals, revocations of the contract;
14. Authorized representatives for billing and contract approval for the subaward; and
15. Annual subaward reconciliation process to be employed.

BILLING REQUIREMENTS

Unique Identification

The Recipient Identification Number (RIN) is required for all client/patients supported by Department funds. A RIN must be requested from the Department, if the client/patient does not have one, prior to billing for any service.

Service Data Reporting (Billing)

Most billing is accomplished electronically utilizing DARTS (Department's Automated Reporting and Tracking System). Appropriate software containing this system is provided free of charge. A flow chart outlining the steps in the billing process is included with this manual.

Organizations can report DARTS and third-party service data on a weekly basis using file transfer protocol (FTP) but must report data at least monthly. Organizations shall also report any other data so requested by SUPR by the prescribed time lines. The preferred method of reporting service data is through software supplied by the Department for any such service that can be reported through this mechanism. The Department assumes no responsibility for late, incomplete or inaccurate data produced by any software.

An adjustment to future disbursement or a suspension or termination of contract may occur unilaterally and without prior notice if an organization is late reporting any required financial or service data. Disbursement may be reinstated when all data is submitted and approved by the Division. Organizations shall be given immediate notice when such suspension or termination has occurred.

The Division may conduct random reviews to determine accuracy of service data. The organization shall be able to verify data entries upon request. The Division may delay or suspend disbursement or terminate funding immediately without prior notice for late reporting. Late reporting is defined as late for two consecutive months or for any three months during the fiscal year. The Division shall immediately notify the organization that such delay, suspension or termination has occurred.

The organization agrees to notify the Division immediately through a written request to the Help Desk upon discovery of any problem relative to the delivery of or submission of any required service or financial data.

Data Reporting Errors

Services will be rejected for errors in data entry or for errors related to the client/patient's eligibility status. If services are rejected in the Edit and Balance process, the organization will receive this information in an Accepted/Rejected report in Mobius. Organizations should review these errors to see if correction is necessary and resubmit, if appropriate.

In all instances, if an error occurs and the service can be rebilled, the service should be resubmitted utilizing DARTS. **Please remember that services should be resubmitted as close to the date of the error report as possible.**

Monitoring/Audits

The Division monitors the patterns, accuracy, and timeliness of organization reporting to determine compliance with programmatic contractual conditions and conducts post-payment audits to determine compliance with required clinical, administrative, and financial standards. Patient and financial records are meant to substantiate compliance. Organizations must establish and maintain audit trails to document

services delivered and billed to eligible patients. Financial and patient record completeness and accuracy are essential for demonstrating compliance and to avoid financial penalty.

Late Payment/Services Submission

The Division has two established billing periods:

- **Medicaid Funds:** Medicaid funds can be paid if accepted for payment and processed within 180 days of the date of service.
- **All Other Division Funds:** Any other Division funds can be paid if they are delivered within the applicable state fiscal year, accepted for payment before annually established dates relative to the end of the lapse period and do not exceed the established fiscal year amount of funding contained in the contract.

Payment or Acceptance of Services Beyond Established Billing Periods:

Requests for payment or service acceptance beyond established billing periods are allowable if the delay in submission was due to Division or Healthcare and Family Services (HFS) processing.

Requests for service acceptance or reimbursement from Division funds other than Medicaid may only be submitted for the prior state fiscal year. Requests for reimbursement from Medicaid may only be submitted up to two years from the date of service. All requests shall be in writing and include the reason the established billing period was exceeded. Supporting documentation must be attached. All requests must also adhere to the conditions specified in the Division contract, applicable manuals and/or letter of agreement or memorandum of understanding. If the request is for reimbursement from a federal project fund, it must reference the federal grant fiscal year funding as specified in the Division contract. All other requests for reimbursement shall be for the same type of program funds identified in the contract. If the request is denied, it will be for one of the following reasons:

- It is determined that the delay in submission is not the fault of the Division or HFS.
- Insufficient funds to satisfy the request in the specific project or program area.
- No availability of funds within the Division's appropriation authority.
- Failure to comply with billing/reporting requirements.

Federal discretionary projects for the applicable federal project year have been fully expended. Thereby, no funds are available to satisfy the claim. If the request for non-Medicaid funds is approved, the Division will apply the appropriate service credit or approve the services for reimbursement from the Illinois Court of Claims. All such approvals are subject to on-site and/or electronic audit. All requests will be responded to in writing and will specify the reason for the denial or acceptance. If the request is for Medicaid funds, the organization will be required to complete an approved HFS form for each Medicaid claim and send to HFS for processing. All such approvals are subject to on-site and/or electronic audit. All requests will be responded to in writing and will specify the reason for the denial or acceptance.

PAYMENT INQUIRY INFORMATION

Please follow the process below to review payments made to your organization.

STEP 1

Go to www.ioc.state.il.us.

Click on “vendor payments” in left column.

STEP 2

Enter the “Vendor TIN Num” in the field provided.

Click “OK.”

STEP 3

Click on “Payments.”

STEP 4

“Select a fiscal year.”

“Select an agency.”

Agency “444” is the IL Department of Human Services.

Click on the “Find Warrants” button.

STEP 5

The left column lists the warrant/EFT#. If the number begins with zeroes, it is an Electronic Funds Transfer (EFT). The funds are deposited directly into the vendor’s bank account. Note the “issue date” in the center column. This is the date of the deposit.

STEP 6

The “Warrant/EFT#” begins with an alpha character. An alpha character indicates that a warrant (check) was issued to the vendor. The “issue date” is the date that the warrant was released. The “paid date” is the date that the warrant cleared. If the “paid date” is blank, the warrant has not been cashed and/or has not cleared.

Double click on the warrant/EFT# for more details regarding the payment.

STEP 7

In the “IOC Accounting Line Details” box, Organization 26 indicates the Division of Substance Use Prevention and Recovery (SUPR).

Notice the “Invoice” number in the top section. The first digit indicates the State Fiscal Year for which services are being paid. The letters following the first character indicate that this is a payment from SUPR. For organization contract payments the alpha characters SA and SB, following the fiscal year number, are the most commonly used by SUPR. The last two characters of the invoice number indicate to which month the payment is related.

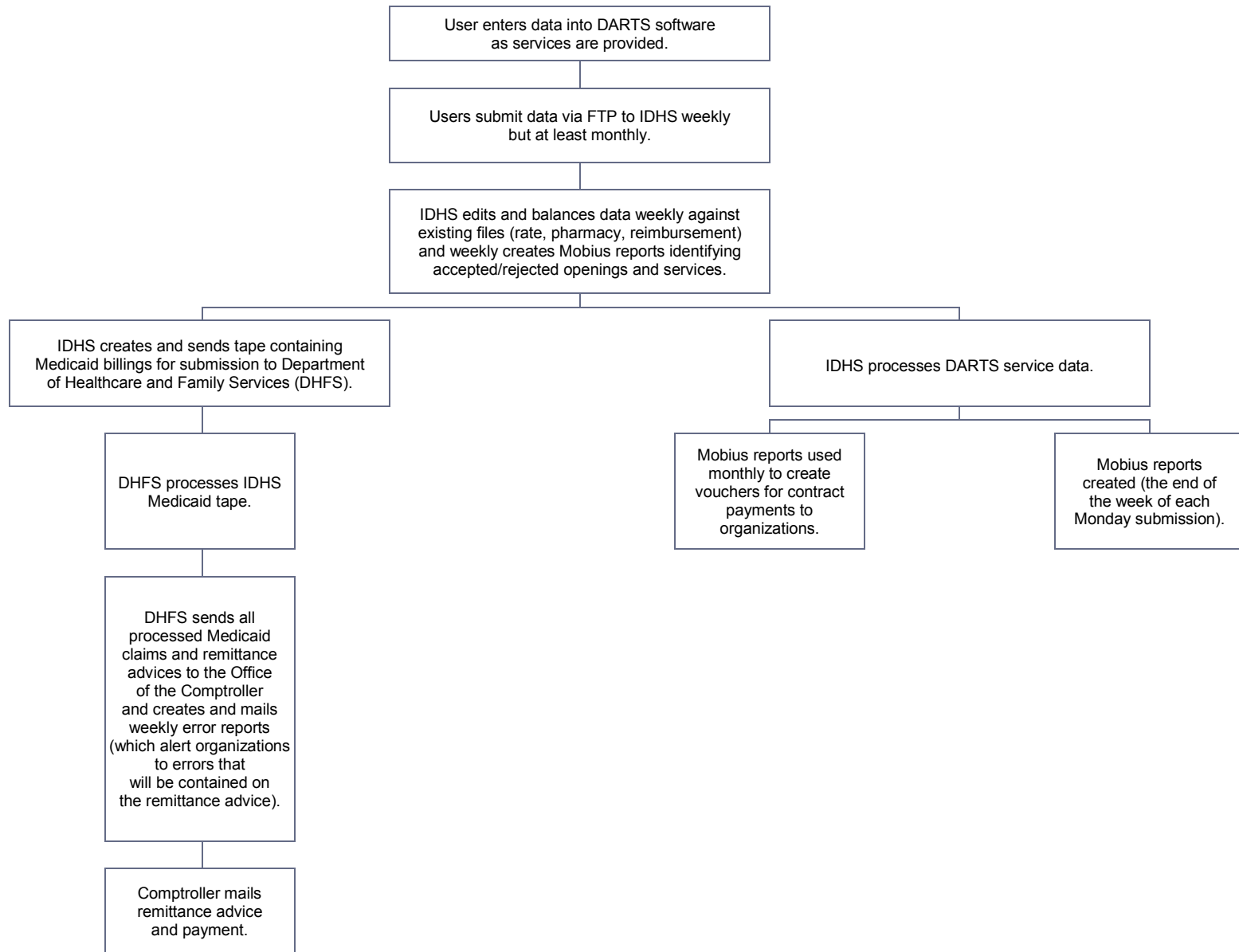
Medicaid payments will have a different invoice numbering scheme. All Medicaid payments will have an “Object” number of 4560.

Access the following links for information about EFT:

<https://illinoiscomptroller.gov/vendors/direct-deposit-sign-up/enhanced-vendor-remittance-user-guide/>

<https://illinoiscomptroller.gov/vendors/direct-deposit-sign-up/>

PAYMENT AND DATA PROCESSING CYCLE FLOW CHART



SERVICE REQUIREMENTS

Introduction

The following are service and deliverable requirements related to primary substance use disorder treatment and/or adjunct services provided to eligible individuals using Division funding. These expectations are to be considered an extension of the applicable State Fiscal Year contract and will be monitored and reviewed as such. Should you have any questions regarding these requirements please contact the Help Desk at DoIT.SUPRHelp@illinois.gov.

Service Requirements

SECTION 1: Service Requirements for Substance Use Disorder Treatment/Ancillary Services/Recovery Services

SECTION 2: Service Requirements for Recovery Home Services

SECTION 3: Service Requirements for Substance Use Disorder Treatment/Ancillary Services/Recovery Services for DCFS Recipients

SECTION 4: Service Requirements for Toxicology Testing for Assessment, Placement Decisions, or Treatment Planning for Substance Use Disorders

SECTION 5: Service Requirements for Substance Use Disorder Treatment/Ancillary Services for Opioid Treatment

SECTION 6: Service Requirements for Toxicology Testing for Recipients of Opioid Treatment

SECTION 7: Service Requirements for Treatment/Ancillary Services/Recovery Services for Gambling Disorders

SECTION 8: Service Requirements for Substance Use Disorder Treatment/Ancillary Services/Recovery Services for Daytime Childcare and Child Domiciliary Services

SECTION 9: Service Requirements for Pregnant Women and Women with Dependent Children (PWWC) Designated Sites

SECTION 1: Service Requirements for Substance Use Disorder Treatment/Ancillary Services/Recovery Services

Target Population: Individuals in Need of Substance Use Disorder Treatment, Adjunct Treatment, or Recovery Services

Introduction: These requirements set forth the terms and conditions applicable to substance use disorder treatment and related services funded by the Illinois Department of Human Services (IDHS), Division of Substance Use Prevention and Recovery.

Specific Administrative Rules

Treatment services are to be provided according to Administrative Rule: Title 77: Public Health Chapter X: Department of Human Services Subchapter D: Licensure Part 2060 Alcoholism and Substance Abuse Treatment and Intervention Licenses Section 2060.401 Levels of Care.

Levels of Care to be Provided or Made Accessible

Introduction: The Section 2060.401 Levels of Care shall be made accessible to individuals screened and assessed for need based upon the most current ASAM patient placement criteria. This accessibility shall be directly provided by the organization or by direct referral and linkage to an alternate organization who is able to provide such service.

ASAM Patient Assessment: Treatment shall be offered in varying degrees of intensity based on the level of care the patient is assessed in need/placed and the subsequent treatment plan developed for that patient. The level of care provided shall be in accordance with that specified in the ASAM Patient Placement Criteria and with the following services definitions and requirements:

Levels of Care

- A. *Level 0.5: Early Intervention:* Services authorized by a treatment license that are sub-clinical or pre-diagnostic (ASAM .05) and designed to screen, identify and address risk factors that may be related to problems associated with substance use disorders, and to assist individuals in recognizing harmful consequences. Such individuals are defined "at risk" and early intervention may be delivered in a wide variety of settings to at-risk adolescents or adults with the length of such service varying according to the type of activity. The goal is the reduction of the effects of use within the targeted community by identifying and engaging those in need of services. Early Intervention shall be provided to an identified individual (in an individual or group setting) and documented in a client record and shall be earned utilizing non-Medicaid funds at the established Early Intervention individual and group rates. The length of such service varies according to the individual's ability to comprehend the information provided and to use that information to make behavior changes to avoid problems related to substance use or the appearance of new problems that require treatment at another level of care. Examples of individuals who might receive early intervention are at-risk individuals (i.e., family members of an individual who is in treatment or in need of treatment) or DUI offenders classified at a moderate risk level.
- B. *Level 1: Outpatient:* Non-residential treatment consisting of clinical services for adults or adolescents. The frequency and intensity of such treatment shall depend on patient need but shall be a planned regimen of regularly scheduled sessions that average less than nine hours per week.
- C. *Level 2: Intensive Outpatient/Partial Hospitalization:* Non-residential treatment consisting of clinical services for adults or adolescents. The frequency and intensity of such treatment shall depend on

patient need but shall be a planned regimen of scheduled sessions for a minimum of nine hours per week.

- D. *Level 3: Inpatient Subacute/Residential*: Residential treatment consisting of clinical services for adults or adolescents. The frequency and intensity of such treatment shall depend on patient need but shall, except in residential extended care as defined in this Part, include a planned regimen of clinical services for a minimum of 25 hours per week. Inpatient care, except for residential extended care as defined in this Part, shall require staff that are on duty and awake, 24 hours a day, seven days per week. During any work period, if professional staff as defined in Section 2060.309(a) of this Part are not on duty, such staff shall be available on call for consultation relative to any aspect of patient care. Residential extended care shall require staff on duty 24 hours a day, seven days per week and that low intensity treatment services be offered at least five hours per week. Any staff providing clinical services shall meet the requirements for professional staff as defined in Section 2060.309(a) of this Part. Individuals who have been in residence for at least three months without relapse may be used to fulfill any remaining staff requirements.
- E. *Level 3: Withdrawal Management*: Residential treatment at Levels of care 3.2 or 3.7 for patients who are intoxicated or experiencing withdrawal and who need 24-hour supervision, observation and support. Lengths of stay in withdrawal management are generally short with stabilization, referral and linkage to treatment as primary goals. The essential difference between the two levels of care is the intensity of clinical services, particularly the degree of involvement of medical and nursing professionals. Level 3.2 is characterized by its emphasis on peer and social support rather than the medical and nursing care required for Level 3.7.
- F. *Level 4: Medically Managed Intensive Inpatient*: Inpatient subacute residential treatment for patients whose acute bio/medical/emotional/behavioral problems are severe enough to require primary medical and nursing care services. Such services are for adults or adolescents and require 24 hours medically directed evaluation, care and treatment and that a physician see the patient daily.

Ancillary Services, Ancillary Treatment, Intervention or Support Services

These services are defined and have the following services protocols:

- A. *Toxicology*: Urine, blood or saliva analysis to determine the presence of alcohol and/or other drugs in patient/clients who receive treatment or intervention services.
- B. *Case Management*: A coordinated approach to the delivery of health and medical treatment, substance use disorder treatment, mental health treatment, and social services, linking patients with appropriate services to address specific needs and achieve stated goals. Services may occur in the home or in other community environments and are for patient engagement and retention in treatment. Case management must be individualized to the specific patient as reflected by an individualized assessment and contained within the treatment plan. Case management may begin with admittance to treatment and proceed through continuing care. All funded case management must be documented in the patient record so that a post-payment audit can confirm the delivery of reported services.
- C. *Community Intervention*: A service that occurs within the community rather than in a treatment setting. These services focus on the community and its residents and include crisis intervention, case finding to identify individuals in need of service including in-reach and outreach to targeted populations or individuals not admitted to treatment. Outreach is the encouragement, engagement or

re-engagement of at-risk individual(s) into treatment through community institutions such as churches, schools and medical facilities (as defined by the community) or through the Illinois Department of Human Services consultation. In-reach is the education of community institutions or State agencies and social services staff regarding the screening and referral of at-risk individuals to treatment programs for the purposes of a clinical assessment. All Community Intervention services shall be earned in staff hours utilizing non-Medicaid funds at the established Community Intervention rate. All funded community intervention must be documented by time, date and duration so that a post-payment audit can confirm the delivery of reported services.

- D. *Recovery Home*: Services as specified in Part 2060.509 and/or in this Manual's Service Requirements Section 2.
- E. *Medications*: Limited reimbursement for the cost of medications for organizations who deliver substance use disorder treatment.
- F. *Interpreter Services*: These are sign and other technology services provided for individuals with a Deaf or Hearing Impairment. These services are for all levels of treatment, adjunct, and recovery services for these individuals.
- G. *Psychiatric Evaluation*: An evaluation of a patient and exchange of information to determine whether the patient's condition is because of alcohol and/or other drugs or a diagnosed psychiatric disorder.
- H. *Medication Monitoring*: Counseling to review a patient's use of medications while in treatment that is conducted by the organization's psychiatrist, physician or physician extender as a part of an individual counseling session.
- I. *Specialized Services/Projects*: The provision of special or unique projects. Descriptions are specified in a provider unique contract via the scope of services section of the applicable IDHS Uniform Grant Agreement.

SECTION 2: Service Requirements for Recovery Home Services

Target Population: Individuals assessed as in need of Recovery Home Services.

Introduction: These requirements set forth the terms and conditions applicable to Recovery Home services funded by the Illinois Department of Human Services (IDHS), Division of Substance Use Prevention and Recovery for individuals recovering from a substance use disorder. Services include housing, intermittent staff support and/or access to ancillary self-help group, or skill building activities, which assist in obtaining or help maintaining a lifestyle free of a substance use disorder.

Administrative Rules/Guidelines

Recovery Home services are to be provided according to Administrative Rule: Title 77: Public Health Chapter X: Department of Human Services Subchapter D: Licensure Part 2060 Alcoholism and Substance Abuse Treatment and Intervention Licenses Section 2060.509 Recovery Homes.

Recovery Home Specific Programmatic/Service Requirements

- A. The organization shall ensure that all individuals receiving recovery home services funded by this award have a substance use disorder diagnosis.
- B. The organization shall ensure that all individuals receiving recovery home services are sufficiently stable and are actively seeking assistance in obtaining or help maintaining an illicit drug and alcohol-free lifestyle. Assistance can include but is not limited to 12-step groups, faith-based recovery activities, or other sobriety-based activities/groups that meet the specific social or cultural needs of the individual.
- C. The organization shall maintain on site an individualized client record, which includes at a minimum:
 1. Documentation supporting that the individual is in recovery from a substance use disorder and needs Recovery Home services;
 2. An individual recovery plan that contains goals and objectives that, at a minimum, identify steps to secure stable permanent housing, needed support services/activities, and employment/vocational development/skill building objectives. The plan shall address how the recovery plan will build supports within the resident's "home living" environment and how the resident will access additional treatment services if needed; and
 3. Documentation of any involvement in the recovery home's organized activities, and access and utilization of natural supports, community-based agency support or other services needed to assist in maintaining the individual recovery plan. Documentation should also include the organization's contacts regarding recovery support services collaboration and supports accessed to support the individual's recovery plan while in residence and post discharge (when possible). Such documentation includes scheduled appointments (medical and/or other), linkage agreements, and recovery services provided to house residents.
- D. If recovery home services are provided to adolescents, the organization shall employ a minimum of seven staff to ensure at least one staff person is present when the residents are in the recovery home including weekends and holidays. The organization shall further ensure that at least two of these seven staff are in management/supervisory roles and meet all professional requirements specified in 77 Illinois Administrative Code, Chapter X, Part 2060.509(g-h).
- E. The organization shall adhere to all requirements specified in Ill. Adm. Rule, Part 2060.325(a-m), pertaining to Patient/Client Records and Part 2060.509 relative to Recovery Home Services.

- F. The organization shall ensure that staff, providing any type of service for a child or adolescent receiving childcare at the Recovery Home, or residing at the Recovery Home with a parent who is a resident, consent to a background check to determine whether they have been indicated as a perpetrator of child abuse or neglect in the Child Abuse and Neglect Tracking System (CANTS), maintained by the Department of Children and Family Services as authorized by the Abused and Neglected Child Reporting Act [325 ILCS 5/11.1(15)]. This background check should also include utilizing the Law Enforcement Agency Data System (LEADS) maintained by the Illinois State Police. The organization shall have a procedure that precludes hiring of indicated perpetrators based on the reasons set forth in 89 Ill. Adm. Code 385.30(a) and procedures wherein exceptions will be made consistent with 89 Ill. Adm. Code 385.30(e) and procedures for record keeping consistent with 89 Ill. Adm. Code 385.60.
- G. The organization shall have documentation of a written emergency plan and practices which meets the requirements of 77 Illinois Administrative Code, Chapter X; Part 2060.305(c-1).
- H. The organization shall have a quality improvement plan, which has documentation of goals, quarterly measures, and reviews of objectives, anticipated outcomes, and results of annual services improvement activities/actions.
- I. All required documented information shall be made available to the Department upon request.
- J. The organization must assure no bedroom is in an attic or in an area with floor more than three feet below the adjacent ground level.
- K. The organization shall attend and participate in Division sponsored meetings, training and technical assistance targeted to recovery home organizations. The organization shall be notified of requests to participate and shall be responsible for all related travel expenses. The organization shall provide staff development training at least annually. These sessions shall include education on cultural competency, awareness, sensitivity, and limited English-speaking services.
- L. Should the organization maintain board approved policies and procedures regarding the use of volunteers for any in-kind staff coverage, house monitoring, house support staff, or house maintenance staff, an annually renewed volunteer agreement shall be maintained. Such agreement shall cover administrative operation policies and procedures, confidentiality requirements, and all personnel policies applicable to paid staff as well as in-kind staff volunteers.
- M. The organization shall not utilize active clients as in-kind volunteers for the program and may not submit any billing for Recovery Home per diem services for volunteer house managers/monitors.
- N. If routine or random toxicology testing is utilized, the organization shall have written policy and procedure that, at a minimum, identifies the method to obtain informed consent from each resident regarding routine and random toxicology. This informed consent should state the purpose of such testing, the frequency of routine testing, the causative factors for random testing and the consequences of test results that indicate the presence of alcohol and/or other illicit drugs. This informed consent must be signed by the client prior to acceptance into the residence and maintained in the client record.

Specific Reporting Requirements

The Recovery Home must maintain a daily attendance and activity log for each site signed daily by each resident and staff. These signatures shall serve as confirmation of the resident's presence at the recovery home and/or be considered original source/records data to support services reporting/earnings.

SECTION 3: Service Requirements for Substance Use Disorder Treatment/Ancillary Services/Recovery Services for DCFS Recipients.

Target Population: Individuals and family members who are being served by the Illinois Department of Children and Family Services (DCFS) as Active Clients

Introduction: These requirements set forth the terms and conditions applicable for substance use disorder treatment and related services funded by the Illinois Department of Human Services (IDHS), Division of Substance Use Prevention and Recovery.

Specific Administrative Rules

Treatment services are to be provided according to Administrative Rule: Title 77: Public Health Chapter X: Department of Human Services Subchapter D: Licensure Part 2060 Alcoholism and Substance Abuse Treatment and Intervention Licenses Section 2060.401 Levels of Care.

Administrative Requirement/Reporting

Reporting: The organization shall complete, via a format approved by the Division and DCFS, a patient progress report monthly for each DCFS patient while the patient is receiving treatment. The completed report is to be forwarded to the patient's assigned DCFS caseworker every 30 days and at the time of discharge from treatment. The organization shall maintain a copy of the report in the patient record. A discharge summary is also to be completed and forwarded to the caseworker upon treatment case closure.

Training and Staff Requirements: The organization shall participate fully in cross training events or other related meetings arranged, convened and/or endorsed by the Division. Organizations shall also send program representatives to regional partnership meetings.

Target Population Specific Service Requirements

- A. The organization shall also ensure that case coordination occurs with DCFS and Purchase of Service offices.
- B. Except for individual cases where circumstances may prohibit, the organization shall conduct an assessment (Form CFS 440-5 Adult Substance Abuse Screen), within five (5) days of receiving a referral. The referring agency shall be informed on a timely basis when the referred patient does not keep an appointment for an assessment and/or outreach services, as defined herein.
- C. The organization shall deliver outreach services to all DCFS involved patients as appropriate to sustain gains made in treatment. Ongoing activities should be designed to support an aggressive community outreach model whenever possible. The provision of outreach services will vary based upon patient need and the level of care provided.
- D. The organization shall assure that all DCFS involved patients receive parenting training approved by DCFS.
- E. The organization shall address the transportation needs of DCFS involved patients receiving outpatient treatment services.
- F. The organization shall assist in meeting the childcare needs of DCFS patients when receiving outpatient treatment services. On-site or off-site childcare arrangements are allowable.

- G. The organization shall establish and maintain linkage agreements with local agencies to help secure any necessary mental health, substance abuse, domestic violence, childcare or housing needs for DCFS patients. Patient referrals to organizations providing the services should be documented in the patient record.
- H. If Childcare or child domiciliary services are provided, such services must be accordance with the Service Protocols Section 8: Service Protocols for Substance Use Disorder Treatment/Ancillary Services/Recovery Services for Daytime Childcare and Child Domiciliary Services.

Treatment Services to be Provided: All levels of care specified in 2060.401 shall be made accessible to individuals screened and assessed for need based upon the most current ASAM patient placement criteria. This accessibility shall be directly provided by the organization or by direct referral and linkage to an alternate service organization who is able to provide such service.

ASAM Patient Assessment: Treatment shall be offered in varying degrees of intensity based on the level of care and the subsequent treatment plan developed for that patient. The level of care provided shall be in accordance with that specified in the ASAM Patient Placement Criteria and with the service definitions and protocols specified in Section 1 of this manual.

SECTION 4: Service Requirements for Toxicology Testing for Assessment, Placement Decisions, or Treatment Planning for Substance Use Disorders

Target Population: Patients receiving substance use disorder treatment services (assessment, placement decisions, or treatment planning)

Introduction: These service requirements for funded toxicology services are applicable to treatment and related services for organizations funded by the Illinois Department of Human Services (IDHS), Division of Substance Use Prevention and Recovery (SUPR). Such funds are not intended to guarantee or cover 100% of the organization's toxicology requirements. Toxicology services shall be used solely for assessment, placement decisions, or treatment planning and must at a minimum meet the requirements specified herein. Toxicology services that could result in adverse criminal or administrative actions must as applicable, also meet the requirements specified in Section 6: Service Requirements for Toxicology Testing for Patients in Opioid Use Disorder Treatment.

- A. Organizations shall either 1) contract with a CLIA certified laboratory or 2) operate a laboratory approved by the U.S. Department of Health and Human Services (Clinical Laboratory Improvement Standards (CLIS)) or 3) if the organization chooses to use "Point of Care" testing/procedures that have low risk of an erroneous result, the organization shall apply for and maintain a Clinical Laboratory Improvement Amendments (CLIA) Certificate of waiver as outlined in federal regulation CFR Title 42 - Public Health/Part 493 (Laboratory Requirements)/Sections 493.35 (Application for a certificate of waiver) and 493.37 (Requirements for a certificate of waiver).
- B. Definition: Point of Care Testing is defined as testing administered at the location of the patient.
- C. Organizations shall have policies for toxicology testing that contain the following:
 - 1. The type, purpose, and limitations of their toxicology testing;
 - 2. Procedures for ensuring compliance with applicable federal, state, and local laws;
 - 3. Procedures for ensuring compliance with specific testing requirements;
 - 4. Procedures for toxicology testing documentation and billing; and
 - 5. Procedures for personnel training and quality improvement.
- D. The rate of payment for toxicology services is identified in the current state fiscal year Contractual Policy Manual.
- E. If the organization submits any patient identifying information with the toxicology samples to an outside vendor, the organization must have an annually renewed business associate agreement on file which addresses all HIPAA and 42 CFR confidentiality requirements.
- F. If the organization enters into a purchase of services agreement with an outside vendor for toxicology laboratory services, the organization must maintain a business/services agreement with the vendor that assures adherence to the requirements herein, including maintaining a copy of the vendor's valid CLIA certification.

Specific Reporting Requirements

To receive reimbursement, the provider shall report all toxicology services using the current State Fiscal Year version of the Department's Automated Reporting and Tracking System (DARTS) software.

SECTION 5: Service Requirements for Substance Use Disorder Treatment/Opioid Use Disorder (OUD) Treatment Services

Target Population: Patients with an Opioid Use Disorder (OUD) diagnosis.

Introduction: These **requirements apply to** services funded by the Illinois Department of Human Services (IDHS), Division of Substance Use Prevention and Recovery (SUPR) for patients with an Opioid Use Disorder diagnosis. Required services include substance use disorder treatment, medication, physical examinations, toxicology, and any other applicable state and federal regulations.

Organizations are responsible for conducting on-going self-sufficiency surveys to determine continued patient eligibility for state-funded services. The provider shall not charge funded patients any separate admission, application, evaluation or registration fee.

Administrative Rules

State

- A. All services must be provided in accordance with: Title 77: Public Health Chapter X: Department of Human Services Subchapter D: Licensure Part 2060 Alcoholism and Substance Abuse Treatment and Intervention Licenses Section 2060.401 Levels of Care (hereafter referred to as Part 2060).

Federal

- B. The organization shall conduct, record, and maintain biennial inventories of narcotic drug stocks as specified in 21CFR1304.11(c).
- C. The organization shall execute, process, and maintain DEA Form 222 as specified in 21CFR1305.
- D. The organization shall maintain current Power of Attorney for DEA Form 222 as specified in 21 CFR1305.07 and shall revoke Power of Attorney for former employees.
- E. The organization shall maintain physical security controls as specified in 21CFR1301.72.
- F. The organization shall satisfy all applicable requirements under 42 CFR 8 SAMHSA including accreditation and 21CFR1301-1307 (DEA) specific to the treatment for OUD and the delivery, storage, security, and accountability of methadone. Documentation of SAMHSA approval, DEA registration, and accreditation must be maintained on-site and be available to SUPR staff on demand. The organization shall notify SUPR immediately upon any change or delay in accreditation status.

Administrative Requirements

- A. The organization shall have a designated Authorized Organization Representative and Medical Director.
- B. The award total has been calculated by multiplying the weekly reimbursement rate by the number of cases funded by 52 weeks.
- C. The rate covers the following components: 1) managing the medical plan of care; 2) ordering the drug; 3) nursing services related to administration; 4) administration of the drug; 5) coordination with other substance use disorder services; and 6) actual drug cost per dose.
- D. The initial medical examination, additional medical services rendered by a practitioner, toxicology services, psychiatric evaluations, assessment, case management, medication monitoring, and substance use disorder treatment are reimbursed separately when the services are medically

necessary and meet all requirements specified in Administrative Rule, Part 2060 and the Medicaid State Plan.

- E. The organization shall forward to the Division, as the State Methadone Authority, copies of all CSAT-approved accrediting body survey reports, organization responses to these surveys, accrediting body responses and subsequent documentation of accrediting body awards or denials. (Organizations may give permission for CSAT-approved accrediting bodies to forward their surveys and documentation of awards or denials directly to the State Methadone Authority. Otherwise, the responsibility to forward these required documents rests with the individual organization.)
- F. Organizations with Automated Dispensing Machines are responsible for:
 - 1. Calibrating the machine on a weekly basis according to manufacturer procedures/specifications.
 - 2. Limiting access to medical order entries, i.e., changes in dosage and pickup orders, to licensed physicians only.
 - 3. Printing daily activity reports for patient dispensing, bottle control, and no shows.
 - 4. Taking physical drug inventories and updating the machines daily.
 - 5. Printing all reports as requested by monitors and the State Methadone Authority.

Documentation

- A. The organization shall maintain on-site and on an ongoing basis, the “Daily/Weekly Medication Accounting Sheet” and the “Exception Medication Record.” These records may be maintained electronically.
- B. The organization shall maintain records as specified in 21CFR1304.
- C. The organization shall submit opiate dispensing information to IDHS, Unified Health Systems, utilizing the approved IDHS interface, on a weekly basis.
- D. The organization shall submit all closings to the Division as follows: within one month after a patient has completed or been transferred, patients in outpatient treatment within 30 days of having no contact and patients in residential treatment within three (3) days of having no contact. The discharge record shall include completion of the National Outcome Measures (NOMS) fields. The organization shall submit opiate dispensing information to IDHS, Unified Health Systems, utilizing the approved IDHS interface, on a weekly basis.
- E. All services documentation must be kept as required by Part 2060.325 Patient/Client Records and/or written correspondence from the Division.

Target Population Specific Requirements Regarding Dosing Services

Opioid Use Disorder (OUD) Treatment Specific Dosing Service requirements are:

- A. The organization shall ensure that the initial dose of methadone does not exceed 30 milligrams and that the total dose for the first day does not exceed 40 milligrams unless the Medical Director documents in the patient’s record that a 40 milligrams dose was not enough to suppress opiate abstinence symptoms (42 CFR 8).
- B. The organization shall ensure that all patients are seen by a Physician and receive a physical examination conducted by a Physician or Physician Extender prior to admission to treatment and ingestion of the initial dose of Methadone. Physician Extenders, i.e., Physician’s Assistants (PAs) and

Advanced Practice Nurses (APNs), may conduct the actual physical examination but the Physician must review and sign off on physicals conducted by PAs or APNs, and see the patient prior to admission to treatment and the initial dose of medication. The Physician is the ONLY staff member who can order the admission to treatment and assign the medication dosage.

- C. The organization shall also ensure that at least eight random tests or analyses are performed on each patient each year (42 CFR 8).
- D. A patient may not receive more than a one-month supply of narcotic drugs at one time (42 CFR 8) unless the organization receives prior approval from CSAT.
- E. Each organization shall be responsible for all programmatic requirements involving continuing treatment.

Medication Exceptions

- A. The organization shall have a policy regarding take-home medication, in accordance with SAMHSA regulations and exceptions to policies regarding take-home supply of medication prior to implementation. The organization shall request and have appropriate CSAT approvals for any policy exceptions to regulations as well as all policies regarding supplies of take-home medication.
- B. An exception may be made to the take-home supply of medication policy, which permits a temporary or permanently reduced clinic attendance schedule, if in the reasonable clinical judgment of the organization's physician:
 - 1. The patient has been found to be responsible in handling narcotic drugs and has a physical disability which interferes with his or her ability to conform to the applicable mandatory clinic attendance schedule; or
 - 2. The patient has been found to be responsible in handling narcotic drugs and has exceptional circumstances, such as illness, family crises, travel, or other hardship.
- C. The rationale for each exception and the physician's approval must be entered into the patient record.

SECTION 6: Service Requirements for Toxicology Testing for Patients in Opioid Use Disorder (OUD) Treatment

Target Population: Patients receiving Opioid Use Disorder Treatment

Introduction: These service requirements are for funded toxicology services applicable to treatment and related services for organizations funded by the Illinois Department of Human Services (IDHS), Division of Substance Use Prevention and Recovery (SUPR). Such funds are not intended to guarantee or cover 100% of the organization's toxicology requirements.

Requirements

- A. The number of panels specified herein is the minimum expectation. The actual number may vary based upon the negotiated costs of each panel and the needs of each organization. The organization must test for the minimum number of panels as described.
- B. The organization shall negotiate the following with the laboratory of the organization's choice:
 1. The choice of testing medium (urine, sputum or sweat) to be used for the toxicology test;
 2. Which five drugs will comprise the standard testing panel;
 3. The cost of each panel;
 4. Onsite versus laboratory testing;
 5. Collection techniques;
 6. The cost and frequency for confirmation testing; and
 7. Any other issues related to toxicology testing for the five drugs comprising the standard testing panel.
- C. OUD Treatment organizations shall ensure that all testing includes, at a minimum, five drugs: one of which must be methadone. It is suggested that tests for Amphetamines and Barbiturates not be routinely requested unless clinically indicated due to the minimal use historically reported by programs. Instead, tests providing more realistic value such as Benzodiazepines, Marijuana, and PCP should be more routinely requested. Additionally, the organization shall ensure that it can test for six (6) Monoacetylmorphine - 10 ng/ml.
- D. The organization shall contract with a laboratory or operate a laboratory that meets the following specified criteria upon the initiation of and through the term of the contract:
 1. Maintain and provide documentation supporting approval from the U.S. Department of Health and Human Services (Clinical Laboratory Improvement Standards (CLIS)).
 2. Participate in one or more of the following controlled programs:
 - a. College of American Pathology Advanced Toxicology Survey.
 - b. American Association of Forensic Science Toxicology Survey.
 - c. Certification for laboratory testing eligibility for Medicare.
 3. Ensure that the chain of custody (COD) is maintained on all specimens.
 4. Test all specimens for adulteration prior to the initial screening test. The laboratory shall test each urine specimen for pH (< 3 or > 11), and/or specific gravity (< 1.001 or > 1.020). When a specimen is adulterated, the laboratory shall notify the organization within 48 hours of receipt of the specimen. The laboratory shall not test an adulterated specimen. (If the organization uses a medium other than urine (i.e., sputum or sweat), the laboratory must provide a protocol to ensure

- that the specimens are not adulterated prior to the initial screening tests and does not test an adulterated specimen).
5. Use an immunoassay procedure for the initial screening tests for all specimens, using immunoassay technology which meets, as minimum standards, the most current requirements as referenced in Mandatory Guidelines for Federal Workplace Drug Testing Programs (53 CFR 11,983), Federal Register, Vol. 73, Number 226, Tuesday, November 23, 2008, and the following cutoffs:
 - a. Amphetamines/Methamphetamine - 500 ng/ml
 - b. Barbiturates - 200 ng/ml
 - c. Benzodiazepines - 200 ng/ml
 - d. Benzoyl ecgonine (cocaine metabolite) - 150 ng/ml
 - e. Marijuana metabolite - 50 ng/ml
 - f. Opiates - 2000 ng/ml
 - g. Phencyclidines - 25 ng/ml
 - h. Methadone - 300 ng/ml
 - i. 6 Monoacetylmorphine - 10 ng/ml
 6. Use GC/MS (Gas Chromatography/Mass Spectrometry) testing for all confirmation tests using the following cutoffs:
 - a. Amphetamines/Methamphetamine - 250 ng/ml
 - b. Barbiturates - 200 ng/ml
 - c. Benzodiazepines - 200 ng/ml
 - d. Benzoyl ecgonine (cocaine metabolite) - 150 ng/ml
 - e. Marijuana metabolite - 15 ng/ml
 - f. Opiates - 2000 ng/ml
 - g. Phencyclidines - 25 ng/ml
 - h. Methadone - 300 ng/ml
 - i. 6 Monoacetylmorphine - 10 ng/ml
 7. Ensure that all specimens submitted for initial screening and/or confirmation testing are tested within two working days of receipt of the specimens. The organization shall be informed by the laboratory of all positive test result(s) from any screening or confirmatory tests within 48 hours of testing via computer or fax. A hard copy of the COC must follow within 10 working days and the confirmation tests must bear the signature of the certifying scientist.
 8. Maintain all records/documents for all specimen tests for a minimum of three years and maintain records/documents for any specimen under legal challenge until the challenge is resolved. It shall be the organization's responsibility to notify the laboratory of which specimens are under legal challenge. Each organization must contract with the laboratory for forensic testimony for any legal challenge to a test result.
 9. The organization must have an annually renewed business associate agreement on file which addresses all HIPAA and 42 CFR confidentiality requirements.
 10. The organization must maintain a business associate agreement with the laboratory services entity that assures the adherence to any requirements within these requirements, including maintaining a copy of the entities valid CLIA certification for the laboratory utilized.

Service Requirements

- E. OUD Treatment organizations may, with SUPR approval, access the provision of necessary toxicology services from the SUPR designated OUD toxicology vendor.

SECTION 7: Service Requirements for Gambling Disorder Services

Target Population: Individuals and family members who need services to address a gambling disorder.

These requirements set forth the terms and conditions applicable to gambling disorder treatment and related services funded by the Illinois Department of Human Services (IDHS), Division of Substance Use Prevention and Recovery (SUPR). Services include gambling disorder screening, assessment, treatment, case management, community intervention and recovery support as specified herein.

Target Organizations: All SUD treatment organizations providing any SUPR licensed and funded level of care.

Administrative Rule

All services are to be provided according to the applicable standards in: Title 77: Public Health Chapter X: Department of Human Services Subchapter D: Licensure Part 2060 Alcoholism and Substance Abuse Treatment and Intervention Licenses.

Service Requirements

All treatment organizations providing any SUPR licensed and funded level of care must meet every requirement specified in Section A. Additionally, organizations with qualified staff must meet every requirement in Sections A-B. Organizations with dedicated funding for gambling disorder services must meet requirements in Section A, B and C.

A. All SUD Treatment Organizations Funded by SUPR

1. Each funded treatment organization shall administer the National Opinion Research Center's DSM Screen for Gambling Problems (NODS), the Brief Bio-Social Gambling Screen (BBGS) or the GA 20 (Gambler's Anonymous) screen prior to the ASAM assessment. Other screens may be approved in writing by the SUPR Gambling Disorder Contract Manager. Organizations shall ensure that all applicable staff participate in SUPR sponsored training, via webinar, regarding administration of these screens prior to implementation.
2. If the patient screens positive for a gambling use disorder, the subsequent ASAM assessment must incorporate the ASAM guidelines for gambling disorder assessment, diagnosis and placement. It is only mandatory to administer a gambling disorder screen once to a patient. If there is a subsequent treatment episode, the screen does not need to be administered again unless the patient screened positive as a result of the first screen or reports a significant change relating to gambling behavior.
3. Each organization shall have referral information for gambling disorder treatment for any patient whose ASAM assessment indicates a need for gambling disorder treatment. At a minimum, this must include the number for the Gambling Disorder Hotline (1-800-GAMBLER), gambling disorder treatment information and identification of any self-help groups or other recovery support services. A roster of gambling disorder treatment organizations is available through this Hotline. A firm referral shall be made for such services and documentation of this referral must be present in the patient record. The firm referral shall include specifications for information sharing regarding the gambling disorder screen and ASAM assessment so that duplicative services are not necessary.
4. The gambling disorder screen is not a Medicaid covered service and should be billed to SUPR funding using the Department's Automated Reporting and Tracking System (DARTS) software.

The screen should be billed at the assessment rate in a 15-minute increment and tagged in DARTS with an "L" tag.

5. The portion of the ASAM assessment that addresses the gambling disorder is billable to Medicaid if the gambling disorder is a secondary diagnosis and a substance use disorder is a primary diagnosis. Any ASAM assessment that results in a primary diagnosis of a gambling disorder is not a Medicaid covered service and should also be billed at the assessment rate and tagged in DARTS with an "L" tag. Gambling disorder treatment is not a Medicaid covered service and should be billed to SUPR funding using the Department's Automated Reporting and Tracking System (DARTS) software and tagged in DARTS with an "L" tag using established standardized or provider specific rates.
6. Organizations that conduct screening, assessment and case management related to the gambling disorder should bill for these services using the "L" tag. Organizations with trained or credentialed staff can provide gambling disorder screening, assessment, case management and treatment and should bill for these services using the "L" tag.

B. All SUD Treatment Organizations Funded by SUPR that also have Qualified Staff

1. The organization shall have at least one staff who will deliver gambling disorder treatment services that meets the professional staff requirements specified in Part 2060.309 and has:
 - a. certification from the International Gambling Counselor Certification Board (IGCCB) as a Nationally Certified Gambling Counselor or;
 - b. certification from the Illinois Certification Board (ICB) as a Problem Counselor's Gambling Certification (PCGC) or;
 - c. participated in the SUPR 30-hour Gambling Disorder Training for Counselors.
2. Such staff shall also obtain at least six additional hours of training in each calendar year related to gambling disorder treatment. Documentation of this training shall be maintained in the organization's personnel file for that staff.
3. The organization shall document the credentials for each staff who will deliver gambling disorder treatment services on the SUPR Gambling Disorder Professional Staff Form. This form shall be submitted to SUPR as indicated on the form and maintained in the organization's personnel file for that staff.
4. All gambling disorder treatment services shall be billed as specified in Section A (#4-6) and must be delivered in accordance with the requirements for SUD treatment contained in Subpart D of Part 2060. Such services are generally delivered in outpatient settings but may be provided to a patient in Level 3.1 and 3.5 residential SUD treatment if deemed medically necessary. When this occurs, the gambling disorder treatment must be delivered in accordance with ASAM guidelines and cannot be part of the clinical hour requirements for these Level 3 SUD treatment services as required by Administrative Rule, Part 2060.401.
5. Gambling disorder treatment shall be offered in varying degrees of intensity based on the level of care in which the patient is placed, identified medical necessity and the subsequent treatment plan developed for that patient. The treatment plan must include goals and objectives for financial recovery. If the gambling disorder treatment is delivered via telehealth, a referral agreement shall

include specifications for information sharing regarding patient demographics, the gambling disorder screen and the ASAM assessment so that duplicative services are not necessary. Any services delivered via telehealth must also adhere to the provisions specified in the most current SUPR Contractual Policy Manual.

6. Organizations delivering gambling disorder treatment should have an average census of 10-15 patients. Organizations that have a census that exceeds 15 patients will be required to develop a dedicated gambling program.

C. All Organizations that Deliver Gambling Disorder Treatment with Additional Dedicated Funding

1. Organizations with gambling disorder dedicated funding can deliver screens, assessments, treatment, case management, community intervention and recovery support services. Services shall be billed using the "L" tag as specified in Section A (#4-6).
2. The organization will ensure that professional staff who deliver gambling disorder services participate in monthly clinical supervision sessions, learning collaboratives, cross-training events and other related meetings arranged or convened by SUPR to share strategies and tools related to delivery of gambling disorder services.
3. The organization shall develop an outreach plan that will identify community intervention activities and strategies to identify, recruit and retain patients who need gambling disorder services. The outreach plan shall include planned activities for Problem Gambling Awareness Month, involvement with community self-help recovery groups and/or the capacity to create groups if none exist, including Gam-Anon, Gambler's Anonymous and other financial recovery groups.
4. The organization must deliver or have linkage to recovery services that focus on connecting the patient to skill building activities that assist in maintaining a lifestyle free of gambling and/or with self-exclusion awareness sites, self-help groups like Gam Anon or Gambling Anonymous and other financial recovery groups.

SECTION 8: Service Requirements for Substance Use Disorder Treatment Organizations that Provide Daytime Childcare and Child Domiciliary Services

Target Population: Children of patients and family members served by funded organizations as active patients in treatment and recovery services.

Introduction: These requirements set forth the terms and conditions applicable to Child Domiciliary services for children whose guardian/Parents are receiving substance use disorder treatment and related services funded by the Illinois Department of Human Services (IDHS), Division of Substance Use Prevention and Recovery (SUPR).

Administrative Rules/Guidelines

All staff providing services to the children must satisfy requirements outlined in Administrative Rule 2060, Parts .309(d), .311(a), and .313(d, f). Results of the CANTS check must be in the employee's personnel file prior to working with children.

A. Child Domiciliary Core Components

The organization shall have the following administrative procedures and policies in place which address the following for all funded child domiciliary services:

1. Written policy and procedures for handling medical emergencies of children residing with their parents in a residential setting.
2. Authorization in writing from the mother or guardian that is included in the child's record for the child to be enrolled in school on-site or off-site (site is defined as the licensed treatment location).
3. Working policies and procedures regarding the administration of medication to children.
4. Utilization of age appropriate safety restraints for transportation of mothers and their children and maintenance of a log documenting all transportation services.
5. Written policy and procedures to ensure adequate oversight and assurance that all transportation vehicle operators have valid driver's licenses and insurance coverage.
6. Appropriate and nutritional meals for all children.
7. Documentation that each child in residence has his or her own bed.
8. Documentation of the age range of children that may be admitted to the childcare program as part of the admission criteria.

Children should be in school or attending childcare programs either on or off-site. If the childcare program is off-site, it must be licensed by the Department of Children and Family Services (DCFS). If the organization chooses to have on-site childcare, they shall be responsible for planning and conducting developmental and age-appropriate activities for the children in their care and must adhere to requirements regarding parental presence and/or all DCFS childcare requirements.

B. Services Documentation

The organization shall maintain written documentation on each child. This documentation may be kept in a separate record or included in the mother's record. Children's records kept separately must contain information linking the mother and her child(ren). This record shall ensure the following documentation is included in each child record:

1. Name, address, gender, birth date, social security number, or documentation of application for social security number of the child;
2. Mother's name and recipient identification number (RIN);

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3. Medical records, child's primary physician contact, immunization records, developmental screenings and resulting services (if any), any known allergies, emergency contact information;
4. The name and number of the child(ren)'s pediatrician and/or primary care physician.
5. Copies of any court documents related to custody/visitation or any other issues specific to the disposition of the child.

SECTION 9: Service Requirements for Pregnant Women and Women with Dependent Children (PWWC) Designated Sites

Target Population: Pregnant Women and Women with Dependent Children

Introduction: These requirements set forth the terms and conditions applicable to substance use disorder treatment and related services funded by the Illinois Department of Human Services (IDHS), Division of Substance Use Prevention and Recovery (SUPR) for Designated PWWC Sites.

Definition: A PWWC Designated Site is one that has been approved and rostered by the Division; has a current award obligation earmarked as dedicated funding; reports all services via DARTS; and adheres to all specialized service and monitoring requirements.

PWWC Site Requirements

A. Federal Requirements

All sites must follow the Substance Abuse Prevention Block Grant Regulations, 45 CFR, Parts 96.124 and 96.131, Requirements Regarding Pregnant Women and Women with Dependent Children.

Women with dependent children include women in treatment who are attempting to regain custody of their children. All PWWC sites shall treat the family as a unit and, therefore, admit both women and their children into treatment services, as appropriate. At a minimum, sites must also provide the following core services:

1. Primary medical care, including referral for prenatal care and, while the women are receiving these services, child care.
2. Primary pediatric care, including immunizations, for their children.
3. Gender specific substance use disorder treatment and other therapeutic interventions for women.
4. Therapeutic interventions for children in the custody of women in treatment which may, among other things, address their developmental needs, their issues of sexual and physical abuse, and neglect.
5. Sufficient case management and transportation to ensure that women and their children have access to the services specified herein.

B. Monitoring Requirements Specific to PWWC Designated Sites

1. PWWC sites will be monitored to determine compliance with the requirements specified herein. Any non-compliance determined because of monitoring will be shared with organization and corrective action plans shall be submitted as requested by the Division. The organization shall comply with all corrective action. Technical assistance may be provided.
2. All PWWC sites shall complete the narrative section of the Annual On-Line Certification Plan Survey (ACP) describing how the organization, in practice, ensures that all staff understand the federal requirements specified herein and how daily practice ensures such compliance.
3. A desk review will be conducted annually that will, at a minimum, review organization policies and procedures.
4. PWWC sites will be selected on a rotating basis for a review of clinical records by an independent peer reviewer.
5. Annual random consumer satisfaction surveys will be conducted.

C. Reporting Requirements

All PWWC services must be reported to DARTS to ensure payment and continued status as a designated site.

D. Best Practices

1. Sites should have supervisors and staff who hold or are in the process of obtaining the Gender Competency Endorsement credential from the Illinois Certification Board (ICB) <http://www.iaodapca.org/credentialing/womens-endorsement/>.
2. Each PWWC site should have an identified representative on any committee established by the Illinois Advisory Council on Substance Use Disorders that is charged with planning a statewide system of care for women and their dependents.
3. PWWC sites are recommended to utilize the *Guidance to States: Treatment Standards for Women with Substance Use Disorders* to evaluate current practices and identify elements that need to be improved and successes to replicate to provide optimal services.
4. Core service elements are as follows:

| | |
|--|--|
| 1. Outreach and Engagement | 14. Trauma/Violence |
| 2. Screening | 15. Life Skills |
| 3. Assessment | 16. Advocacy |
| 4. Substance Use Disorder Counseling/Education | 17. Family Strengthening |
| 5. Crisis Intervention | 18. Parenting Skills and Child Development Education |
| 6. Treatment Planning | 19. Housing Supports and Assistance |
| 7. Coordinated Case Management | 20. Linkages with Social Services and the Child Welfare System |
| 8. Continuing Care | 21. Linkages with Social Services and the Child Welfare System |
| 9. Medication-Assisted Treatment | 22. Recovery and Community Support Services (including Faith-Based Organization Support) |
| 10. Medication Monitoring | 23. Transportation |
| 11. Withdrawal Management | 24. Child Care and Child Development Services |
| 12. Medical Care/Primary Health Care | 25. Recreational Services |
| 13. Mental Health | |

5. Staffing within a PWWC Designated Site should be specialized. Supervisors and most staff working within these programs should hold or be working towards obtaining the Illinois Certification Board’s Gender Competency Endorsement (GCE) along with their credentials. The mission of the GCE is to be committed to the provision and improvement of effective, gender-specific specialized treatment services for women in Illinois. Professionals with GCE combine a distinct knowledge base with human service skills to deal with the unique attitudes and behaviors associated with the support for treatment of substance use disorders in women. Knowledge and skill bases may be acquired through a combination of specialized training, education, and supervised work experiences.¹
6. Policies and procedures need to ensure all new staff have the competencies to serve the targeted population. The Division recommends SAMHSA’s Women, Children and Families Technical Assistance on-line training for new staff: Introduction to Women and Substance Use Disorders,

¹ The Illinois Model for the Gender Competency Endorsement, ICB

which is a 12-hour, self-paced course that helps counselors and other practitioners working with women to better understand women's substance use, treatment and recovery experiences and effective interventions for women.²

7. A Program Self-Assessment such as the Gender-Responsive Program Assessment tool can be utilized to assist in determining if a site is providing optimal services to pregnant women and women with dependent children. The Division recommends the Gender-Responsive Program Assessment tool which was developed for program administrators, evaluators, agency monitors and staff to use to evaluate the gender responsiveness of programs for women and girls. The assessment instrument is based on the fundamental elements of quality programming including the guiding principles from the Gender-Responsive Strategies: Research, Practice, and Guiding Principles for Women Offenders Report (Bloom, Owen, & Covington, 2003)³

E. Resources

- Women's Plan and Practitioner's Toolkit 2018-2019: Women's Committee of the Illinois Advisory Council on Alcoholism and Other Drug Dependency.
- Substance Abuse and Mental Health Services Administration, Guidance Document for Supporting Women in Co-ed Settings. HHS Publication No. (SMA) 16-4979. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2016. <https://store.samhsa.gov/product/Guidance-Document-for-Supporting-Women-in-Co-ed-Settings/sma16-4979>
- Center for Substance Abuse Treatment. Substance Abuse Treatment: Addressing the Specific Needs of Women. Treatment Improvement Protocol (TIP) Series 51. HHS Publication No. (SMA) 09-4426. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2009. <https://store.samhsa.gov/product/TIP-51-Substance-Abuse-Treatment-Addressing-the-Specific-Needs-of-Women/SMA15-442>
- Center for Substance Abuse Treatment. Trauma-Informed Care in Behavioral Health Services. Treatment Improvement Protocol (TIP) Series 57. HHS Publication No. (SMA) 14-4816. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014. <http://store.samhsa.gov/product/TIP-57-Trauma-Informed-Care-in-Behavioral-Health-Services/SMA14-4816>
- Substance Abuse and Mental Health Services Administration (2011). Addressing the Needs of Women and Girls: Developing Core Competencies for Mental Health and Substance Abuse Service Professionals. HHS Pub. No. (SMA) 11-4657. Rockville, MD: Substance Abuse and Mental Health Services Administration. <http://atccppwtools.org/ResourceMaterials/SMA11-4657.pdf>

² <http://healthecknowledge.org/course/info.php?id=44>

³ <http://www.centerforgenderandjustice.org/pdf/GRProgramAssessmentTool%20CJ%20Final.pdf>