



HALFWAY HOUSE FACILITY APPLICATION FOR PARTICIPATION IN BCBSM'S MENTAL HEALTH AND SUBSTANCE ABUSE MANAGED CARE NETWORK(S)

GENERAL INFORMATION

I. BCBSM's Halfway House Facility Program for the State of Michigan Mental Health Case Management Network

Halfway House facilities provide treatment in a semi-residential living arrangement for individuals requiring a more structured living environment than outpatient or day treatment would offer. It provides a controlled environment during those times the individual is not undergoing treatment or engaged in specific constructive activity.

Halfway Houses are not currently eligible to participate in Blue Cross Blue Shield of Michigan's (BCBSM) Traditional network, however, BCBSM offers participation to Halfway Houses in the BCBSM State of Michigan Mental Health Case Management (SOM-MHCM) network. The SOM-MHCM network is one of two Mental Health and Substance Abuse Managed Care (MHSAMC) Networks maintained by BCBSM for mental health services. BCBSM's MHSAMC networks are utilized by select BCBSM customer groups that have chosen a managed care program for their mental health and substance abuse benefits. For the SOM-MHCM network, all care is currently managed (preauthorized) by vendor care managers. Members are subject to substantial out-of-network copayments, deductibles, and/or reduced or no benefits when they go outside of their designated mental health network without an authorization from the care manager. For some benefit plans, out-of-network referrals are not allowed. In general, services provided in a non-network Halfway House facility are not reimbursed by BCBSM to either the facility or the member.

The selection of network providers is based upon the provider's demonstrated commitment to appropriate, high quality, cost-effective care and their agreement to bill BCBSM for covered services and to accept the applicable MHSAMC network payment as payment in full for covered services, except for applicable copayments and deductibles. In support of these commitments, network providers are required to meet guidelines relative to quality of care, cost control, appropriate utilization, access, and other standards

The attached application and information applies to Halfway House facilities that wish to apply for participation in the SOM-MHCM network that is used by eligible BCBSM members (such as the Federal Employee Program, Ford Hourly National PPO Plan members, and select MESSA members). Note that not all members that use the SOM-MHCM network for mental health services have a covered benefit for Halfway House treatment. Therefore, member benefits and eligibility should always be verified with BCBSM *before* providing services. Pre-authorization of all services is a program requirement.

II. BCBSM's Halfway House Facility Qualification Requirements

In order to participate with BCBSM in the SOM-MHCM network, each Halfway House facility and all approved sites must, at minimum, have to maintain the following:

- Full accreditation, for either three or four years, for each facility by one of the following:
 - Joint Commission on Accreditation of Healthcare (JCAHO)
 - American Osteopathic Association (AOA)
 - Council on Accreditation (COA)
 - Commission on Accreditation of Rehabilitation Facilities (CARF)

If you have questions regarding whether the accreditation status you are seeking is accepted by BCBSM, such as the level or length of accreditation, please contact the person listed at the end of the Applications Instructions section.

- Licensure by the state of Michigan for either residential or outpatient substance abuse programs
- A facility administrator who oversees the daily operation of the facility
- Have an absence of fraud and illegal activities
- Maintain adequate patient and financial records

Note: It is BCBSM's policy to recredential participating providers every 2-3 years to verify continued compliance with all qualification requirements.

III. Halfway House Facility Reimbursement

Reimbursement for covered services is based upon an all-inclusive per-diem. If you obtained a copy of the application from our corporate website (bcbsm.com) you may contact us for a sample Halfway House rate schedule. The rate schedule is BCBSM's standard rate schedule and is not negotiable. Participating network providers are required to bill BCBSM for covered services and to accept BCBSM's payment as payment in full for covered services, except for any applicable member copayments and/or deductibles.

IV. The BCBSM State of Michigan Mental Health Case Management Participation Agreement

The State of Michigan Mental Health Case Management participation agreement for Halfway Houses will be sent if/when the facility is approved. If the facility would like to review the agreement prior to submitting the application, you may request a sample copy from the BCBSM Provider Contracting department. The contract is also on file with the Michigan Office of Financial and Insurance Services and its terms and provisions are not negotiable.

NOTE: The information supplied in this application is general information only and is subject to change without notice. The application does not constitute a provider agreement or a provider manual and members' benefit plans will vary.

**HALFWAY HOUSE FACILITY
BCBSM MENTAL HEALTH AND SUBSTANCE ABUSE MANAGED CARE NETWORK(S)
APPLICATION INSTRUCTIONS**

Please do not submit the application until the facility believes it meets all BCBSM qualification requirements and has all documents BCBSM requires (e.g., accreditation). Print (in ink) or type the information required in the space provided. If the application was retrieved from the provider enrollment section of the BCBSM website (bcbsm.com), you may print, complete and mail the application. Be certain that the application is complete and all required attachments are enclosed at the time of submission to BCBSM. Please do not put the application in a binder or use sheet protectors, folders or dividers.

Please mail (do not fax) the completed application, along with the required attachments to:

Marilyn Smith
Provider Contracting – 513E
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd.
Detroit, MI 48226-2998

Contact the person listed at the end of this section if you do not receive a letter within two weeks from the date you sent the application. It takes approximately two weeks for us to review a complete application. Incomplete applications may be returned, delaying the review process.

After we review the application and accompanying documentation, we may contact the designated representative of the facility to set up an appointment for an on-site visit. The on-site visit includes a review of a sample of medical records to evaluate the applicant's compliance with BCBSM requirements, as outlined in this application. The facility must be ready for the on-site review at the time of submitting the application. If the facility is approved for program participation, the participation agreement will be offered. If the facility is not approved, we will send notification in writing indicating the reason(s) for the denial.

The facility may not submit claims and is not eligible for reimbursement unless and until the application for participation is approved by BCBSM and both parties sign the Halfway House facility participation agreement. If the facility is approved and offered a participation agreement, it will be asked to retain the agreement for its record and return the signed Signature Document to BCBSM. The countersigned copy of the Signature Document will be returned to the facility after the BCBSM Halfway House facility's BCBSM facility code has been activated for billing purposes, generally within three weeks of our receipt of the signed Signature Document. The effective date for participation will be 30 days from the date the signed Signature Document is received by BCBSM. It is not retroactive to the date the application was sent or received. If this application pertains to an ownership change and BCBSM approves an agreement effective date retroactive to the date of the ownership change, this is not in any way a guarantee that old claims will process. The facility is still subject to any applicable claims filing limitations.

Usually, a separate BCBSM facility code is assigned to each approved and contracted location. Once use of the National Provider Identifier (NPI) is implemented, BCBSM will crosswalk the claims from the facility's NPI to the BCBSM facility code (i.e., BCBSM's internal identifier) for processing. Therefore, BCBSM recommends obtaining one NPI (in accordance with federal guidelines), for each location and provider type. Federal guidelines also allow for an NPI to be obtained for unique combinations of tax ID, location and taxonomy (specialty) codes. However, if your organization has chosen a single NPI for multiple Halfway House facility sites, you can be contracted by BCBSM in a way that lists any additional sites as "approved sites" in the primary site's participation agreement(s). This may cause inquiry

and/or directory problems, however, since only the primary site's BCBSM code will be loaded on our claims processing systems. All payments will go to the same location and will appear to have been provided by the primary site.

Upon completion of the application and contracting process, the facility will receive a welcome package with information on how to sign up for electronic billing and access to web-DENIS, BCBSM's web-based information system for providers. Through web-DENIS the facility will have access to provider manuals, newsletters (e.g., *The Record*), the Magellan Behavioral Health Medical Necessity Criteria Adapted for BCBSM, and patient data such as contract eligibility and benefits. It is the facility's responsibility to be familiar with and to adhere to the Magellan Criteria and all BCBSM billing and benefit requirements. It is also the responsibility of the facility to ensure its billing department (or billing agency) is compliant with all of BCBSM's billing requirements.

Participating Halfway House facilities must bill BCBSM on a UB-04 claim form or its electronic equivalent. BCBSM no longer accepts facility paper claims (with some exceptions.) Facilities that would like more information about internet claims submission or who wish to bill electronically should contact BCBSM's Electronic Data Input (EDI) Helpline at (800) 542-0945 for electronic billing information *after* their BCBSM facility code has been received. They must also register their NPI with EDI after their BCBSM facility code has been received.

Facilities that participate in the SOM-MHCM network must notify BCBSM *immediately* of any change in the facility's ownership, tax identification number, NPI, address, telephone number, etc.

Multiple Locations

If the facility is applying for participation (or an ownership change) for more than one location, each location must meet all requirements in order to be approved. A separate application must be submitted for each location. Before completing the application, please make/print additional copies. The application for the first location must be completed in its entirety (with all attachments submitted). For each additional application submitted, complete the following sections: General Information (1.0), Accreditation (3.0), Licensure (4.0), Program Services (6.0) and Staffing (7.0). For all other sections, indicate "same" where there is no difference. Where the information for a location is different than the first location, answer the questions and submit corresponding attachments. Before submitting the applications, please review all sections carefully to be sure appropriate information was completed for each location. If, however, you prefer to submit a "complete" application for each site, you may choose to do so.

Please direct any questions regarding completion of the application to:

Marilyn Smith
Qualifications Consultant
MSmith1@bcbsm.com

Telephone: 313-448-7895
Fax: 866-393-8533

**BLUE CROSS BLUE SHIELD OF MICHIGAN
HALFWAY HOUSE APPLICATION
MENTAL HEALTH AND SUBSTANCE ABUSE MANAGED CARE PROGRAM
STATE OF MICHIGAN MENTAL HEALTH CASE MANAGEMENT NETWORK**

1.0 General Information

Indicate the type of application being submitted: (Check all that apply)

- The facility would like to participate as a Halfway House facility in BCBSM's SOM-MHCM network
- Ownership change involving a change in the facility's federal Tax Identification Number. **Please contact the person listed on the previous page regarding the ownership change before completing this application.**

1.1 Business Name (This is the name the facility uses when doing business, or the DBA. It will be used for directories.)

1.2 Facility Site Address (for directory)

Suite number _____ County _____

City _____ State MI Zip Code _____

1.3 Facility site telephone number (for directory) (____) _____

1.4 Date facility began servicing clients under the federal tax ID indicated in Section 1.9 (MM/DD/YEAR) _____

1.5 Is the facility accepting new patients at this time?

- Yes
- No

1.6 Remittance address (This is the location where all BCBSM vouchers, checks and remittance advices should be sent.)

Suite number _____

City _____ State _____ Zip Code _____

1.7 Tax Name (This is the name on file with the IRS and may be different from the facility's business name.)

1.8 Enter the facility's 10 digit National Provider Identifier (NPI).

1.9 Enter the facility's federal tax identification number (TIN).

1.10 Attach a copy of the IRS notification letter (form SS4-147c), EFTPS (form-9787), or another document issued by the IRS with the facility's federal tax identification number (TIN) on it. BCBSM does not accept W-9s.

1.11 Check applicable field.
 For profit
 Nonprofit/Tax Exempt

1.12 If facility is nonprofit, attach the IRS document authorizing tax exempt status.

1.13 Fiscal Year End (MM/DD/YEAR) _____

1.14 Facility's website (URL), if applicable _____

Note: *The percentage of ownership for items 1.15 and 1.16 combined must equal 100%.*

1.15 List the following information for the facility **if** it is owned by an individual(s). Attach additional pages if necessary.

Name: _____ Ownership _____%
Home Address: _____
Occupation: _____

Name: _____ Ownership _____%
Home Address: _____
Occupation: _____

Name: _____ Ownership _____%
Home Address: _____
Occupation: _____

1.16 Provide the following information for the facility **if** an organization owns it or has managing control (e.g., hospital, corporation, governmental and/or tribal organizations, partnerships and limited partnerships, charitable and/or religious organizations, etc.)

<u>Organization's name</u>	<u>Percent ownership (if applicable)</u>
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_____ Ownership _____%

_____ Ownership _____%

2.0 Administration

2.1 Attach a copy of the Halfway House Facility's organizational chart.

2.2 List the name and credentials of the facility's administrator:

Name _____

Credentials (Degrees/Certificates, etc.) _____

2.3 Administrator's scheduled number of hours per week _____

2.4 Attach a copy of the administrator's job description and qualifications.

2.5 Has the facility or an officer, director, owner (e.g., individuals or parent organizations) or principal (those with significant authority and responsibility) of the facility ever had any convictions, guilty pleas, nolo contendere pleas, remands to diversion programs, civil judgments or settlement of civil actions that are related to the provision or payment of health care services?

Yes

No

If "Yes," please explain:

2.6 Has the facility or its owner(s) (e.g., individuals or parent organizations) ever been subject to a Corporate Integrity Agreement or been found to have been non-compliant with self-dealing and/or anti-kickback laws and regulations?

Yes

No

If "Yes," please provide a complete explanation below and/or attach additional pages if necessary

3.0 Accreditation

3.1 Check all that apply

Joint Commission on Accreditation of Health Care Organization (JCAHO)

American Osteopathic Association (AOA)

Council on Accreditation (COA)

Commission on Accreditation of Rehabilitation Facilities (CARF)

None

3.2 Attach a copy of the facility's current accreditation certificate. Note: accreditation documentation must be specific to either residential or outpatient substance abuse services and each facility location listed in this application must be identified as accredited.

3.3 If this application is being submitted due to a change of ownership, attach a copy of the letter indicating the transfer or extension of accreditation to the new owner.

4.0 Licensure

4.1 Has the facility's license ever been revoked, suspended or terminated for substance abuse program services, or has the facility or any of its owners ever been excluded from any federal programs?

- Yes
- No

If "Yes," explain:

4.2 Attach a copy of the facility's current license for residential or outpatient substance abuse programs that was issued by the state of Michigan. The license must be specific to the site address.

5.0 Availability of Program Services

5.1 Psychotherapy and counseling

- Didactics
- Group
- Individual
- Self-help group therapy
- Treatment not provided
- Other (describe below)

5.2 Which population is served by the facility? Check all that apply

- Male Adult Female Adult
- Male Geriatric Female Geriatric

5.3 Indicate the number of beds available at this facility:

- ____ Male
- ____ Female
- ____ Total

5.4 Indicate below any special (e.g., hearing impaired, specific ethnic groups, etc.) services offered at this facility

5.5 Indicate the hours that one or more direct care staff members are on duty to provide services.

Number of hours per day _____ Number of days per week _____

5.6 Indicate which of the following services are available in case of emergencies.

- Direct Assistance Yes No
- Referral Yes No

5.7 Indicate the staff to resident ratio:

Day ratio _____

Night ratio _____

5.8 Does the facility have arrangements with an area hospital for the referral of residents requiring acute detoxification or other hospital care?

Yes

No

If “Yes,” attach a copy of a transfer agreement with an area hospital.

6.0 Staffing

6.1 Attach a copy of a current staff roster with credentials (e.g., MD, DO, RN, etc.) and job titles for all professional/clinical staff (including physicians).

6.2 Attach a copy of the current Michigan licenses for all professional/clinical staff listed in 6.1.

7.0 Medical Record Documentation

The medical record must contain documentation of the need for and the provision of all services rendered. All documentation must be clearly legible, signed, and dated.

7.1 Attach a copy of all of the facility's medical record forms.

7.2 Attach copies of the facility's medical record documentation policies and procedures, including:

- **Treatment plans**
- **Monitoring of leisure activity**
- **Monitoring of social networking in the community**

8.0 Admission Criteria

The facility should have published admission criteria, which may address any or all of the following:

- Minimal length of abstinence
- Recent treatment
- Drug of preference
- Referral source
- Motivation

8.1 Attach a copy of the facility's admission criteria.

8.2 Are drug screens administered to residents to verify abstinence?

Yes

No

8.3 Attach a copy of the facility's drug screening policy and procedure.

9.0 Discharge and Aftercare Planning

Discharge planning should begin at the onset of treatment. At the time of completion of a course of therapy, a summary of the client’s experience in the therapy program should be written. Any or all of the following should be used for evaluation for discharge.

- Participation in treatment
- Employment
- Length of Abstinence
- Supports
- Independent Housing

9.1 Attach copies of policies and procedures relative to the discharge and aftercare planning.

10.0 Financial and Billing Information

10.1 Does the facility maintain records of transactions that conform to generally accepted accounting principles?

- Yes
- No

10.2 Are billing charges uniformly applied? (i.e., for identical services is the charge the same for all patients?)

- Yes
- No

If "No," provide an explanation below:

10.3 In the past five years, has the facility filed a petition for relief under the U.S. Bankruptcy Code, or has any action been taken to dissolve, liquidate, terminate, consolidate, merge or sell all or substantially all of facility's assets?

- Yes
- No

If "Yes," provide an explanation below:

10.4 Does the facility use a billing department or billing agency that is located outside of Michigan?

- Yes
- No

If “Yes,” please indicate the company name, address, telephone number, contact person (and e-mail address if available) for the company or billing agency that is responsible for submitting claims for services provided at the facility.

Contact person _____

Company Name _____

Mailing Address _____

City _____ State _____ Zip Code _____

Telephone number (____) _____

E-mail address _____

11.0 Management Contracts

- 11.1 Does the facility have management contract(s) with an outside organization for the provision of core services (e.g., administrative services, staffing services, and personnel management, etc.)?
 Yes
 No

If "Yes," please provide the name of the organization and describe the services provided by this outside entity in the space provided below. BCBSM may request a copy of the management contract at a later date.

12.0 Contact Person

- 12.1 Please give the following information for a contact person for any questions BCBSM may have regarding this application:

Name: _____

Title: _____

Mailing address: _____

Telephone number: _____

E-mail address: _____

13.0 Signature and Attestation

I certify by my signature below that:

- I have reviewed the information in this application and to the best of my knowledge it is a complete and accurate representation of this facility's operations.
- I understand that BCBSM may choose to do an on-site survey after review of this application to verify program compliance and to verify the accuracy of any information provided.
- All licenses for professional providers who provide direct patient care for this facility are current and valid in Michigan.
- Facility's Michigan license as a substance abuse provider is current and valid in Michigan.
- Facility's accreditation is current and valid.
- The enclosed policies and procedures have been implemented and are enforced by this facility.
- The facility maintains financial records that conform to generally accepted accounting principles and practices.
- I understand the effective date of participation, if approved, is the date designated by BCBSM and is *not* the date the application was sent or received.
- I understand the facility is not eligible to submit claims for payment under the MHSAMC program until it is approved by BCBSM, both parties sign the participating agreement, BCBSM's claims processing systems are activated, and the facility has received a copy of the countersigned Signature Document from BCBSM.
- I understand BCBSM's payment rates and the terms of its standard participation agreement are not negotiable.

Note: This application must be signed by the person at the facility who is responsible for the overall administration of the halfway house program.

Authorized facility representative

By X
 (signature – required)

Name _____
 (print or type)

Title _____
 (print or type)

Date _____

Return completed application with all attachments to:

Marilyn Smith
Blue Cross Blue Shield of Michigan
Provider Contracting – 513E
600 E. Lafayette Blvd.
Detroit, MI 48226-2998

Checklist for Halfway House Application Attachments*

- Copy of the IRS notification letter (form SS4-147c), EFTPS (form-9787), or another document issued by the IRS with the facility's federal tax identification number (TIN) on it.
- IRS document authorizing tax exempt status (if applicable)
- facility's organizational chart
- copy of the administrator's job description and qualifications
- current accreditation certificate for substance abuse services
- copy of the most recent accreditation survey
- copy of accreditation extension letter to new owner for an ownership change (if applicable)
- current Michigan license for residential or outpatient substance abuse programs
- facility's transfer agreement with an area hospital
- facility's current staff roster, credentials and job titles
- current licenses for all professional/clinical staff
- facility's medical record forms
- facility's policies and procedures related to halfway house services
- facility's admission criteria
- facility's drug screening policy and procedure
- facility's discharge and aftercare policy and procedure
- attestation statement signed by an authorized facility representative
- any other information you want considered in the facility's application

***If this application is for multiple address sites the following information must be submitted**

- staff roster for each site with full time equivalents
- facility's substance abuse licensure for each site
- facility's accreditation for each site address
- facility's policies and procedures if different by site
- facility's hospital transfer agreements if different by site
- facility's program services if different by site
- any other information contained in this application that is different by site