BEHAVIORAL HEALTH AND INTELLECTUAL AND DEVELOPMENTAL DISABILITY SUPPORTS AND SERVICES

This chapter is comprised of two parts:

The **BEHAVIORAL HEALTH AND INTELLECTUAL AND DEVELOPMENTAL DISABILITY SUPPORTS AND SERVICES** portion of the chapter outlines the PIHP requirements and services for specialty behavioral health and intellectual and developmental disability supports and services.

The **NON-PHYSICIAN BEHAVIORAL HEALTH APPENDIX** portion of the chapter includes requirements for psychologists, social workers and professional counselors providing behavioral health services for fee for service beneficiaries.

BEHAVIORAL HEALTH AND INTELLECTUAL AND DEVELOPMENTAL DISABILITY SUPPORTS AND SERVICES

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SECTION 1 – GENERAL INFORMATION

This chapter applies to Mental Health providers. Information contained in this chapter is to be used in conjunction with other chapters of this manual including the Billing & Reimbursement Chapters and the Practitioner Chapter, as well as the related procedure code databases and fee schedules located on the Michigan Department of Health and Human Services (MDHHS) website. (Refer to the Directory Appendix for website information.)

1.1 MDHHS APPROVAL

Pursuant to Michigan's Medicaid State Plan and federally approved 1915(b) waiver and 1915(c) Habilitation Supports Waiver (HSW), community-based mental health, substance abuse and developmental disability specialty services and supports are covered by Medicaid when delivered under the auspices of an approved Prepaid Inpatient Health Plan (PIHP). To be an approved Medicaid provider, a PIHP must be certified as a Community Mental Health Services Program (CMHSP) by MDHHS in accordance with Section 232a of the Michigan Mental Health Code. A PIHP may be either a single CMHSP, or the lead agency in an affiliation of CMHSPs approved by the Specialty Services Selection Panel. Service providers may contract with the PIHP or an affiliate of the PIHP. PIHPs must be enrolled with MDHHS as Medicaid providers. (Refer to the General Information for Providers Chapter of this manual for additional information.) The PIHP must offer, either directly or under contract, a comprehensive array of services, as specified in Section 206 of the Michigan Mental Health Code, being Public Act 258 of 1974, as amended, and all of those specialty services/supports included in this manual.

For the Specialty Services and Supports Program, Centers for Medicare & Medicaid Services gave Michigan permission to use Section 1915(b)(3) of the Social Security Act which allows a state to use Medicaid funds to provide services that are in addition to the state plan services. Those services are described in the Additional Mental Health Services (B3s) section of this chapter. Services selected during the person-centered planning process may be a mix of state plan, HSW, and additional/B3 services, or state plan or HSW or additional/B3 services only, depending on what services best meet a beneficiary's needs and will assist in achieving his goals.

The 1915(c) Children's Waiver services are delivered under the auspices of a CMHSP that has been enrolled as a Children's Waiver provider. Children's Waiver services are reimbursed by MDHHS through a fee-for-service (FFS) payment system. The Children's Waiver program is described in the Children's Home and Community-Based Services Waiver Section of this chapter.

1.2 STANDARDS

The PIHP shall comply with the standards for organizational structure, fiscal management, administrative record keeping, and clinical record keeping specified in this section. In order for a state plan or HSW service to be reported as a Medicaid cost, it must meet the criteria in this chapter.

1.3 ADMINISTRATIVE ORGANIZATION

The administrative organization shall assure effective and efficient operation of the various programs and agencies in a manner consistent with all applicable federal and state laws, regulations, and policies. Effective and efficient operation includes value purchasing. As applied to services and supports, value purchasing assures appropriate access, quality, and the efficient and economic provision of supports and

services. Quality is measured by meeting or exceeding the sets of outcome specifications in the beneficiary's individual plan of service, developed through the person-centered planning process or, for substance abuse services, the individualized treatment plan. Efficient and economic is the lowest cost of the available alternatives that has documented capacity to meet or exceed the outcome quality specifications identified in the beneficiary's plan. There shall be clear policy guidelines for decision-making and program operations and provision for monitoring same. The PIHP must offer direct assistance to explore and secure all applicable first- and third-party reimbursements, and assist the beneficiary to make use of other community resources for non-Medicaid services, or Medicaid services administered by other agencies. MDHHS encourages the use of natural supports to assist in meeting an individual's needs to the extent that the family or friends who provide the natural supports are willing and able to provide this assistance. PIHPs may not require a beneficiary's natural support network to provide such assistance as a condition for receiving specialty mental health supports and services. The use of natural supports must be documented in the beneficiary's individual plan of service.

1.4 Provider Registry

The PIHPs must register with MDHHS any Medicaid state plan, HSW, or additional/B3 service they provide directly or through one of their contracted providers, or an affiliate as applicable, as specified in the MDHHS /PIHP contract. The PIHPs should contact the Division of Quality Management and Planning for more information about the provider registry, and the Bureau of Community Based Services for MDHHS approval of special programs. (Refer to the Directory Appendix for contact information.) PIHPs must update the registry whenever changes (address, scope of program, additions, deletions) occur, according to the format and schedule specified by MDHHS.

Children's Waiver providers must be registered by the CMHSPs.

1.5 Programs Requiring Special Approval

Certain programs and sites require the PIHP to request specific approval by MDHHS prior to service delivery. Programs must be approved by MDHHS prior to service provision in order to be reported as a Medicaid cost. (Refer to the Directory Appendix for contact information.) Programs previously approved by MDHHS and delivered by CMHSPs that are now affiliates do not need to be approved again. Programs requiring specific approval are:

- Assertive Community Treatment Programs
- Clubhouse Psychosocial Rehabilitation Programs
- Crisis Residential Programs
- Day Program Sites
- Drop-in Programs
- Home-Based Services
- Intensive Crisis Stabilization
- Wraparound

The PIHP shall notify MDHHS of changes in providers of these programs or sites, including change of address or discontinuation.

1.6 BENEFICIARY ELIGIBILITY

A Medicaid beneficiary with mental illness, serious emotional disturbance or developmental disability who is enrolled in a Medicaid Health Plan (MHP) is eligible for specialty mental health services and supports when his needs exceed the MHP benefits. (Refer to the Medicaid Health Plans Chapter of this manual for additional information.) Such need must be documented in the individual's clinical record.

The following table has been developed to assist health plans and PIHPs in making coverage determination decisions related to outpatient care for MHP beneficiaries. Generally, as the beneficiary's psychiatric signs, symptoms and degree/extent of functional impairment increase in severity, complexity and/or duration, the more likely it becomes that the beneficiary will require specialized services and supports available through the PIHP/CMHSP. For all coverage determination decisions, it is presumed that the beneficiary has a diagnosable mental illness or emotional disorder as defined in the most recent Diagnostic and Statistical Manual of the Mental Disorders published by the American Psychiatric Association.

In general, MHPs are responsible for outpatient mental health in the following situations:	**In general, PIHPs/CMHSPs are responsible for outpatient mental health in the following situations:**
▪ The beneficiary is experiencing or demonstrating mild or moderate psychiatric symptoms or signs of sufficient intensity to cause subjective distress or mildly disordered behavior, with minor or temporary functional limitations or impairments (self-care/daily living skills, social/interpersonal relations, educational/vocational role performance, etc.) and minimal clinical (self/other harm risk) instability. ▪ The beneficiary was formerly significantly or seriously mentally ill at some point in the past. Signs and symptoms of the former serious disorder have substantially moderated or remitted and prominent functional disabilities or impairments related to the condition have largely subsided (there has been no serious exacerbation of the condition within the last 12 months). The beneficiary currently needs ongoing routine medication management without further specialized services and supports.	▪ The beneficiary is currently or has recently been (within the last 12 months) seriously mentally ill or seriously emotionally disturbed as indicated by diagnosis, intensity of current signs and symptoms, and substantial impairment in ability to perform daily living activities (or for minors, substantial interference in achievement or maintenance of developmentally appropriate social, behavioral, cognitive, communicative or adaptive skills). ▪ The beneficiary does not have a current or recent (within the last 12 months) serious condition but was formerly seriously impaired in the past. Clinically significant residual symptoms and impairments exist and the beneficiary requires specialized services and supports to address residual symptomatology and/or functional impairments, promote recovery and/or prevent relapse.

The "mental health conditions" listed in the table above are descriptions and are intended only as a general guide for PIHPs and MHPs in coverage determination decisions. These categories do not constitute unconditional boundaries and hence cannot provide an absolute demarcation between health plan and PIHP responsibilities for each individual beneficiary. Cases will occur which will require collaboration and negotiated understanding between the medical directors from the MHP and the PIHP. The critical clinical decision-making processes should be based on the written local agreement, common sense and the best treatment path for the beneficiary.

Medicaid beneficiaries who are not enrolled in a MHP, and whose needs do not render them eligible for specialty services and supports, receive their outpatient mental health services through the fee-for-service (FFS) Medicaid Program when experiencing or demonstrating mild or moderate psychiatric symptoms or signs of sufficient intensity to cause subjective distress or mildly disordered behavior, with minor or temporary functional limitations or impairments (self-care/daily living skills, social/interpersonal relations, educational/vocational role performance, etc.) and minimal clinical (self/other harm risk) instability. Refer to the Practitioner Chapter of this manual for coverages and limitations of the FFS mental health benefit.

Medicaid beneficiaries are eligible for substance abuse services if they meet the medical eligibility criteria for one or more services listed in the Substance Abuse Services Section of this chapter.

Medicaid-covered services and supports selected jointly by the beneficiary, clinician, and others during the person-centered planning process and identified in the plan of service must meet the medical necessity criteria contained in this chapter, be appropriate to the individual's needs, and meet the standards herein. A person-centered planning process that meets the standards of the Person-centered Planning Practice Guideline attached to the MDHHS/PIHP contract must be used in selecting services and supports with mental health program beneficiaries who have mental illness, serious emotional disturbance, or developmental disabilities.

1.7 Definition of Terms

This list of terms is not exhaustive, but rather the most commonly used terms, listed alphabetically:

Amount	The number of units (e.g., 25 15-minute units of community living supports) of service identified in the individual plan of service or treatment plan to be provided.
Child Mental Health Professional	▪ A person who is trained and has one year of experience in the examination, evaluation, and treatment of minors and their families and who is either a physician, psychologist, licensed professional counselor or registered professional nurse; or ▪ A person with at least a bachelor's degree in a mental health-related field from an accredited school who is trained, and has three years of supervised experience in the examination, evaluation, and treatment of minors and their families; or ▪ A person with at least a master's degree in a mental health-related field from an accredited school who is trained, and has one year of experience in the examination, evaluation, and treatment of minors and their families.
Covered Services or Medicaid Covered Services	For the purposes of this manual, Medicaid State Plan Services and Additional Mental Health Services (B3s).
Duration	The length of time (e.g., three weeks, six months) it is expected that a service identified in the individual plan of service or treatment plan will be provided.
Health Care Professional	A physician, registered nurse, physician's assistant, nurse practitioner, or dietitian. Services provided must be relevant to the health care professional's scope of practice. Refer to the Staff Provider Qualifications in the Program Requirements Section of this chapter.

Individual Plan of Services (also referred to as the "plan" or "plan of services and supports" or "treatment plan" for beneficiaries receiving substance abuse treatment)	The document that identifies the needs and goals of the individual beneficiary and the medical necessity, amount, duration, and scope of the services and supports to be provided. For beneficiaries receiving mental health or developmental disabilities services, the individual plan of services must be developed through a person-centered planning process. In the case of minors with developmental disabilities, serious emotional disturbance or mental illness, the child and his family are the focus of service planning, and family members are an integral part of the planning process.
Medical Necessity	Determination that a specific service is medically (clinically) appropriate, necessary to meet needs, consistent with the person's diagnosis, symptomatology and functional impairments, is the most cost-effective option in the least restrictive environment, and is consistent with clinical standards of care. Medical necessity of a service shall be documented in the individual plan of services.
Mental Health Professional	A physician, psychologist, licensed master's social worker, licensed professional counselor, licensed marriage and family therapist, or registered nurse. (Refer to Staff Provider Qualifications in the Program Requirements Section of this chapter.)
Prescription	A written order for a service or item by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under Michigan law that contains all of the following: ▪ Beneficiary's name; ▪ Prescribing practitioner's name, address and telephone number; ▪ Prescribing practitioner's signature (a stamped signature is not acceptable); ▪ The date the prescription was written; ▪ The specific service or item being prescribed; ▪ The expected start date of the order (if different from the prescription date); and ▪ The amount and length of time that the service or item is needed. A verbal order from a physician or other licensed practitioner of the healing arts within their scope of practice may be used to initiate occupational therapy (OT), physical therapy (PT), or Speech, Hearing and Language services or to dispense medically necessary equipment or supplies when a delay would be medically contraindicated. The written prescription must be obtained within 14 days of the verbal order. The qualified therapist (OT, PT or Speech) responsible for furnishing or supervising the ordered service, or supports coordinator or case manager must receive and document the date of the verbal order in the individual plan of service. Upon receipt of the signed prescription, it shall be verified with the verbal order and entered into the individual plan of service.

Qualified Mental Health Professional (QMHP)	An individual who has specialized training or one year of experience in treating or working with a person who has mental illness; and is a psychologist, physician, educator with a degree in education from an accredited program, licensed or limited licensed master's or bachelor's social worker, physical therapist, occupational therapist, speech pathologist or audiologist, registered nurse, therapeutic recreation specialist, rehabilitation counselor, licensed or limited licensed professional counselor or individual with a human services degree hired and performing in the role of QMHP prior to January 1, 2008. (Refer to Staff Provider Qualifications in the Program Requirements Section of this chapter for specific requirements of the professionals.) NOTE: If an individual was hired and performed the role of a QMHP prior to January 1, 2008 and later transfers to a new agency, his/her QMHP status will be grandfathered into the new agency.
Qualified Intellectual Disability Professional (QIDP)	An individual who meets the qualifications under 42 CFR 483.430. A QIDP is a person who has specialized training or one year of experience in treating or working with a person who has an intellectual disability; and is a psychologist, physician, educator with a degree in education from an accredited program, licensed or limited licensed master's or bachelor's social worker, physical therapist, occupational therapist, speech pathologist or audiologist, registered nurse, therapeutic recreation specialist, rehabilitation counselor, licensed or limited licensed professional counselor or individual with a human services degree hired and performing in the role of QIDP prior to January 1, 2008. (Refer to Staff Provider Qualifications in the Program Requirements Section of this chapter for specific requirements of the professionals.) NOTE: If an individual was hired and performed the role of a QIDP prior to January 1, 2008 and later transfers to a new agency, his/her QIDP status will be grandfathered into the new agency.
Scope of Service	The parameters within which the service will be provided, including: ▪ Who (e.g., professional, paraprofessional, aide supervised by a professional); ▪ How (e.g., face-to-face, telephone, taxi or bus, group or individual); and ▪ Where (e.g., community setting, office, beneficiary's home).
Substance Abuse Treatment Specialist	▪ An individual who has licensure in one of the following areas, and is working within their scope of practice: ➢ Licensed Bachelor's Social Worker (LBSW) ➢ Licensed Marriage and Family Therapist ➢ Licensed Master's Social Worker (LMSW) ➢ Licensed Practical Nurse (LPN) ➢ Licensed Professional Counselor (LPC) ➢ Licensed Psychologist (LP) ➢ Limited Licensed Bachelor's Social Worker (LLBSW) ➢ Limited Licensed Marriage and Family Therapist ➢ Limited Licensed Master's Social Worker (LLMSW) ➢ Limited Licensed Professional Counselor (LLPC) ➢ Limited Licensed Psychologist (LLP)

	➢ Nurse Practitioner (NP) ➢ Physician (MD, DO) ➢ Physician Assistant (PA) ➢ Registered Nurse (RN) ➢ Temporary Limited Licensed Psychologist (TLLP) and who has a registered development plan leading to certification and is timely in its implementation (Development Plan – Counselor (DP-C) – approved development plan in place); or who is functioning under a time-limited exception plan approved by the regional PIHP; or • An individual who has one of the following Michigan Certification Board of Addiction Professionals (MCBAP) or International Certification and Reciprocity Consortium (IC & RC) credentials: ➢ Certified Advanced Alcohol and Drug Counselor – IC & RC (CAADC) ➢ Certified Alcohol and Drug Counselor – IC & RC (CADC) ➢ Certified Alcohol and Drug Counselor – Michigan (CADC-M) ➢ Certified Co-Occurring Disorders Professional – IC & RC (CCDP) ➢ Certified Co-Occurring Disorders Professional Diplomat – IC & RC (CCDP-D) ➢ Certified Criminal Justice Professional – IC & RC - Reciprocal (CCJP-R) or; ▪ An individual who has one of the following approved alternative certifications: ➢ for medical doctors: American Society of Addiction Medicine (ASAM) ➢ for psychologists: American Psychological Association (APA) specialty in addiction ➢ for counselors/therapists: Certification through the Upper Midwest Indian Council on Addiction Disorders (UMICAD) ➢ for Licensed Professional Counselors: National Certified Counselor (NCC) with concurrent Master Addictions Counselor (MAC) certification A physician (MD, DO), physician assistant, nurse practitioner, registered nurse or licensed practical nurse who provides substance use disorder treatment services within the scope of their practice is considered to be specifically-focused treatment staff and is not required to obtain MCBAP credentials. If one of these professionals provides substance use disorder treatment services outside their scope of practice, the appropriate MCBAP/IC & RC credential applies.
Substance Abuse Treatment Practitioner	An individual who has a registered MCBAP certification development plan (Development Plan – Counselor (DP-C) – approved development plan in place), is timely in its implementation, and is supervised by a Certified Clinical Supervisor – Michigan (CCS-M) or Certified Clinical Supervisor – IC & RC (CCS); or who has a registered development plan to obtain the supervisory credential (Development Plan – Supervisor (DP-S) – approved development plan in place) while completing the requirements of the plan (6000 hours).

SECTION 2 – PROGRAM REQUIREMENTS

2.1 MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES SERVICES

Mental health and developmental disabilities services (state plan, HSW, and additional/B3) must be:

- Provided under the supervision of a physician, or other licensed health professional whose profession is relevant to the services being provided. This includes professionals who are licensed or certified in Michigan in a human services field typically associated with mental health or developmental disabilities services. (Refer to Staff Provider Qualifications later in this section.)
- Provided to the beneficiary as part of a comprehensive array of specialized mental health or developmental disabilities services.
- Coordinated with other community agencies (including, but not limited to, Medicaid Health Plans [MHPs], family courts, local health departments [LHDs], MI Choice waiver providers, school-based services providers, and local MDHHS offices).
- Provided according to an individual written plan of service that has been developed using a person-centered planning process and that meets the requirements of Section 712 of the Michigan Mental Health Code. A preliminary plan must be developed within seven days of the commencement of services or, if a beneficiary is hospitalized, before discharge or release. Pursuant to state law and in conjunction with the Balanced Budget Act of 1997, Section 438.10 (f)(6)(v), each beneficiary must be made aware of the amount, duration, and scope of the services to which he is entitled. Therefore, each plan of service must contain the expected date any authorized service is to commence, and the specified amount, scope, and duration of each authorized service. The beneficiary must receive a copy of his plan of services within 15 business days of completion of the plan.
- The individual plan of service shall be kept current and modified when needed (reflecting changes in the intensity of the beneficiary's health and welfare needs or changes in the beneficiary's preferences for support). A beneficiary or his/her guardian or authorized representative may request and review the plan at any time. A formal review of the plan with the beneficiary and his/her guardian or authorized representative shall occur not less than annually to review progress toward goals and objectives and to assess beneficiary satisfaction. The review may occur during person-centered planning.
- Provided without the use of aversive, intrusive, or restrictive techniques unless identified in the individual plan of service and individually approved and monitored by a behavior treatment plan review committee.

2.2 Substance Abuse Services

Substance abuse services must be furnished by service providers licensed by the State of Michigan to provide each type of substance abuse services for which they contract. Substance abuse service providers also must be accredited as an alcohol and/or drug abuse program by one of the following national accreditation bodies:

- The Joint Commission;
- Commission on Accreditation of Rehabilitation Facilities (CARF);
- American Osteopathic Association (AOA);
- Council on Accreditation of Services for Families and Children (COA);
- National Committee on Quality Assurance (NCQA); or
- Accreditation Association for Ambulatory Health Care (AAAHC).

Substance abuse services must be coordinated with other community services as appropriate to an individual's needs and circumstances. Services must also be provided according to an individualized treatment plan. All standard requirements of the Michigan Public Health Code, Article 6 - Substance Abuse apply.

2.3 Location of Service [Change Made 7/1/18]

Services may be provided at or through PIHP service sites or contractual provider locations. Unless otherwise noted in this manual, PIHPs are encouraged to provide mental health and developmental disabilities services in integrated locations in the community, including the beneficiary's home, according to individual need and clinical appropriateness. For office or site-based services, the location of primary service providers must be within 60 minutes/60 miles in rural areas, and 30 minutes/30 miles in urban areas, from the beneficiary's residence.

Substance abuse covered services must generally be provided at state licensed sites. Licensed providers may provide some activities, including outreach, in community (off-site) settings. Mental health case management may be provided off-site, as necessary, to meet individual needs when case management is purchased as a component of a licensed service. For office or site-based services, the location of primary service providers must be within 60 minutes/60 miles in rural areas, and 30 minutes/30 miles in urban areas, from the beneficiary's home.

For beneficiaries residing in nursing facilities, only the following clinic services may be provided:

- Nursing facility mental health monitoring;
- Psychiatric evaluation;
- Psychological testing, and other assessments;
- Treatment planning;
- Individual therapy, including behavioral services;
- Crisis intervention; and
- Services provided at enrolled day program sites.

Refer to the Nursing Facility Chapter of this manual for PASARR information as well as mental health services provided by Nursing Facilities.

Medicaid does not cover services delivered in Institutions for Mental Diseases (IMD) for individuals between ages 22 and 64, as specified in §1905(a)(B) of the Social Security Act. Medicaid does not cover services provided to children with serious emotional disturbance in Child Caring Institutions (CCI) unless it is licensed as a "children's therapeutic group home" as defined in Section 722.111 Sec.1(f) under Act No. 116 of the Public Acts of 1973, as amended, or it is for the purpose of transitioning a child out of an institutional setting (CCI). Medicaid may also be used for the purpose of transitioning a child out of Hawthorn Center. For both the CCI and Hawthorn Center, the following mental health services initiated by the PIHP (the case needs to be open to the PIHP/CMHSP) may be provided within the designated timeframes:

- Assessment of a child's needs for the purpose of determining the community based services necessary to transition the child out of a CCI or Hawthorn Center. This should occur up to 180 days prior to the anticipated discharge from a CCI or Hawthorn Center.
- Wraparound planning, case management or supports coordination. **(revised 7/1/18)** This should occur up to 180 days prior to discharge from a CCI or Hawthorn Center.

Medicaid does cover services provided to children with developmental disabilities in a CCI that exclusively serves children with developmental disabilities, and has an enforced policy of prohibiting staff use of seclusion and restraint. Medicaid does not cover services provided to persons/children involuntarily residing in non-medical public facilities (such as jails, prisons or juvenile detention facilities).

Refer to the Amount and Scope of Service subsection for additional information regarding Wraparound program expectations.

2.3.A. Day Program Sites

The PIHP may organize a set of state plan, HSW or additional/B3 services at a day program site, but the site and the set of services must be approved by MDHHS. Some services (e.g., inpatient or respite) may not be provided at a day program site. (Refer to individual program descriptions in this chapter for more information on those limitations.)

Mental health and developmental disabilities day program sites are defined as places other than the beneficiary's/family's home, nursing facility, or a specialized residential setting where an array of mental health or developmental disability services and supports are provided:

- To assist the beneficiary in achieving goals of independence, integrated employment and/or community inclusion, as specified in his individual plan of services.
- Through a predetermined schedule, typically in-group modalities.
- By staff under the immediate and on-site supervision of a professional possessing at least a bachelor's degree in a human service field, and at least two years work experience providing services to beneficiaries with serious mental illness and developmental disabilities.

Medicaid providers wishing to provide mental health and/or developmental disability services and supports at a day program site must obtain approval of the day program site by MDHHS. (Refer to the Directory Appendix for contact information.) MDHHS approval will be based upon adherence to the following requirements:

- Existence of a program schedule of services and supports.
- Existence of an individual beneficiary schedule of state plan, HSW, and additional/B3 services and supports with amount, duration and scope identified.
- The beneficiary's services and supports must be based upon the desired outcomes and/or goals of the individual defined through a person-centered planning process.
- Direct therapy services must be delivered by professional staff, or aides under the supervision of professional staff, who are licensed, certified, or registered to provide health-related services within the scope of practice for the discipline.
- If an aide under professional supervision delivers direct therapy services, that supervision must be documented in the beneficiary's clinical record.

Approval of new program sites will be contingent upon submission of acceptable enrollment information to MDHHS by the PIHP, and upon a site visit by MDHHS.

2.4 Staff Provider Qualifications [Change Made 7/1/18]

Providers of specialty services and supports (including state plan, HSW, and additional/B3) are chosen by the beneficiary and others assisting him/her during the person-centered planning process, and must meet the staffing qualifications contained in program sections in this chapter. In addition, qualifications are noted below for provider staff mentioned throughout this chapter, including the Children's Waiver. The planning team should also identify other competencies that will assure the best possible outcomes for the beneficiary. Credentialing and re-credentialing standards located in the Quality Assessment and Performance Improvement Program in the MDHHS/PIHP contract must be followed. Michigan laws regarding licensing and registration of professionals are found in the Public Health Code, the Mental Health Code and the Michigan Administrative Rules. These regulations define the scope of practice for each professional as well as requirements for supervision.

All providers must be:

- At least 18 years of age.
- Able to prevent transmission of any communicable disease from self to others in the environment in which they are providing supports.
- Able to communicate expressively and receptively in order to follow individual plan requirements and beneficiary-specific emergency procedures, and report on activities performed.
- In good standing with the law according to the MDHHS/PIHP contract.

Aides	Must be able to perform basic first aid procedures. Children's Waiver aides must also successfully complete training in recipient rights and implementation of the child's individual plan of services.

Audiologist	A licensed individual; has the equivalent educational requirements and work experience necessary for the license; or has completed the academic program and is acquiring supervised work experience to qualify for the license.
Dietitian	An individual who is a Registered Dietitian or an individual who meets the qualification of Registered Dietitian established by the Academy of Nutrition and Dietetics.
Licensed Practical Nurse (LPN)	An individual who is licensed by the State of Michigan to practice as a licensed practical nurse under the supervision of a registered nurse, physician, or dentist. LPNs include licensed psychiatric attendant nurses per MCL§ 333.17209.
Nurse Practitioner (NP)	An individual licensed to practice as a registered nurse and certified in a nursing specialty by the State of Michigan.
Occupational Therapist (OT)	An individual who is licensed by the State of Michigan to practice as an occupational therapist.
Occupational Therapy Assistant (OTA)	An individual who is licensed by the State of Michigan to practice as an occupational therapy assistant and who is supervised by a qualified occupational therapist.
Physical Therapist (PT)	An individual licensed by the State of Michigan as a physical therapist.
Physical Therapy Assistant	An individual who is a graduate of a physical therapy assistant associate degree program accredited by an agency recognized by the Commission on the Accreditation in Physical Therapy Education (CAPTE), and who is supervised by the physical therapist licensed by the State of Michigan. The individual must be supervised by the physical therapist licensed by the State of Michigan.
Physician (MD or DO)	An individual who possesses a permanent license to practice medicine in the State of Michigan, a Michigan Controlled Substances license, and a Drug Enforcement Administration (DEA) registration.
Physician Assistant	An individual licensed by the State of Michigan as a physician assistant. Practice as a physician assistant means the practice of medicine with a participating physician under a practice agreement. **(revised 7/1/18)**
Professional Counselor	An individual who is fully licensed or limited-licensed by the State of Michigan to practice professional counseling. This includes Rehabilitation Counselors.
Psychologist	An individual who possesses a full license by the State of Michigan to independently practice psychology; or a master's degree in psychology (or a closely related field as defined by the state licensing agency) and licensed by the State of Michigan as a limited-licensed psychologist (LLP); or a master's degree in psychology (or a closely related field as defined by the state licensing agency) and licensed by the State of Michigan as a temporary-limited-licensed psychologist.
Registered Nurse (RN)	An individual licensed by the State of Michigan to practice nursing (MCL 333.17201).
Social Worker	An individual who possesses Michigan licensure as a master's social worker, or Michigan licensure as a bachelor's social worker, or has a limited license as a bachelor's social worker or master's social worker. Limited licensed social workers must be supervised by a licensed MSW (MCL 333.18501 - 507).
Speech Pathologist (SLP)	An individual engaged in the practice of Speech-Language Pathology and is licensed by the State of Michigan to provide such services.

Refer to the Provider Qualifications on the MDHHS website for specific provider qualifications for each covered service. (Refer to the Directory Appendix for website information.)

2.5 Medical Necessity Criteria

The following medical necessity criteria apply to Medicaid mental health, developmental disabilities, and substance abuse supports and services.

2.5.A. Medical Necessity Criteria

Mental health, developmental disabilities, and substance abuse services are supports, services, and treatment:

- Necessary for screening and assessing the presence of a mental illness, developmental disability or substance use disorder; and/or
- Required to identify and evaluate a mental illness, developmental disability or substance use disorder; and/or
- Intended to treat, ameliorate, diminish or stabilize the symptoms of mental illness, developmental disability or substance use disorder; and/or
- Expected to arrest or delay the progression of a mental illness, developmental disability, or substance use disorder; and/or
- Designed to assist the beneficiary to attain or maintain a sufficient level of functioning in order to achieve his goals of community inclusion and participation, independence, recovery, or productivity.

2.5.B. Determination Criteria

The determination of a medically necessary support, service or treatment must be:

- Based on information provided by the beneficiary, beneficiary's family, and/or other individuals (e.g., friends, personal assistants/aides) who know the beneficiary;
- Based on clinical information from the beneficiary's primary care physician or health care professionals with relevant qualifications who have evaluated the beneficiary;
- For beneficiaries with mental illness or developmental disabilities, based on person-centered planning, and for beneficiaries with substance use disorders, individualized treatment planning;
- Made by appropriately trained mental health, developmental disabilities, or substance abuse professionals with sufficient clinical experience;
- Made within federal and state standards for timeliness;
- Sufficient in amount, scope and duration of the service(s) to reasonably achieve its/their purpose; and
- Documented in the individual plan of service.

2.5.C. Supports, Services and Treatment Authorized by the PIHP

Supports, services, and treatment authorized by the PIHP must be:

- Delivered in accordance with federal and state standards for timeliness in a location that is accessible to the beneficiary;
- Responsive to particular needs of multi-cultural populations and furnished in a culturally relevant manner;
- Responsive to the particular needs of beneficiaries with sensory or mobility impairments and provided with the necessary accommodations;
- Provided in the least restrictive, most integrated setting. Inpatient, licensed residential or other segregated settings shall be used only when less restrictive levels of treatment, service or support have been, for that beneficiary, unsuccessful or cannot be safely provided; and
- Delivered consistent with, where they exist, available research findings, health care practice guidelines, best practices and standards of practice issued by professionally recognized organizations or government agencies.

2.5.D. PIHP Decisions

Using criteria for medical necessity, a PIHP may:

- Deny services:
  - that are deemed ineffective for a given condition based upon professionally and scientifically recognized and accepted standards of care;
  - that are experimental or investigational in nature; or
  - for which there exists another appropriate, efficacious, less-restrictive and cost-effective service, setting or support that otherwise satisfies the standards for medically-necessary services; and/or
- Employ various methods to determine amount, scope and duration of services, including prior authorization for certain services, concurrent utilization reviews, centralized assessment and referral, gate-keeping arrangements, protocols, and guidelines.

A PIHP may not deny services based **solely** on preset limits of the cost, amount, scope, and duration of services. Instead, determination of the need for services shall be conducted on an individualized basis.

SECTION 3 – COVERED SERVICES

The Mental Health Specialty Services and Supports program is limited to the state plan services listed in this section, the services described in the Habilitation Supports Waiver for Persons with Developmental Disabilities Section of this chapter, and the additional/B3 services described in the Additional Mental Health Services (B3s) section of this chapter. The PIHP is not responsible for providing state plan covered services that MDHHS has designated another agency to provide (refer to other chapters in this manual for additional information, including the Chapters on Medicaid Health Plans, Home Health, Hospice, Pharmacy and Ambulance), nor is the PIHP responsible for providing the Children's Waiver Services or Serious Emotional Disturbance Waiver Services described in this chapter. However, it is expected that the PIHP will assist beneficiaries in accessing these other Medicaid services. (Refer to the Substance Abuse Section of this chapter for the specific program requirements for substance abuse services.) It is expected that PIHPs will offer evidence based and promising practices as part of the Medicaid covered specialty services where applicable. PIHPs shall assure that these practices are provided by staff who have been appropriately trained in the model(s) and are provided to the population for which the model was intended. NOTE: Certain services are State Plan EPSDT services when delivered to children birth-21 years as noted specifically under those services listed in the Additional Mental Health Services (B3s) section of this chapter. Each affected service is appropriately identified within the subsections.

3.1 BEHAVIORAL HEALTH TREATMENT SERVICES/APPLIED BEHAVIOR ANALYSIS

Refer to the Behavioral Health Treatment Services/Applied Behavior Analysis Section of this chapter for specific program requirements.

3.2 ASSERTIVE COMMUNITY TREATMENT

Refer to the Assertive Community Treatment Program (ACT) Section of this chapter for specific program requirements.

3.3 ASSESSMENTS [CHANGE MADE 4/1/18]

Health Assessment	Health assessment includes activities provided by a registered nurse, physician assistant, nurse practitioner, or dietitian to determine the beneficiary's need for medical services and to recommend a course of treatment within the scope of practice of the nurse or dietician.
Psychiatric Evaluation	A comprehensive evaluation performed face-to-face by a psychiatrist or psychiatric mental health nurse practitioner that investigates a beneficiary's clinical status, including the presenting problem; the history of the present illness; previous psychiatric, physical, and medication history; relevant personal and family history; personal strengths and assets; and a mental status examination. This examination concludes with a written summary based on a recovery model of positive findings, a biopsychosocial formulation and diagnostic statement, an estimate of risk factors, initial treatment recommendations, estimate of length of stay when indicated, and criteria for discharge.

Psychological Testing	Standardized psychological tests and measures rendered by full, limited-licensed, or temporary-limited-licensed psychologists. The beneficiary's clinical record must indicate the name of the person who administered the tests, the results of the tests, the actual tests administered, and any recommendations. The protocols for testing must be available for review.
All Other Assessments and Testing	Generally accepted professional assessments or tests, other than psychological tests, that are conducted by a mental health care professional within their scope of practice for the purposes of determining eligibility for specialty services and supports, and the treatment needs of the beneficiary. The Child and Adolescent Functional Assessment Scale (CAFAS) must be used for the assessment of children 7 to 18 years of age with suspected serious emotional disturbance, and must be performed by staff who have been trained in the implementation of CAFAS. The Preschool and Early Childhood Functional Assessment Scale (PECFAS) must be used for the assessment of young children, 4 to 7 years of age, with suspected serious emotional disturbance, and must be performed by staff who have been trained in the implementation of the PECFAS. The Devereux Early Childhood Assessment (DECA) must be used for the assessment of infants and young children, 1 month to 47 months, with suspected serious emotional disturbance, and must be performed by staff who have been trained in the implementation of the DECA. **(revised 4/1/18)**

3.4 BEHAVIOR TREATMENT REVIEW

The 1997 federal Balanced Budget Act requires states to assure that enrollees in their PIHPs will "be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in other Federal regulations on the use of restraints or seclusion" [42 CFR 438.100 (b)(2)(v)].

A behavior treatment plan, where needed, is developed through the person-centered planning process that involves the beneficiary. The person-centered planning process should determine whether a comprehensive assessment should be done in order to rule out any physical or environmental cause for the behavior. Any behavior treatment plan that proposes aversive, restrictive or intrusive techniques, or psycho-active medications for behavior control purposes and where the target behavior is not due to an active substantiated psychotic process, must be reviewed and approved by a specially constituted body comprised of at least three individuals, one of whom shall be a fully- or limited-licensed psychologist and one of whom shall be a licensed physician/psychiatrist. The psychologist or physician must be present during the review and approval process. At least one of the committee members shall not be the developer or implementer of the behavior treatment plan. The approved behavioral plan shall be based on a comprehensive assessment of the behavioral needs of the beneficiary. Review and approval (or disapproval) of such treatment plans shall be done in light of current research and prevailing standards of practice as found in current peer-reviewed psychological/psychiatric literature. Any proposed aversive, intrusive or restrictive technique not supported in current peer-reviewed psychological/psychiatric literature must be reviewed and approved by MDHHS prior to implementing. Acceptable behavioral treatment plans are designed to reduce maladaptive behaviors, to maximize behavioral self-control, or to restore normalized psychological functioning, reality orientation, and emotional adjustment, thus enabling the beneficiary to function more appropriately in interpersonal and social relationships. Such reviews shall be completed prior to the beneficiary's signing and implementation of the plan and as expeditiously as possible. Staff implementing the individual's behavior treatment plan must be trained in how to implement the plan. This coverage includes the monitoring of the behavior treatment plan by the committee or a designee of the committee which shall occur as indicated in the individual plan of service.

3.5 Child Therapy

Treatment activity designed to prevent deterioration, reduce maladaptive behaviors, maximize skills in behavioral self-control, or restore or maintain normalized psychological functioning, reality orientation and emotional adjustment, thus enabling the child to function more appropriately in interpersonal and social relationships. A child mental health professional may provide child therapy on an individual or group basis.

3.6 Clubhouse Psychosocial Rehabilitation Programs

Refer to the Clubhouse Psychosocial Rehabilitation Programs Section of this chapter for specific program requirements.

3.7 Crisis Interventions

Unscheduled activities conducted for the purpose of resolving a crisis situation requiring immediate attention. Activities include crisis response, crisis line, assessment, referral, and direct therapy.

The standard for whether or not a crisis exists is a "prudent layperson" standard. That means that a prudent layperson would be able to determine from the beneficiary's symptoms that crisis services are necessary. Crisis situation means a situation in which an individual is experiencing a serious mental illness or a developmental disability, or a child is experiencing a serious emotional disturbance, and one of the following applies:

- The individual can reasonably be expected within the near future to physically injure himself, or another individual, either intentionally or unintentionally.
- The individual is unable to provide himself food, clothing, or shelter, or to attend to basic physical activities such as eating, toileting, bathing, grooming, dressing, or ambulating, and this inability may lead in the near future to harm to the individual or to another individual.
- The individual's judgment is so impaired that he is unable to understand the need for treatment and, in the opinion of the mental health professional, his continued behavior as a result of the mental illness, developmental disability, or emotional disturbance can reasonably be expected in the near future to result in physical harm to the individual or to another individual.

If the beneficiary developed a crisis plan, the plan is followed with permission from the beneficiary.

3.8 Crisis Residential Services

Refer to the Crisis Residential Services Section of this chapter for specific program requirements.

3.9 Family Therapy

Family Therapy is therapy for a beneficiary and family member(s), or other person(s) significant to the beneficiary, for the purpose of improving the beneficiary/family function. Family therapy does not include individual psychotherapy or family planning (e.g., birth control) counseling. Family therapy is provided by a mental health professional or limited licensed master's social worker supervised by a fully licensed master's social worker.

3.10 Health Services

Health Services are provided for purposes of improving the beneficiary's overall health and ability to care for health-related needs. This includes nursing services (on a per-visit basis, not on-going hourly care), dietary/nutritional services, maintenance of health and hygiene, teaching self-administration of medication, care of minor injuries or first aid, recognizing early symptoms of illness and teaching the beneficiary to seek assistance in case of emergencies. Health assessments are covered under Assessments subsection above. A registered nurse, nurse practitioner, physician's assistant, or dietician must provide these services, according to their scope of practice. Health services must be carefully coordinated with the beneficiary's health care plan so that the PIHP does not provide services that are the responsibility of the MHP.

3.11 Home-Based Services

Refer to the Home-Based Services Section of this chapter for specific program requirements.

3.12 Individual/Group Therapy

Treatment activity designed to reduce maladaptive behaviors, maximize behavioral self-control, or restore normalized psychological functioning, reality orientation, remotivation, and emotional adjustment, thus enabling improved functioning and more appropriate interpersonal and social relationships. Evidence-based practices such as integrated dual disorder treatment for co-occurring disorders (IDDT/COD) and dialectical behavior therapy (DBT) are included in this coverage. Individual/group therapy is performed by a mental health professional within their scope of practice or a limited licensed master's social worker supervised by a full licensed master's social worker.

3.13 Inpatient Psychiatric Hospital Admissions

Refer to the Inpatient Psychiatric Hospital Admissions Section of this chapter for specific program requirements.

3.14 Intensive Crisis Stabilization Services

Refer to the Intensive Crisis Stabilization Services Section of this chapter for specific program requirements.

3.15 Intermediate Care Facility for Individuals With Intellectual Disabilities (ICF/IID) Services

Health and rehabilitative services provided in a state-licensed facility of 16 beds or less that is certified to meet ICF/IID standards that are specified in 42 CFR 483.400 and 42 CFR 442 Subpart C. Beneficiaries must meet ICF/IID level of care criteria and require a continuous active treatment program that is defined in their individual plan of services and coordinated and monitored by a qualified intellectual disability professional (QIDP). The active treatment program includes specialized and generic training, treatment, health and related services that are directed toward acquisition of behaviors necessary for the beneficiary to function with as much self-determination and independence as possible, and the prevention or deceleration of regression or loss of current optimal functional status (42 CFR 483.440 (a)(1)(i & ii). Treatment services are provided by qualified professionals within their scope of practice. Direct care staff must meet aide level qualifications.

3.16 Medication Administration

Medication Administration is the process of giving a physician-prescribed oral medication, injection, intravenous (IV) or topical medication treatment to a beneficiary. This should not be used as a separate coverage when other health services are utilized, such as Private Duty Nursing or Health Services, which already include these activities. A physician, physician's assistant, nurse practitioner, or registered nurse may perform medication administration under the direction of the physician. A licensed practical nurse who is assisting a physician may perform medication administration as long as the physician is on-site.

For injections administered through the CMHSP clinic, refer to the Injectable Drugs and Biologicals subsection of the Practitioner Chapter of this manual.

3.17 Medication Review

Medication Review is evaluating and monitoring medications, their effects, and the need for continuing or changing the medication regimen. A physician, physician assistant, nurse practitioner, registered nurse, licensed pharmacist, or a licensed practical nurse assisting the physician may perform medication reviews. Medication review includes the administration of screening tools for the presence of extra pyramidal symptoms and tardive dyskinesia secondary to untoward effects of neuroactive medications.

3.18 Nursing Facility Mental Health Monitoring

This service is the review of the beneficiary's response to mental health treatment, including direct beneficiary contact and, as appropriate, consultation with nursing facility staff to determine whether recommendations from mental health assessments are carried out by the nursing facility. Nursing facility mental health monitoring is intended to allow follow-up for treatment furnished in response to emerging problems or needs of a nursing facility resident. It is not intended to provide ongoing case management, nor is it for monitoring of services unrelated to the mental health needs of the beneficiary. Nursing facility mental health monitoring can be provided by a physician, physician assistant, or nurse practitioner. If nursing facility mental health monitoring is provided by a limited licensed master's social worker or limited licensed bachelor's social worker, they must be supervised by a licensed master's social worker. If monitoring is provided by a licensed bachelor's social worker or a registered nurse, they need to be supervised by a professional. A "professional" is a physician, physician assistant, nurse practitioner, licensed master's social worker, professional counselor, QIDP or QMHP.

3.19 Occupational Therapy

Evaluation	Therapy
Physician/licensed physician assistant/family nurse practitioner -prescribed activities provided by an occupational therapist licensed by the State of Michigan to determine the beneficiary's need for services and to recommend a course of treatment. An occupational therapy assistant may not complete evaluations.	It is anticipated that therapy will result in a functional improvement that is significant to the beneficiary's ability to perform daily living tasks appropriate to his chronological developmental or functional status. These functional improvements should be able to be achieved in a reasonable amount of time and should be durable (i.e., maintainable). Therapy to make changes in components of function that do not have an impact on the beneficiary's ability to perform age-appropriate tasks is not covered.

Evaluation	Therapy
	Therapy must be skilled (requiring the skills, knowledge, and education of a licensed occupational therapist). Interventions that could be expected to be provided by another entity (e.g., teacher, registered nurse, licensed physical therapist, family member, or caregiver) would not be considered as a Medicaid cost under this coverage. Services must be prescribed by a physician/licensed physician's assistant/family nurse practitioner and may be provided on an individual or group basis by an occupational therapist or occupational therapy assistant, licensed by the State of Michigan or by an occupational therapy aide who has received on-the-job training. The occupational therapist must supervise and monitor the assistant's performance with continuous assessment of the beneficiary's progress, but on-site supervision of an assistant is not required. An aide performing an occupational therapy service must be directly supervised by a qualified occupational therapist who is on site. All documentation by an occupational therapy assistant or aide must be reviewed and signed by the appropriately credentialed supervising occupational therapist.

3.20 Outpatient Partial Hospitalization Services

Refer to the Outpatient Partial Hospitalization Services Section of this chapter for specific program requirements.

3.21 Personal Care in Licensed Specialized Residential Settings

Refer to the Personal Care in Licensed Specialized Residential Settings Section for specific program requirements.

3.22 Physical Therapy

Evaluation	Therapy
Physician/licensed physician's assistant-prescribed activities provided by a physical therapist currently licensed by the State of Michigan to determine the beneficiary's need for services and to recommend a course of treatment. A physical therapy assistant may not complete an evaluation.	It is anticipated that therapy will result in a functional improvement that is significant to the beneficiary's ability to perform daily living tasks appropriate to his chronological, developmental or functional status. These functional improvements should be able to be achieved in a reasonable amount of time and should be durable (i.e., maintainable). Therapy to make changes in components of function that do not have an impact on the beneficiary's ability to perform age-appropriate tasks is not covered.

Evaluation	Therapy
	Physical therapy must be skilled (it requires the skills, knowledge, and education of a licensed physical therapist). Interventions that could be expected to be provided by another entity (e.g., teacher, registered nurse, licensed occupational therapist, family member or caregiver) would not be considered as a Medicaid cost under this coverage. Services must be prescribed by a physician/licensed physician's assistant and may be provided on an individual or group basis by a physical therapist or a physical therapy assistant currently licensed by the State of Michigan, or a physical therapy aide who is receiving on-the-job training. The physical therapist must supervise and monitor the assistant's performance with continuous assessment of the beneficiary's progress. On-site supervision of an assistant is not required. An aide performing a physical therapy service must be directly supervised by a physical therapist that is on-site. All documentation by a physical therapy assistant or aide must be reviewed and signed by the appropriately credentialed supervising physical therapist.

3.23 Speech, Hearing, and Language

Evaluation	Therapy
Activities provided by a licensed speech-language pathologist or licensed audiologist to determine the beneficiary's need for services and to recommend a course of treatment. A speech-language pathology assistant may not complete evaluations.	Diagnostic, screening, preventive, or corrective services provided on an individual or group basis, as appropriate, when referred by a physician (MD, DO). Therapy must be reasonable, medically necessary and anticipated to result in an improvement and/or elimination of the stated problem within a reasonable amount of time. An example of medically necessary therapy is when the treatment is required due to a recent change in the beneficiary's medical or functional status affecting speech, and the beneficiary would experience a reduction in medical or functional status were the therapy not provided. Speech therapy must be skilled (i.e., requires the skills, knowledge, and education of a licensed speech-language pathologist) to assess the beneficiary's speech/language function, develop a treatment program, and provide therapy. Interventions that could be expected to be provided by another entity (e.g., teacher, registered nurse, licensed physical therapist, licensed occupational therapist, family member, or caregiver) would not be considered as a Medicaid cost under this coverage.

Evaluation	Therapy
	Services may be provided by a licensed speech-language pathologist or licensed audiologist or by a speech pathology or audiology candidate (i.e., in his clinical fellowship year or having completed all requirements but has not obtained a license). All documentation by the candidate must be reviewed and signed by the appropriately licensed supervising speech-language pathologist or audiologist.

3.24 Substance Abuse

Refer to the Substance Abuse Services Section of this chapter for specific program requirements relating to substance abuse services.

3.25 Targeted Case Management

Refer to the Targeted Case Management Section of this chapter for specific program requirements.

3.26 Telemedicine

A CMH/PIHP can be either an originating or distant site for telemedicine services. Practitioners must meet the provider qualifications for the covered service provided via telemedicine.

Refer to the Telemedicine Section of the Practitioner Chapter for additional information regarding telemedicine services.

Refer to the Additional Code/Coverage Resource Materials subsection of the General Information for Providers Chapter for additional information regarding coverage parameters.

3.27 Transportation

PIHPs are responsible for transportation to and from the beneficiary's place of residence when provided so a beneficiary may participate in a state plan, HSW or additional/B3 service at an approved day program site or in a clubhouse psychosocial rehabilitation program. MHPs are responsible for assuring their enrollees' transportation to the primary health care services provided by the MHPs, and to (non-mental health) specialists and out-of-state medical providers. MDHHS is responsible for assuring transportation to medical appointments for Medicaid beneficiaries not enrolled in MHPs; and to dental, substance abuse, and mental health services (except those noted above and in the HSW program described in the Habilitation Supports Waiver for Persons with Developmental Disabilities Section of this chapter) for all Medicaid beneficiaries. (Refer to the local MDHHS office or MHP for additional information, and to the Ambulance Chapter of this manual for information on medical emergency transportation.)

PIHP's payment for transportation should be authorized only after it is determined that it is not otherwise available (e.g., MDHHS, MHP, volunteer, family member), and for the least expensive available means suitable to the beneficiary's need.

3.28 Treatment Planning

Activities associated with the development and periodic review of the plan of service, including all aspects of the person-centered planning process, such as pre-meeting activities, and external facilitation of person-centered planning. This includes writing goals, objectives, and outcomes; designing strategies to achieve outcomes (identifying amount, scope, and duration) and ways to measure achievement relative to the outcome methodologies; attending person-centered planning meetings per invitation; and documentation. Monitoring of the individual plan of service including specific services, when not performed by the case manager or supports coordinator, is included in this coverage.

Case managers and supports coordinators perform these functions as part of the case management and supports coordination services; therefore, they should not report this activity as "Treatment Planning." Other mental health and health professionals who attend the beneficiary's person-centered planning should report the activity as "Treatment Planning."

For the Children's Waiver, the attendance of all clinicians and case managers during treatment planning is included in the monthly case management coverage.

3.29 Wraparound Services for Children and Adolescents

Wraparound services for children and adolescents is a highly individualized planning process facilitated by specialized supports coordinators.

Wraparound utilizes a Child and Family Team, with team members determined by the family often representing multiple agencies and informal supports. The Child and Family Team creates a highly individualized Wraparound plan with the child/youth and family that consists of mental health specialty treatment, services and supports covered by the Medicaid mental health state plan, waiver, B3 services and other community services and supports.

The Wraparound plan may also consist of other non-mental health services that are secured from, and funded by, other agencies in the community. The Wraparound plan is the result of a collaborative team planning process that focuses on the unique strengths, values and preferences of the child/youth and family, and is developed in partnership with other community agencies. This planning process tends to work most effectively with children/youth and their families who, due to safety and other risk factors, require services from multiple systems and informal supports. The Community Team, which consists of parents/guardians/legal representatives, agency representatives, and other relevant community members, oversees Wraparound.

Children/youth and families served in Wraparound shall meet two or more of the following criteria:

- Children/youth who are involved in multiple child/youth serving systems.
- Children/youth who are at risk of out-of-home placements or are currently in out-of-home placement.
- Children/youth who have been served through other mental health services with minimal improvement in functioning.

- The risk factors exceed capacity for traditional community-based options.
- Numerous providers are serving multiple children/youth in a family and the identified outcomes are not being met.

Children/youth receiving Wraparound would not also receive, at the same time, the Supports Coordination coverage or the state plan coverage Targeted Case Management. In addition, PIHPs shall not pay for the case management function provided through home-based services and Wraparound at the same time.

Medicaid providers delivering Wraparound services (provided either as a 1915(b) Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) service or an SEDW service) must request approval to provide Wraparound from MDHHS through an enrollment process defined by MDHHS, and re-enrollment must occur every three years. Programs are to be re-enrolled to ensure policy and Wraparound model fidelity adherence.

3.29.A. Organizational Structure

The required organizational structure of Wraparound programs must include a Wraparound facilitator, supervisor, and Community Team; define the roles and responsibilities of those staff and the Community Team; and delineate expectations regarding caseload sizes.

- Wraparound facilitators may not have more than one provider role with any one family (i.e., may not be both the home-based therapist and Wraparound facilitator for the same child/youth and family).
- The responsibility for directing, coordinating, and supervising the staff/program shall be assigned to a specific staff position who meets the requirements of a Child Mental Health Professional (CMHP).
- Services and supports identified in the Wraparound planning process shall be available to the child/youth and family and provided as outlined in the Wraparound plan.
- The caseload ratio shall be reflective of the needs of individual children/youth and families being served and shall not exceed a ratio of one facilitator to 10 child/youth and family teams. Caseloads may increase to a maximum of 12 when two child/youth and family teams are transitioning from Wraparound.
- If facilitators are assigned to other programs as well as Wraparound, the number of Wraparound child/youth and family teams they facilitate shall correlate to the percentage of their position dedicated to providing Wraparound facilitation. For example, if a worker is a .50 FTE Wraparound facilitator, the number of teams assigned to that Wraparound facilitator shall not exceed six when one team is in transition. In addition, mixed caseloads shall not exceed 15 total cases.

3.29.B. Qualified Staff

Wraparound facilitators must:

- Complete the MDHHS three-day new facilitator training within 90 days of hire. The Medicaid encounter cannot be reported until after completion of the initial training.

- Complete a minimum of two MDHHS Wraparound trainings per calendar year.
- Demonstrate proficiency in facilitating the Wraparound process, as monitored by their supervisor and Community Team.
- Participate in and complete MDHHS-required evaluation and fidelity tools.
- Possess a bachelor's degree and be a CMHP or be supervised by a CMHP.

Wraparound supervisors shall:

- Complete the MDHHS three-day Wraparound new facilitator training within 90 days of hire and one additional MDHHS supervisory training in their first year of supervision. If the supervisor is working directly with children and families, they must complete the initial training prior to reporting Medicaid encounters.
- Attend two MDHHS Wraparound trainings annually, one of which shall be a Wraparound supervisor training.
- Participate on the Community Team.
- Provide individualized clinical supervision and coaching to the Wraparound staff weekly based on their individual needs and experience, and maintain a supervision log. Supervision logs will be available at site reviews and re-enrollment.
- Ensure documentation of attendance at required trainings is maintained for all Wraparound staff and available for review upon request.

The Community Team shall:

- Provide a gate-keeping role that includes determination of eligibility, review of referrals, review and authorization of Wraparound Plans of Service, and Wraparound budgets.
- Provide oversight of model fidelity through the review of Wraparound Plans.
- Provide support to Wraparound staff, supervisors, and child/youth and family teams and problem-solve barriers/needs to improve outcomes for children/youth and families.
- Maintain evidence of the review and approval of Wraparound plans, budget, crisis and safety support plans, and outcomes.
- Provide guidance and oversight to Wraparound staff regarding model fidelity and safety assurance.

3.29.C. PLANS OF SERVICE

The Wraparound plan shall reflect a family-driven/youth-guided approach, and shall include the following:

- Evidence that the child/youth and family team completed each step/phase of the Wraparound process, including completion of the strengths/culture discoveries, needs assessments, crisis/safety support plans, Wraparound plans, outcomes, and the development of the family mission statement.

- Individualized child/youth and family outcomes that are developed and measured by each child/youth and family team.
- A strength-based, needs-driven, and culturally-relevant Wraparound plan that is stated in the language of the child/youth and family.
- Evidence of regular updates as the needs of the child/youth and family change (annual updates alone are not sufficient).
- Any services, supports, and interventions that are provided to the family.
- A mixture of formal and informal support and services.
- An individualized crisis/safety support plan that reflects the child's/youth's and family's strengths and culture, and seeks to build skills/competencies that reduce risk.
- Measurement of outcomes identifying when transition plans should be developed. Transition plans will address any barriers to graduation, and identify how services and supports will be maintained after Wraparound has ended.
- Evidence that the child/youth and family team review and measure outcomes at least monthly and present outcomes and measurement to the Community Team for their review at least quarterly.

3.29.D. Amount and Scope of Service

- All Wraparound team meetings shall be documented in the form of minutes.
- All collateral contacts shall be documented in the form of contact/progress notes.
- Meeting frequency is guided by the family's needs and level of risk. Child/youth and family teams shall meet weekly until the Wraparound plan has been developed and is being implemented.
- Exceptions to Wraparound model expectations regarding the frequency of meetings can occur to fit the family's need and availability, and must be documented in the case file.
- When the Wraparound plan is successfully implemented and the child/youth and family have stabilized, meeting frequency may decrease to twice monthly.
- Wraparound child/youth and family teams begin to transition from the formal process when the outcomes identified by child/youth and family teams are met and shall not exceed three months in duration. Monthly meetings may occur during the transition phase.
- When the transition phase is successfully completed, the child/youth and family will graduate from the process.
- Upon graduation, documentation will be developed that will include the strengths and needs identified by the child/youth and family team, progress toward outcomes, continuing services and supports, and who will provide them. The family will receive a copy of this document.

3.29.E. Evaluation and Outcomes Measurement [Change Made 4/1/18]

The enrolled provider will comply with the State of Michigan Wraparound evaluation requirements. Current evaluation requirements are:

- Completion of the Family Status Report form at intake and every three months until the family graduates from Wraparound. Upon graduation, the facilitator will complete the post-graduation/follow-up Family Status Report.
- Additional evaluation tools will be completed as identified and requested by MDHHS.
- Ensure completion of the Child and Adolescent Functional Assessment Scale (CAFAS), the Preschool and Early Childhood Functional Assessment Scale (PECFAS), or the Devereux Early Childhood Assessment (DECA) at intake, quarterly, and at graduation. **(revised 4/1/18)**
- Adherence to Wraparound model fidelity may be reviewed at enrollment, re-enrollment, and at site reviews through case file review, family interviews, and evaluation and fidelity tools.

SECTION 4 – ASSERTIVE COMMUNITY TREATMENT PROGRAM

Assertive Community Treatment (ACT) is a therapeutic set of intensive clinical, medical and psychosocial services provided by a mobile multi-disciplinary treatment team that includes case/care management, psychiatric services, counseling/psychotherapy, housing support, Substance Use Disorders treatment, and employment and rehabilitative services provided in the beneficiary's home or community.

ACT provides basic services and supports essential to maintaining the beneficiary's ability to function in community settings, including assistance with accessing basic needs through available community resources (such as food, housing, medical care and supports) to allow beneficiaries to function in social, educational, and vocational settings.

ACT is an individually tailored combination of services and supports that may vary in intensity over time and is based on individual need. ACT includes availability of multiple daily contacts and 24-hour, 7-days-per-week crisis availability provided by the multi-disciplinary ACT team which includes psychiatric and skilled medical staff. ACT services are based on the principles of recovery and person-centered practice and are individually tailored to meet the needs of each beneficiary. Services are provided in the beneficiary's residence or other community locations by all members of the ACT team staff.

The Prepaid Inpatient Health Plans (PIHPs) and the Community Behavioral Health Services Programs (CMHSPs) offer a continuum of adult services including case/care management, outpatient therapy, and psychiatric services that can be used in varying intensities and combinations to assist beneficiaries in a recovery-oriented system of care. The beneficiary's level of need and preferences must be considered in the admission process. ACT is the most intensive non-residential service in the continuum of care within the service array of the public behavioral health system.

4.1 TEAM APPROVAL

Medicaid providers wishing to become providers of ACT services must obtain approval from MDHHS and meet the program components outlined below. Provider programs with more than one ACT team must have individually approved and registered ACT teams. All ACT teams are subject to MDHHS re-approval every three years.

4.2 TARGET POPULATION

The intensity of ACT services is intended for the beneficiary with a primary diagnosis of serious mental illness and who, without ACT, would require more restrictive services and/or settings. ACT is not an appropriate service for a beneficiary with a primary diagnosis of a personality disorder, a primary diagnosis of a Substance Use Disorder, or a primary diagnosis of intellectual disability. A beneficiary with a primary diagnosis of a serious mental illness may also be diagnosed with a personality disorder or co-occurring Substance Use Disorder and benefit from ACT services.

ACT services are targeted to beneficiaries demonstrating acute or severe psychiatric symptoms that are seriously impairing the beneficiary's ability to function independently, and whose symptoms impede the return of normal functioning as a result of the diagnosis of a serious mental illness. Areas of impairment are significant, and are considered individually for each beneficiary.

These areas of difficulty may include:

- Maintaining or having interpersonal relationships with family and friends;
- Accessing needed mental health and physical health care;
- Addressing issues relating to aging, especially where symptoms of serious mental illness may be exacerbated or confused by complex medical conditions or complex medication regimens;
- Performing activities of daily living or other life skills;
- Managing medications without ongoing support;
- Maintaining housing;
- Avoiding arrest and incarceration, navigating the legal system, and transitioning back to the community from jail or prison;
- Coping with relapses or return of symptoms given an increase in psychosocial stressors or changes in the environment resulting in frequent use of hospital services, emergency departments, crisis services, crisis residential programs or homeless shelters;
- Maintaining recovery to meet the challenges of a co-occurring Substance Use Disorder;
- Encountering difficulty in past or present progress toward recovery despite participation in long-term and/or intensive services.

4.3 ESSENTIAL ELEMENTS [CHANGES MADE 4/1/18]

Team-Based Service Delivery	ACT is a team-based behavioral health service that includes shared service delivery responsibility that provides consistent continuity of care. Case/care management, psychiatric services, counseling/psychotherapy, peer support services, housing support, substance use disorder treatment, employment and rehabilitative services are interwoven with treatment and rehabilitative services, and services are provided by all members of the ACT team in the beneficiary's home or community. All ACT staff must obtain a basic knowledge of ACT programs and principles acquired through participation in MDHHS-approved ACT-specific initial training, and subsequent participation in at least one MDHHS-approved ACT-specific training annually thereafter. All initial training of ACT staff must occur within six months of hire for work in ACT. Physicians/Nurse Practitioners must participate in the MDHHS-approved Physicians/Nurse Practitioners training one time, with additional ACT training/participation for Physicians/Nurse Practitioners encouraged, but not mandatory. Team meetings occur Monday through Friday on business days and are attended by all ACT staff members on duty. Physicians and/or Nurse Practitioners are expected to participate in ACT team meetings at least weekly. Agendas for daily team meetings include the status of all beneficiaries, updates from on-call, clinical and case/care management needs, crisis management, schedule organization, and finalized plans for ACT staff deployment into the community. A minimum of 80% of ACT contacts provided by the team are in the beneficiary's home or other agreed upon community location. Treatment groups identified in the Individual Plan of Service (IPOS), such as Family Psychoeducation, Alcoholics Anonymous, etc., are excluded from the 80% community visit standard regardless of where the group is held. The average number of visits per day/week/month/etc. provided by the whole team, not individual ACT team members, to an individual consumer will comprise 80% of home or community contacts.
Team Composition and Size *A minimum of 80% of ACT contacts provided by the team are in the beneficiary's home or other agreed-upon community location.*	The ACT team requires a sufficient number of qualified staff to assure the provision of an intensive array of services on a 24-hour basis. Teams must have at least three staff members, but generally are comprised of 4-9 staff members, with the expected team average of 6-7. The minimum ACT staffing requirements are below. ACT teams that need to operate with as few as 3 members or more than 9 members must have MDHHS approval. The scope of services for individual ACT staff members requires that some staff will work in the community more often than others. ▪ A full-time team leader with a minimum of a Master's degree in a relevant discipline and with appropriate licensure or certification to provide clinical supervision to the ACT team staff, plus a minimum of two years post-degree clinical experience with adults who have serious mental illness is required. The ACT team leader is a Qualified Mental Health Professional (QMHP) or Mental Health Professional (MHP). The ACT team leader also provides direct services to beneficiaries in the community within their scope of practice. ▪ A full-time registered nurse (RN) is required on the ACT team. The RN provides integrated behavioral and physical healthcare, including managing medication, assessing and coordinating physical/medical care, and providing direct services to the beneficiary in the community.

The average number of visits per day/week/month/etc. provided by the whole team, not individual ACT team members, to an individual consumer will comprise 80% of home or community contacts. *Telepractice is the use of telecommunications and information technologies for the provision of psychiatric services to ACT consumers and is subject to the same service provisions as psychiatric services provided in person. The telepractice modifier, 95, must be used in conjunction with ACT encounter reporting code H0039 when telepractice is used.* *All telepractice interactions shall occur through real-time interactions between the ACT consumer and the physician/nurse practitioner from their respective physical location. Psychiatric services are the only ACT services that are approved to be provided in this manner.* *Refer to the General Information for*	▪ A physician who provides psychiatric coverage for all beneficiaries served by the ACT team is required. The physician is considered a part of the ACT team, but is not counted in the staff-to-beneficiary ratio. The physician participates in the team meeting at least weekly and is assigned to the ACT team at least 15 minutes per beneficiary per week in a capacity that allows for immediate access to the physician so that emergency, urgent or emergent situations may be addressed. The expectation is that some beneficiaries will need more physician time and some beneficiaries will need less time during any given week. The physician may delegate psychiatric activities to a nurse practitioner, but the nurse practitioner must be supervised by that physician. Typically, although not exclusively, physician activities may include team meetings, beneficiary appointments during regular office hours, psychiatric evaluations, psychiatric meetings/consultations, medication reviews, home visits, telephone consultations and telepractice. **(revised 4/1/18)** The physician (MD or DO) must possess a valid license to practice medicine in Michigan, a Michigan Controlled Substance License, and a Drug Enforcement Administration (DEA) registration. ▪ A nurse practitioner may perform clinical tasks delegated by and under the supervision of the physician. The nurse practitioner must hold a specialty certification as a nurse practitioner in Michigan, a current license to practice nursing in Michigan, and a master's degree in psychiatric mental health nursing. If the ACT team includes a nurse practitioner, he/she may substitute for a portion of the physician time, but may not substitute for the ACT RN. The nurse practitioner is not counted in the staff-to-beneficiary ratio. Typically, although not exclusively, nurse practitioner activities may include team meetings, beneficiary appointments during regular office hours, evaluations, psychiatric meetings/consultations, medication reviews, home visits, telephone consultations and telepractice. **(revised 4/1/18)** ▪ A case or care manager with a minimum of a Bachelor's degree in a human services discipline with appropriate licensure to provide the core elements of case or care management, with at least one year of experience providing services to adults with a mental illness, is required. This individual shall be a Qualified Mental Health Professional (QMHP). If the case or care manager has a Bachelor's degree, but is without the specialized training or experience, the case or care manager must be supervised by a QMHP who does possess the training or experience. ▪ A Qualified Mental Health Professional (QMHP) with a clinically prepared Master's Degree shall provide individual/family counseling. ▪ Up to one Full Time Equivalent (FTE) Peer Support Specialist (PSS) may substitute for one QMHP to achieve the 1:10 required staff-to-beneficiary ratio. Under the supervision of the ACT team leader, a PSS may provide documentation in beneficiary records. This supervision is documented in the beneficiary record. ▪ Up to one FTE paraprofessional staff to work with ACT teams may be counted in the staff-to-beneficiary ratio. Paraprofessional staff may have a bachelor's degree or related training in a field other than behavioral sciences (e.g., certified occupational therapy assistance, home health care); or have a high school equivalency and work or life experience with adults with severe mental illness or co-occurring substance use disorders. ▪ If the ACT team provides substance use disorder services, there must be a designated Substance Abuse Treatment Specialist who has one or more credentials through the Michigan Certification Board of Addiction Professionals (MCBAP). If the ACT team provides co-occurring treatment or substance use disorder

Providers Chapter of this manual for the complete Health Insurance Portability and Accountability Act (HIPAA) compliance requirements for the provision of telepractice services. ***(text added 4/1/18)*** *Treatment Groups identified in the IPOS, such as Family Psychoeducation, Alcoholics Anonymous, etc., are excluded from the 80% community visit standard regardless of where the group is held.* *The scope of services for individual ACT staff members require that some staff will work in the community more often than others.*	treatment, the Organization must have a substance use disorder treatment license issued by the State of Michigan. Additional staff positions reflect the needs of the population, such as the ability to obtain housing, employment services and rehabilitative services for beneficiaries who request them, and shall minimally be a QMHP.
Staff-to-Beneficiary Ratio	The staff-to-beneficiary ratio shall be no less than 1:10, i.e., a maximum of 10 beneficiaries to each ACT staff. With the exceptions of the limitations on paraprofessionals and peer support specialists described above, the ratio includes all ACT team members, excluding the clerical support staff and physicians or nurse practitioners.
Fixed Point of Responsibility	The ACT team is the fixed point of responsibility for the development of the individual plan of service (IPOS) using the person-centered planning process and for supporting beneficiaries in all aspects of community living. The process addresses all services and supports to be provided to or obtained for the beneficiary by the team, including consultation with other disciplines and/or coordination of other supportive services as appropriate.

Availability of Services *Pre-admission screens for ACT beneficiaries must be reported by including the TG modifier with the ACT encounter code of H0039.* ***(text added 4/1/18)***	Availability of ACT services must include: ▪ 24-hour/7-day crisis response coverage (including psychiatric availability) that is handled directly by members of the ACT team. For 3-member teams, 'on call' services may be a part of the larger organization's on-call system if approved by MDHHS. ▪ The ACT team is responsible for performing the required pre-admission screen for all beneficiaries enrolled in an ACT program seeking inpatient psychiatric admission. **(text added 4/1/18)** ▪ The capacity to provide a rapid response to early signs of relapse, including the capability to provide multiple contacts daily with beneficiaries in acute need or with emergent conditions. ▪ The ACT team has the ability to provide needed services to the beneficiary 7 days a week as per the IPOS.
Individual Plan of Service (IPOS)	ACT services and interventions must be consistent and balanced through medical necessity and the preferences of the beneficiary while embracing person-centered principles, wellness and behavioral health recovery with a goal of maximizing independence and a progression into less intensive services. Beneficiaries with co-occurring substance use disorders must have both behavioral health and substance use disorders addressed in the IPOS. Beneficiaries who need a less intensive service than ACT, such as case/care management, have documentation in the IPOS detailing the transition plan to the new service and a plan to return to ACT should the need occur.
In Vivo Settings	ACT teams provide a wide array of clinical, medical and rehabilitative services during face-to-face interactions designed to promote the beneficiary's growth in recovery. ACT services and supports are focused on acquiring needed behavioral health services, substance misuse services, physical health care, performing activities of daily living, obtaining and/or maintaining employment, developing leisure activities, developing and maintaining meaningful relationships, maintaining housing, avoiding arrest and incarceration, navigating the legal system, transitioning successfully into the community from jail or prison, and relapse prevention. Services for ACT beneficiaries may include those defined elsewhere in this chapter, as well as others that are consistent with individual preferences, professionally accepted standards of care, and that are medically necessary. ACT services may be used as an alternative to hospitalization as long as beneficiary health and safety issues can be reasonably well-managed with ACT supports that do not require 24-hour-per-day supervision.

4.4 ELIGIBILITY CRITERIA

Utilization of ACT in high acuity conditions and situations allows beneficiaries to remain in their community of residence and may prevent the use of more restrictive alternatives which may be detrimental to a beneficiary's existing natural supports and occupational roles. This level of care is appropriate for beneficiaries with a history of serious mental illness who may be at risk for inpatient hospitalization or intensive crisis residential or partial hospitalization services, but can remain safely in their communities with the considerable support and intensive interventions of ACT. In addition to meeting the following criteria, these beneficiaries may also be likely to require or benefit from continuing psychiatric rehabilitation.

The ACT acute service selection guideline covers criteria in the following domains:

Diagnosis	The beneficiary must have a serious mental illness, as reflected in a primary, validated, current version of Diagnostic and Statistical Manual of Mental Disorders (DSM) or International Classification of Diseases (ICD) diagnosis (not including ICD-9 V-codes and ICD-10 Z-codes).
Severity of Illness	Psychiatric Status ▪ Prominent disturbance of thought processes, perception, affect, memory, consciousness, somatic functioning (due to a mental illness) which may manifest as intermittent hallucinations, transient delusions, panic reactions, agitation, obsessions, ruminations, severe phobias, depression, etc., and is serious enough to cause disordered or aberrant conduct, impulse control problems, questionable judgment, psychomotor acceleration or retardation, withdrawal or avoidance, compulsions, rituals, impaired reality testing and/or impairments in functioning and role performance. Self-Care/Independent Functioning ▪ Disruptions of self-care, limited ability to attend to basic physical needs (nutrition, shelter, etc.), seriously impaired interpersonal functioning, and/or significantly diminished capacity to meet educational/occupational/parental role performance expectations. ▪ Drug/Medication Conditions - Drug/medication adherence and/or a co-existing general medical condition which needs to be simultaneously addressed along with the psychiatric illness and which cannot be carried out at a less intensive level of care. Medication use requires monitoring or evaluation for adherence to achieve stabilization, to identify atypical side effects or concurrent physical symptoms and medical conditions. ▪ Risk to Self or Others - Symptom acuity does not pose an immediate risk of substantial harm to the beneficiary or others, or if a risk of substantial harm exists, protective care (with appropriate medical/psychiatric supervision) has been arranged. Harm or danger to self, self-mutilation and/or reckless endangerment or other self-injurious activity is an imminent risk.

Intensity of Service	ACT team services are medically necessary to provide treatment in the least restrictive setting, to allow beneficiaries to remain in the community, to improve the beneficiary's condition and /or allow the beneficiary to function without more restrictive care, and the beneficiary requires at least one of the following: ▪ An intensive team-based service is needed to prevent elevation of symptom acuity, to recover functional living skills and maintain or preserve adult role functions, and to strengthen internal coping resources; ongoing monitoring of psychotropic regimen and stabilization necessary for recovery. ▪ The beneficiary's acute psychiatric crisis requires intensive, coordinated and sustained treatment services and supports to maintain functioning, arrest regression and forestall the need for inpatient care in a 24-hour protective environment. ▪ The beneficiary has reached a level of clinical stability (diminished risk) obviating the need for continued care in a 24-hour protective environment but requires intensive coordinated services and supports. ▪ Consistent observation and supervision of behavior are needed to compensate for impaired reality testing, temporarily deficient internal controls, and/or faulty self-preservation inclinations. ▪ Frequent monitoring of medication regimen and response is necessary and adherence is doubtful without ongoing monitoring and support. ▪ Routine medical observation and monitoring are required to affect significant regulation of psychotropic medications and/or to minimize serious side effects.

Discharge *For beneficiaries who have progressed forward on their journey toward recovery and are ready for a less intensive service, the IPOS should document the transition from ACT to a less intensive service, such as case/care management.*	Cessation or control of symptoms is not sufficient for discharge from ACT. For beneficiaries who have progressed forward on their journey toward recovery and are ready for a less intensive service, the IPOS should document the transition from ACT to a less intensive service, such as case/care management. Recovery must be sufficient to maintain functioning without the support of ACT as identified through the person-centered planning process as described below: ▪ The beneficiary no longer meets severity-of-illness criteria and has demonstrated the ability to meet all major role functions for a period of time sufficient to show clinical stability. Beneficiaries who meet medical-necessity criteria for ACT services usually require and benefit from long-term participation in ACT. ACT is not a service that is appropriate for short-term stabilization and then transition into another program. If a beneficiary requests transition to other service(s) because he/she believes maximum benefit has been reached in ACT, consideration for transition into less intensive services must be reviewed during the person-centered planning process. If clinical evidence supports the beneficiary's desire to transition, this evidence and the transition plan must be detailed in a revised IPOS developed through the person-centered planning process. The plan must identify what supports and services will be made available, and contain a provision for re-enrollment into ACT services, if needed. ▪ Engagement of the beneficiary in ACT is not possible as deliberate, persistent and frequent assertive team outreach, including face-to-face engagement attempts and legal mechanisms when necessary, have been consistent, unsuccessful, and documented over many months, and an appropriate alternative plan has been established with the beneficiary. ▪ Beneficiary has moved outside of the geographic service area. Contact continues until service has been established in the new location.

SECTION 5 – CLUBHOUSE MODEL PROGRAMS

A Clubhouse is a community-based program organized to support individuals living with mental illness. Participants are known as Clubhouse members, and member choice is a key feature of the model. Clubhouses are vibrant, dynamic communities where meaningful work opportunities drive the need for member participation, thereby creating an environment where empowerment, relationship-building, skill development and related competencies are gained. Through what is referred to as the work-ordered day, the Clubhouse provides opportunities for member involvement and ownership in all areas of Clubhouse operation. Members and staff work side-by-side in the program as colleagues. Comprehensive opportunities are provided within the Clubhouse, including supports and services related to employment, education, housing, community inclusion, wellness, community resources, advocacy, and recovery. In addition, members participate in the day-to-day decision-making and governance of the program. Through Clubhouse involvement, members achieve or regain the confidence and skills necessary to lead satisfying, meaningful lives and successfully manage their mental illness. The Clubhouse model is included in the National Registry of Evidence-based Programs and Practices (NREPP), which can be found on the NREPP website. (Refer to the Directory Appendix for website information.)

5.1 PROGRAM APPROVAL

- PIHPs must seek approval for providers of Clubhouse services from the MDHHS Behavioral Health Developmental Disabilities Administration (BHDDA).
- To ensure fidelity to the model of the evidence-based practice of Psychosocial Rehabilitation, Clubhouses must acquire and maintain Clubhouse International accreditation. Additional information regarding Clubhouse International accreditation is available on the International Center for Clubhouse Development (ICCD) website. (Refer to the Directory Appendix for website information.)
- All new Clubhouses must participate in the Clubhouse International's New Clubhouse Development Training.
- MDHHS approval will be based on adherence to the requirements outlined below.

Requests for approval of Clubhouse services may be submitted to the MDHHS-BHDDA Community Practices and Innovation Section, Division of Quality Management & Planning. (Refer to the Directory Appendix for contact information.)

5.2 TARGET POPULATION

Clubhouse programs are appropriate for adults with a serious mental illness who wish to participate in a structured community with staff and peers and who desire to work on the goal areas reflected in the Core Psychiatric Rehabilitation Components subsection of this document. The beneficiary must be able to participate in, and benefit from, the activities necessary to support the program and its members.

5.3 Essential Elements of the Clubhouse Model

Member Choice/ Involvement	Member choice and involvement are an ongoing essential process imbedded in all aspects of the Clubhouse model. ▪ Membership is voluntary. ▪ Clubhouse Membership is without time-limits; access to an intentional community supports the recovery process. ▪ All members have access to the services/supports and resources with no differentiation based on diagnosis or level of functioning. ▪ Members establish their own schedule of attendance and choose a work unit that they will regularly participate in during the work-ordered day. ▪ Members are actively engaged and supported on a regular basis by Clubhouse staff in the activities and tasks that they have chosen. ▪ Membership in the program and access to supportive services reflects the beneficiary's preferences and needs, building on the person-centered planning process. ▪ Both formal and informal decision-making opportunities are part of the Clubhouse work units and program structures. Members can influence and shape program operations. Clubhouse decisions are generally made by consensus. ▪ Staff and members work side-by-side to generate and accomplish individual/team tasks and activities necessary for the development, support, and maintenance of the program.
Work-Ordered Day	▪ The work-ordered day is a primary component of the program and provides an opportunity for members to regain self-worth, purpose, and confidence. It consists of tasks and activities necessary for the operation of the Clubhouse and typically occurs during normal business hours. ▪ Although participation in the work-ordered day provides opportunities to develop a variety of interpersonal and vocationally related skills, it is not intended to be job-specific training. ▪ Member participation in the work-ordered day provides experiences that will support members' recovery, and is designed to assist members to acquire personal, community and social competencies and to establish and navigate environmental support systems. ▪ The program's structure and schedule identifies when the various program components occur (e.g., work-ordered day, vocational/educational). Other activities, such as self-help groups and social activities, are scheduled before or after the work-ordered day. ▪ The work done in the Clubhouse is exclusively the work generated by the Clubhouse in the operation and enhancement of the Clubhouse community. No work for outside individuals or agencies, whether for pay or not, is acceptable work in the Clubhouse. Members are not paid for any Clubhouse work, nor are there any artificial reward systems. ▪ The amount, scope, and variety of tasks are sufficient enough to engage the membership in meaningful activities throughout the work-ordered day.

	▪ All staff are Clubhouse generalists. Their responsibilities are housed in a unit and they routinely work side-by-side with members to complete unit work. ▪ Staff help to identify meaningful work opportunities for members and are able to facilitate workgroups. ▪ Staff are dynamic and skilled at developing relationships with members. Staff utilizes a strengths-based approach and promotes an equal culture with members, thereby allowing members to experience themselves as valued colleagues in the Clubhouse community.
Employment Services	▪ The Clubhouse provides its own employment services, including Transitional Employment (TE), Supported Employment (SE), and Independent Employment (IE), consistent with Clubhouse International standards and guidelines, which are available on the ICCD website. (Refer to the Directory Appendix for website information.) ▪ Additional resources for benefits planning are available.
Educational Services	• The Clubhouse provides resources and connections to assist members with goals to return to formal educational settings. This should include some of the following supports: ➢ connections with local colleges and General Educational Development (GED) centers, ➢ assistance with admission and financial aid applications, ➢ tutoring assistance with fellow members when appropriate, ➢ formal education groups, and ➢ other activities that support member success. Educational programming should be individualized and should enhance the Clubhouse work-ordered day.
Community Supports	• Community support services are provided by members and staff of the Clubhouse. Community support activities are centered in the work unit structure of the Clubhouse and include outreach, entitlements, housing, advocacy, promoting wellness, as well as assistance in finding quality medical, psychological, pharmacological and substance use disorder treatment services in the community. • The Clubhouse has an advisory board that meets regularly to provide support. Advisory board composition includes individuals from the local community who are able to assist with connections and/or advice in areas such as employment, education, legal assistance, finances, and advocacy. The board also includes member leaders. • The Clubhouse must engage with the local community. Activities may include speaking engagements, connections with media outlets, awareness-raising, political advocacy, community service projects, open houses, participating with the statewide Clubhouse coalition, and relevant conferences. ▪ The Clubhouse ensures that access to the building, Clubhouse-sponsored community activities, and employment sites are available through public transportation or other alternative modes of transportation. The Clubhouse provides or arranges for effective alternatives whenever access to public transportation is limited.

Social Supports	• Opportunities are available for members to develop a sense of a community through planning and organizing Clubhouse social activities. This may include opportunities to explore recreational resources and activities in the community. The interests and desires of the membership determine both spontaneous and planned activities. ▪ Members may have access to the Clubhouse programming during times other than the work-ordered day, including evenings, weekends, and holidays (New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, and Christmas Day). Access during these times should be based on the needs of the Clubhouse community and decided by members and staff.
Wellness Supports	▪ The Clubhouse supports and encourages physical wellness. This may include enhanced nutrition, weight loss, exercise, smoking cessation, and promoting wellness throughout the Clubhouse. Wellness opportunities occur both within the Clubhouse and through connections with community resources. ▪ The voluntary nature of the Clubhouse is respected for all wellness activities. Wellness programming should enhance the Clubhouse work-ordered day rather than detract from it.
Community Setting	▪ The program is designed as an intentional community, rather than a clinical setting. The Clubhouse does not include clinical personnel such as psychiatrists, nurses, or therapists, nor does it include classes or groups that are of a clinical nature. ▪ The Clubhouse is located in its own physical space. It is separate from any mental health center or institutional settings, and is impermeable to other programs. The Clubhouse is designed to facilitate the work-ordered day and at the same time be attractive, adequate in size, and convey a sense of respect and dignity. ▪ To promote pride and ownership, the Clubhouse has its own identity, including its own name, mailing address, fax, e-mail, and telephone number. ▪ All Clubhouse space is member and staff accessible. There are no staff-only or members-only spaces. ▪ There are no staff-only or members-only meetings where program decisions are made.

5.4 Core Psychiatric Rehabilitation Components

The Clubhouse model is not limited to a narrow set of components. A broad contextual perspective is present throughout the Model.

Broad Context	▪ The Clubhouse model is embedded in the overarching goals of psychiatric rehabilitation. The aims and objectives of Clubhouse communities are to support the access to preferred living, learning, working, and socialization roles for members in their communities. ▪ Outcomes that move beyond the clinical condition and facilitate the recovery process from mental illness are more relevant, such as social role functioning (e.g., meaningful roles in society; social inclusion), establishing relationships, social support networks and social capital, work, recreation, and improved quality of life.

Personal Goal Development	Each Clubhouse member has goals based on his or her Individual Plan of Service (IPS) developed through the Person-Centered planning process and carried out throughout the member's participation in the Clubhouse. Staff may also work informally with members on individual recovery goals while working side-by-side in the Clubhouse.
Psychiatric Rehabilitation Components, Goals and Objectives	Clubhouse environments support recovery in a variety of ways. Generally, expected outcomes associated with accredited Clubhouse participation include greater personal and interpersonal competencies, links with community resources, access to social support networks, increased illness and symptom management, vocational and educational competencies and opportunities, and overall increased personal independence and psychosocial functioning. • Competency Building Community living competencies (e.g., self-care, cooking, money management, personal grooming, maintenance of living environment) are built and include: ➢ Social and interpersonal competencies (e.g., conversational competency, developing and/or maintaining positive self-image, interpersonal problem-solving, regaining the ability to evaluate the motivation and feelings of others to establish and maintain positive relationships). ➢ Personal adjustment competencies (e.g., developing and enhancing intrapersonal abilities and problem-solving in everyday experiences, resolving crises, or managing stress with the goal of facilitating self-efficacy and personal independence). ➢ Vocational competencies (e.g., focused tasks that teach how to apply for jobs, conduct employment interviews, provide opportunities of graded steps to promote job entry or reentry, improve co-worker communication and relationships, and task focus and completion). ➢ Cognitive competency (e.g., task-oriented activities to develop and maintain cognitive abilities, maximize independent functioning such as increased attention, improved concentration, better memory, and enhanced empathy). • Community Support, Inclusion, and Participation Identification of support, inclusion and participation through existing natural supports is necessary to: ➢ Achieve optimal levels of community membership ➢ Increase satisfaction with living environment ➢ Support community participation and integration/inclusion ➢ Reduce stigma through education, community awareness, and community networking ➢ Facilitate social capital via peer and social networks, both internal and external to Clubhouse ➢ Promote utilization of organizational support, community resources, and other collateral support systems, as well as linking with community resources, supports, and services for continuity of care.

	▪ Illness Management and Recovery The identification and management of situations and prodromal symptoms to reduce the frequency, duration, and severity of psychiatric relapses include the following: ➢ Gaining competence regarding how to respond to and manage a psychiatric crisis (includes working in partnership with members who express desire to develop a recovery plan and incorporate natural supports in crisis planning). ➢ Gaining competence in understanding the role psychotropic medication plays in the stabilization of the members' well-being or recovery. ➢ Working in partnership to increase confidence and personal self-efficacy through Clubhouse participation. ➢ Gaining access to holistic approaches to recovery that includes education, information and support for health and personal wellness. ➢ Gaining access to information to support decision making and increased empowerment through Clubhouse participation. • Recovery Enhancing Environment An environment that fosters strength and resilience and practices the inclusion of the following: ➢ Is collaborative and non-hierarchical; ➢ Supports work and high levels of activity; ➢ Respects choice and control; and ➢ Provides access to social and peer support.

5.5 DOCUMENTATION

Documentation of members' progress in the Clubhouse modality differs from documentation requirements in individual treatment modalities and is demonstrated in the following process.

- Recovery progress can be documented in a variety of ways and, at a minimum, should be documented on at least a monthly basis.
- The documentation process, regardless of the established frequency or process, should be streamlined to minimally disrupt the work-ordered day.
- Progress note processing should be integrated into unit work.
- Members have the opportunity to write his or her own progress notes.
- Generally, all notes should be signed by both members and staff.

5.6 ELIGIBILITY

Clubhouse services are intended for beneficiaries with a primary diagnosis of serious mental illness. Clubhouse is not an appropriate service for beneficiaries with a primary intellectual/developmental disability.

Clubhouse services are not appropriate for beneficiaries who exhibit:

- Behaviors that would threaten or pose a current health and safety risk to themselves or others.
- A severity of symptoms requiring a more intensive level of treatment.
- Behaviors that disrupt the daily work of the Clubhouse.
- Behaviors that require excessive redirection and/or monitoring.

The Clubhouse director has the responsibility to ensure the safety of the Clubhouse.

All changes to a member's service provision must follow due process and all policies and procedures at local, state, and federal levels.

Discharge criteria are only met if the member moves on voluntarily or if one or more of the above criteria are met. Cessation or control of symptoms alone is not sufficient criteria for discharge from the Clubhouse.

5.7 Staff Capacity

Clubhouse staff effectively facilitate the program with direct, inclusive and collegial member involvement. Sufficient staffing ratios allow for employment development, Transitional Employment management/coverage, supported education, and consistent engagement of the membership throughout the work-ordered day.

Clubhouse staff shall include:

- One full-time on-site Clubhouse director who has a minimum of:
  - A bachelor's degree in a health or human services field and is licensed, certified or registered by the State of Michigan or a national organization to provide health care services, with two years' experience working at a Clubhouse accredited by Clubhouse International; or
  - A master's degree in a health or human services field with appropriate licensure and one year experience working at a Clubhouse.
- Other diverse and uniquely qualified professional staff, typically with a bachelor's education level. If staff are not licensed, certified or registered by the State of Michigan or a national organization to provide health care services, they shall operate under a qualified professional.

All Clubhouse staff function as generalists sharing Clubhouse duties such as employment, social recreation, evening, weekend, and holiday coverage. All Clubhouse generalist staff should be paid at a level commensurate with like staff at the auspice agency. The Clubhouse director is responsible for all aspects of Clubhouse operations. Members are actively involved in the hiring process for both directors and generalists. Exceptions may be requested to the above staffing requirements and/or qualifications and must be submitted in writing to MDHHS for review and potential approval.

5.8 Training Requirements

All Clubhouse staff must have a basic knowledge of the Clubhouse Model acquired through MDHHS approved Clubhouse-specific training within six months of hire, and then at least one MDHHS-approved Clubhouse specific training annually. In addition, as part of the accreditation process, the Clubhouse director, members, staff and other appropriate persons participate in a comprehensive training program in the Clubhouse Model at an accredited training base. This team will also schedule a six-month follow-up site visit with the Training Base Clubhouse.

- This training requires the development of an action plan for developing the Clubhouse; and upon returning from training, all Clubhouses will submit their action plan to MDHHS.
- Exceptions may be requested to the above training requirements and must be submitted in writing to MDHHS for review and potential approval.

SECTION 6 – CRISIS RESIDENTIAL SERVICES

Crisis residential services are intended to provide a short-term alternative to inpatient psychiatric services for beneficiaries experiencing an acute psychiatric crisis when clinically indicated. Services may only be used to avert an inpatient psychiatric admission, or to shorten the length of an inpatient stay.

6.1 POPULATION

Services are designed for a subset of beneficiaries who meet psychiatric inpatient admission criteria or are at risk of admission, but who can be appropriately served in settings less intensive than a hospital. The goal of crisis residential services is to facilitate reduction in the intensity of those factors that lead to crisis residential admission through a person-centered and recovery/resiliency-oriented approach.

6.2 COVERED SERVICES

Services must be designed to resolve the immediate crisis and improve the functioning level of the beneficiaries to allow them to return to less intensive community living as soon as possible.

The covered crisis residential services include:

- Psychiatric supervision;
- Therapeutic support services;
- Medication management/stabilization and education;
- Behavioral services;
- Milieu therapy; and
- Nursing services.

Individuals who are admitted to the crisis residential services must be offered the opportunity to explore and learn more about crises, substance abuse, identity, values, choices and choice-making, recovery and recovery planning. Recovery and recovery planning is inclusive of all aspects of life including relationships, where to live, training, employment, daily activities, and physical well-being.

6.2.A. CHILD CRISIS RESIDENTIAL SERVICES

Child Crisis Residential Services may not be provided to children with serious emotional disturbances in a Child Caring Institution (CCI) unless it is licensed as a "children's therapeutic group home" as defined in Section 722.111 Sec. 1(f) under Act No. 116 of the Public Acts of 1973, as amended. The program must include on-site nursing services (RN or LPN under appropriate supervision). On-site nursing must be provided at least one hour per day, per resident, seven days per week, with 24-hour availability on-call.

6.2.B. Adult Crisis Residential Services

The program must include on-site nursing services (RN or LPN under appropriate supervision).

- For settings of six beds or fewer: on-site nursing must be provided at least one hour per day, per resident, seven days per week, with 24-hour availability on-call.
- For 7-16 beds: on-site nursing must be provided eight hours per day, seven days per week, with 24-hour availability on-call.

6.3 Provider Criteria

The PIHP must seek and maintain MDHHS approval for the crisis residential program in order to use Medicaid funds for program services.

6.4 Qualified Staff [Change Made 4/1/18]

Treatment services must be clinically-supervised by a psychiatrist. A psychiatrist need not be present when services are delivered, but must be available by telephone at all times. The psychiatrist shall provide psychiatric evaluation or assessments at the crisis residential home or at an appropriate location in the community. A psychiatric evaluation completed by a treating psychiatrist that resulted in the admission to the program fulfills this requirement as long as the program psychiatrist has consulted with that physician as part of the admission process**.** Medication reviews performed at the crisis residential home must be performed by appropriately licensed medical personnel acting within their scope of practice and **(revised 4/1/18)** under the clinical supervision of the psychiatrist. The covered crisis residential services (refer to Covered Services subsection) must be supervised on-site eight hours a day, Monday through Friday (and on call at all other times), by a mental health professional possessing at least a master's degree in human services and one year of experience providing services to beneficiaries with serious mental illness, or a bachelor's degree in human services and at least two years of experience providing services to beneficiaries with serious mental illness.

Treatment activities may be carried out by paraprofessional staff who have at least one year of satisfactory work experience providing services to beneficiaries with mental illness, or who have successfully completed a PIHP/MDHHS-approved training program for working with beneficiaries with mental illness.

Peer support specialists may be part of the multidisciplinary team and can facilitate some of the activities based on their scope of practice, such as facilitating peer support groups, assisting in transitioning individuals to less intensive services, and by mentoring towards recovery.

6.5 Location of Services

Services must be provided to beneficiaries in licensed crisis residential foster care or group home settings not exceeding 16 beds in size. Homes/settings must have appropriate licensure from the state and must be approved by MDHHS to provide specialized crisis residential services. Services must not be provided in a hospital or other institutional setting.

6.6 Admission Criteria

Crisis residential services may be provided to adults or children who are assessed by, and admitted through, the authority of the local PIHP. Beneficiaries must meet psychiatric inpatient admission criteria but have symptoms and risk levels that permit them to be treated in such alternative settings. Services are designed for beneficiaries with mental illness or beneficiaries with mental illness and another concomitant disorder, such as substance abuse or developmental disabilities. For beneficiaries with a concomitant disorder, the primary reason for service must be mental illness.

6.7 Duration of Services

Services may be provided for a period up to 14 calendar days per crisis residential episode. Services may be extended and regularly monitored, if justified by clinical need, as determined by the interdisciplinary team.

6.8 Individual Plan of Service

Services must be delivered according to an individual plan based on an assessment of immediate need. The plan must be developed within 48 hours of admission and signed by the beneficiary (if possible), the parent or guardian, the psychiatrist, and any other professionals involved in treatment planning, as determined by the needs of the beneficiary. If the beneficiary has an assigned case manager, the case manager must be involved in the treatment as soon as possible, and must also be involved in follow-up services.

The plan must contain:

- Clearly stated goals and measurable objectives, derived from the assessment of immediate need, stated in terms of specific observable changes in behavior, skills, attitudes, or circumstances, structured to resolve the crisis.
- Identification of the activities designed to assist the beneficiary to attain his/her goals and objectives.
- Discharge plans, the need for aftercare/follow-up services, and the role of, and identification of, the case manager.

If the length of stay in the crisis residential program exceeds 14 days, an interdisciplinary team must develop a subsequent plan based on comprehensive assessments. The team is comprised of the beneficiary, the parent or guardian, the psychiatrist, the case manager and other professionals whose disciplines are relevant to the needs of the beneficiary, including the individual ACT team, outpatient services provider or home-based services staff, when applicable. If the beneficiary did not have a case manager prior to initiation of the intensive crisis residential service, and the crisis episode exceeds 14 days, a case manager must be assigned and involved in treatment and follow-up care. (The case manager may be assigned prior to the 14 days, according to need.)

For children's intensive crisis residential services, the plan must also address the child's needs in context with the family's needs. Educational services must also be considered and the plan must be developed in consultation with the child's school district staff.

SECTION 7 – HOME-BASED SERVICES

Mental health home-based services programs are designed to provide intensive services to children and their families with multiple service needs who require access to an array of mental health services. The primary goals of these programs are to support families in meeting their child's developmental needs, to support and preserve families, to reunite families who have been separated, and to provide effective treatment and community supports to address risks that may increase the likelihood of a child being placed outside the home. Treatment is based on the child's needs, with the focus on the family unit. The service style must support a family-driven and youth-guided approach, emphasizing strength-based, culturally relevant interventions, parent/youth and professional teamwork, and connection with community resources and supports.

NOTE: This service is a State Plan EPSDT service when delivered to children under 21 years of age.

7.1 PROGRAM APPROVAL

Applications for enrollment must identify home-based providers, either internal or contractual, who will serve children under 21 years of age. Home-based services can be provided by one or more providers who serve one or more age groups. Once enrolled, a program must re-enroll every three years. (Refer to the Directory Appendix for contact information.) MDHHS approval will be based on adherence to the requirements outlined below.

Applications for enrollment must identify the target population to be served by the program. Providers must assure that staff providing home-based services meet the required qualifications. Information submitted to MDHHS must include basic program information submitted in a format prescribed by MDHHS. If necessary during an initial period, the provider may receive provisional approval that will allow them to provide services. However, any necessary additional actions must be completed within the timeframe specified by MDHHS or provisional approval will be withdrawn.

Organizational Structure	The organizational structure through which the mental health home-based services program shall be delivered must be specified. The following requirements must be met: ▪ Enrolled home-based services providers are available and sufficient to ensure that home-based services are provided to children ages 0-17 and meet the need across the entire catchment area. ▪ Responsibility for directing, coordinating, and supervising the staff/program must be assigned to a specific staff position. The supervisor of the staff/program must meet the qualifications of a Qualified Mental Health Professional and be a child mental health professional with three years of clinical experience. ▪ One staff member or a team of staff may provide these services. Home-based services programs are designed to provide intensive services to children and families in their home and community. The degree of intensity will vary to meet the needs of families. ▪ The maximum full-time home-based services worker-to-family ratio is 1:12. This can be adjusted to accommodate families transitioning out of home-based services. The maximum worker-to-family ratio in those circumstances is 1:15 (12 active/3 transitioning). ▪ If providers wish to utilize clinicians who serve mixed caseloads (home-based services plus other services, e.g., outpatient, case management, etc.), the percentage of each position dedicated to home-based services must be specified. The number of home-based services cases assigned to each partial position cannot exceed the same percentage of the maximum active home-based services caseload. For example, a 50% home-based position could serve no more than 6 home-based cases. The total maximum caseload, including home-based and other services cases, for a full-time clinician serving a mixed caseload is 20 cases. ▪ To determine the appropriate caseload size for any home-based services worker, the intensity of service need presented by each family should be considered. The worker-to-family ratio can always be lower than the maximum to accommodate families with very high service needs. ▪ Home-based services staff must receive weekly clinical supervision (one-on-one and/or group) to help them navigate the intense needs of the families receiving home-based services. Evidence of the provision of this clinical supervision must be recorded via supervision logs, sign–in sheets, or other methods of documentation. ▪ The organization must have a policy or policies in place that support providing a comprehensive crisis/safety training curriculum that is required for all home-based services staff that includes de-escalation skills among other relevant trainings. ▪ There must be an internal mechanism for coordinating and integrating the home-based services with other mental health services, as well as general community services relevant to the needs of the child and family.

Qualified Staff	Properly credentialed staff must deliver home-based services. Home-based services professional staff must meet the qualifications of a child mental health professional. The initial training curriculum and 24 hours of annual child-specific training for home-based services staff should be relevant to the age groups served and the needs of the children and families receiving home-based services. For home-based services programs serving infants/toddlers (birth through age three) and their families, staff must be trained in infant mental health interventions and, effective October 1, 2009, must minimally have Endorsement Level 2 by the Michigan Association of Infant Mental Health; Level 3 is preferred. For home-based services programs serving children with developmental disabilities, the child mental health professional must meet the qualifications, as defined above, and also be a Qualified Intellectual Disability Professional (QIDP). Trained paraprofessional assistants may assist home-based services professional staff with implementation of treatment plan behavioral goals related to positive skill development and development of age-appropriate social behaviors. Services to be provided by the home-based services assistant must be identified in the family plan of service, must relate to identified treatment goals, and must be under the supervision of relevant professionals. Home-based services assistants must be trained regarding the beneficiary's treatment plan and goals, including appropriate intervention and implementation strategies, prior to beginning work with the beneficiary and family. Activities of home-based services assistants do not count as part of the minimum four hours of face-to-face home-based services provided by the primary home-based services worker per month. The home-based services assistant's face-to face time would be in addition to hours provided by the primary home-based services worker.
Plan of Service	Home-based services must be provided in accordance with a plan of service that focuses on the child and his family. The plan of service is a comprehensive plan that identifies child and family strengths and individual needs, determines appropriate interventions, and identifies supports and resources. It is developed in partnership with family members and other agencies through a person-centered, family-driven and youth-guided planning process. The plan of service should include evidence of a blending of perspectives and information from the child/youth, family, home-based services worker, assessment tools, and other relevant parties. Goals should be based on family needs and priorities and reflect the family culture and voice. Refer to the Family-Driven and Youth-Guided Policy and Practice Guideline (attached to the MDHHS/PIHP contract) for more explicit information on this topic. The plan of service for youth receiving home-based services must also include individualized crisis and safety plans that explicitly outline responses to family-specific crisis situations and safety risks and delineate who, including the family and others, is accountable for the various responses identified.

Amount and Scope of Service	Home-based services programs combine services to restore or enhance social, psychological, or biophysical functioning of individuals, couples, or families and/or individual therapy, family therapy, group therapy, crisis intervention, case management, and collateral contacts. The family is defined as immediate or extended family or individual(s) acting in the role of family. Services provided in a home-based services program range from assisting beneficiaries to link to other resources that might provide food, housing, and medical care, as well as providing more therapeutic interventions such as family therapy or individual therapy, or services to restore or enhance functioning for individuals, couples, or families. A minimum of four hours of individual and/or family face-to-face home-based services per month will be provided by the primary home-based services worker or, if appropriate, the evidence-based practice therapist. In addition, it is expected that adequate collateral contacts, including non-face-to-face collateral contacts, with school, caregivers, child welfare, court, psychiatrist, etc., will be provided to implement the plan of service. The amount and scope of home-based services to families as they transition out of home-based services into a less intensive service or to case closure can be determined by family-driven and youth-guided decision making to maintain continuity of treatment and ensure stability. Variation from the required intensity of services for families transitioning out of home-based services must be documented in the plan of service. This transition period is not to exceed three months. Crisis intervention services must be available 24 hours a day, 7 days a week, via availability of home-based services staff or agency on-call staff. If after-hours crisis intervention services are provided to a family by staff other than the primary home-based services worker, procedures must be in place which provide the on-call staff access to information about any impending crisis situations and the family's crisis and safety plans.
Location of Service	Services are provided in the family home or community. Any contacts that occur other than in the home or community must be clearly explained in case record documentation as to the reason, the expected duration, and the plan to address issues that are preventing the services from being provided in the home or community.

7.2 ELIGIBILITY CRITERIA

The criteria for home-based services are described below for children birth through age three, children age four through age six, and children age seven through age seventeen. These criteria do not preclude the provision of home-based services to an adult beneficiary who is a parent for whom it is determined home-based services would be the treatment modality that would best meet the needs of the adult beneficiary and the child. This would include a parent who has a diagnosis within the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or International Classification of Diseases (ICD) that results in a care-giving environment that places the child at-risk for serious emotional disturbance. These criteria do not preclude the provision of home-based services when it is determined through a person-centered, family-driven and youth-guided planning process that these services are necessary to meet the needs of the child and family. For continuing eligibility reviews during the transition to less intensive services, the child and family may be maintained in home-based services, even if they do not meet these criteria. Variation from the required criteria for families transitioning out of home-based services must be documented in the plan of service. This transition period is not to exceed three months.

7.2.A. Birth Through Age Three

Unique criteria must be applied to define serious emotional disturbance for the birth to age three population, given:

- The magnitude and speed of developmental changes through pregnancy and infancy;
- The limited capacity of the very young to symptomatically present underlying disturbances;
- The extreme dependence of infants and toddlers upon caregivers for their survival and well-being; and
- The exceptional vulnerability of the very young to other relationship and environmental factors.

Operationally, the above parameters dictate that the mental health professional must be cognizant of the primary indicators of emotional disorder in very young children, and of the importance of assessing the constitutional/physiological and/or care-giving/ environmental factors which reinforce the severity and intractability of the child's disorder. Furthermore, the rapid development of very young children results in transitory disorders and/or symptoms, requiring the professional to regularly re-assess children in the appropriate developmental context.

The following is the recommended procedure for determining when a beneficiary is considered seriously emotionally disturbed or at high risk for serious emotional disturbance, qualifying for Mental Health Home-Based Services. All of the dimensions must be considered when determining if a child is eligible for home-based services.

Diagnosis	A child has an intellectual, behavioral, or emotional disorder sufficient to meet diagnostic criteria (specified within the current version of the DSM or ICD consistent with the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood; Revised Edition) not solely the result of an intellectual disability or other developmental disability, drug abuse/alcoholism or those with an ICD-9 V-code or ICD 10 Z-code diagnosis, and the beneficiary meets the criteria listed below for degree of disability/functional impairment and duration/service history.

Functional Impairment	Substantial interference with, or limitation of, the child's proficiency in performing age-appropriate skills as demonstrated by at least one indicator drawn from one of the following areas: ▪ General and/or specific patterns of reoccurring behaviors or expressiveness indicating affect/modulation problems, e.g., uncontrollable crying or screaming, sleeping and eating disturbances, and recklessness; the absence of developmentally expectable affect, such as pleasure, displeasure, joy, anger, fear, curiosity; apathy toward environment and caregiver. ▪ Distinct behavioral patterns coupled with sensory, sensory motor, or organizational processing difficulty (homeostasis concerns) that inhibits the child's daily adaptation and interaction/relationships. For example, a restricted range of exploration and assertiveness, dislike for changes in routine, and/or a tendency to be frightened and clinging in new situations, coupled with over-reactivity to loud noises or bright lights, inadequate visual-spatial processing ability, etc. ▪ Incapacity to obtain critical nurturing (often in the context of attachment-separation concerns), as determined through the assessment of child, caregiver and environmental characteristics. For example, the infant shows a lack of motor skills and/or language expressiveness; appears diffuse, unfocused and undifferentiated; expresses anger/obstinacy and whines, in the presence of a caregiver who often interferes with the infant's goals and desires, dominates the infant through over-control, does not reciprocate to the child's gestures, and/or whose anger, depression or anxiety results in inconsistent care giving. An assessment tool specifically targeting social-emotional functioning which can assist in determining functional impairment is the Devereux Early Childhood Assessment, Infant/Toddler or Preschool Version. Observational tools to assist in the assessment of infants, toddlers and their caregiver include the Massie Campbell Attachment During Stress (birth to 18 months of age) and Parenting Interactions with Children: Checklist of Observations Linked to Outcomes (PICCOLO) (for young children from 12 to 36 months). Other assessment tools may be utilized by the practitioner based on the needs of the infant/toddler or parent(s).
Duration/History	The very young age and rapid transition of infants and toddlers through developmental stages makes consistent symptomatology over time unlikely. However, indicators that a disorder is not transitory and will endure without intervention include: ▪ The infant/toddler disorder(s) is affected by persistent multiple barriers to normal development (regulatory disorders, inconsistent care giving, chaotic environment, etc.); or ▪ Infant/toddler did not respond to less intensive, less restrictive intervention.

7.2.B. AGE FOUR THROUGH SIX

Decisions regarding whether a child age four through six is seriously emotionally disturbed and in need of home-based services and supports utilize similar dimensions to older children. The dimensions include a diagnosable behavioral or emotional disorder, substantial functional impairment/limitation of major life activities, and duration of condition. However, as with younger children birth through age three, assessment must be sensitive to the critical indicators of development and functional impairment for the age group. Significant impairments in functioning are revealed across life domains in the

child's expression of affect/self-regulation, social development (generalization of attachment beyond parents, capacity for peer relationships and play, etc.), physical and cognitive development, and the emergence of a sense of self. All of the dimensions must be considered when determining if a child is eligible for home-based services.

Diagnosis	A child has an intellectual, behavioral or emotional disorder sufficient to meet diagnostic criteria specified within the current version of the DSM or ICD not solely the result of an intellectual disability or other developmental disability, drug abuse/alcoholism or those with an ICD-9 V-code or ICD-10 Z-code diagnosis, and the beneficiary meets the criteria listed below for degree of disability/functional impairment and duration/service history.
Functional Impairment	Substantial interference with, or limitation of, the child's proficiency in performing age-appropriate skills across domains and/or consistently within specific domains as demonstrated by at least one indicator drawn from at least two of the following areas: ▪ Impaired physical development, sensory, sensory motor or organizational processing difficulty, failure to control bodily functions (e.g., bed wetting). ▪ Limited cognitive development, as indicated by restricted vocabulary, memory, cause and effect thinking, ability to distinguish between real and pretend, transitioning from self-centered to more reality-based thinking, etc. ▪ Limited capacity for self-regulation, inability to control impulses and modulate anxieties as indicated by frequent tantrums or aggressiveness toward others, prolonged listlessness or depression, inability to cope with separation from primary caregiver, inflexibility and low frustration tolerance, etc. ▪ Impaired or delayed social development, as indicated by an inability to engage in interactive play with peers, inability to maintain placements in day care or other organized groups, failure to display social values or empathy toward others, absence of imaginative play or verbalizations commonly used by preschoolers to reduce anxiety or assert order/control on their environment, etc. ▪ Care-giving factors which reinforce the severity or intractability of the childhood disorder and the need for multifaceted intervention strategies (e.g., home-based services) such as a chaotic household/constantly changing care-giving environments, inappropriate caregiver expectations, abusive/neglectful or inconsistent care-giving, occurrence of traumatic events, subjection to others' violent or otherwise harmful behavior. The standardized assessment tool specifically targeting social-emotional functioning for children 4 through 6 years of age recommended for use in determining degree of functional impairment is the Pre-School and Early Childhood Functional Assessment Scale (PECFAS). Additional assessment tools may be utilized based on the needs of the child and/or parent(s).
Duration/History	The following specify length of time criteria for determining when the child's functional disabilities justify his referral for enhanced support services: ▪ Evidence of three continuous months of illness; ▪ Three cumulative months of symptomatology/dysfunction in a six-month period; or ▪ Conditions that are persistent in their expression and are not likely to change without intervention.

7.2.C. Age Seven Through Seventeen

NOTE: For EPSDT, this same criteria should be utilized to determine eligibility for home-based services for young adults ages 18-21.

Decisions regarding whether a child or adolescent has a serious emotional disturbance and is in need of home-based services is determined by using the following dimensions: the child has a diagnosable behavioral or emotional disorder, substantial functional impairment/limitation of major life activities, and duration of the condition. For children age seven through seventeen, the Child and Adolescent Functional Assessment Scale (CAFAS) is used to make discriminations within the functional impairment dimension. All of the dimensions, as well as family voice and choice, must be considered when determining if a child is eligible for home-based services.

Diagnosis	The child/adolescent currently has, or had at any time in the past, a diagnosable behavioral or emotional disorder of sufficient duration to meet diagnostic criteria specified within the current version of the DSM or ICD, excluding those with a diagnosis other than, or in addition to, alcohol or drug disorders, a developmental disorder, or social conditions (ICD-9 V-codes and ICD-10 Z-codes).
Functional Impairment	For purposes of qualification for home-based services, children/adolescents may be considered markedly or severely functionally impaired if the minor has: ▪ An elevated subscale score (20 or greater) on at least two elements of the Child/Adolescent Section of the CAFAS; or ▪ An elevated subscale score (20 or greater) on one element of the CAFAS Child/Adolescent Section, combined with an elevated subscale score (20 or greater) on at least one CAFAS element involving Caregiver/Care-giving Resources; or ▪ A total impairment score of 80 or more on the CAFAS Child/Adolescent Section.
Duration/History	The following specify the length of time the youth's functional disability has interfered with his daily living and led to his referral for home-based services: ▪ Evidence of six continuous months of illness, symptomatology, or dysfunction; ▪ Six cumulative months of symptomatology/dysfunction in a 12-month period; or ▪ On the basis of a specific diagnosis (e.g., schizophrenia), disability is likely to continue for more than one year.

SECTION 8 – INPATIENT PSYCHIATRIC HOSPITAL ADMISSIONS

The PIHP is responsible to manage and pay for Medicaid mental health services in community-based psychiatric inpatient units for all Medicaid beneficiaries who reside within the service area covered by the PIHP. This means that the PIHP is responsible for timely screening and authorization/certification of requests for admission, notice and provision of several opinions, and continuing stay for inpatient services, defined as follows:

- **Screening** means the PIHP has been notified of the beneficiary and has been provided enough information to make a determination of the most appropriate services. The screening may be provided on-site, face-to-face by PIHP personnel, or over the telephone.
- **Authorization/certification** means that the PIHP has screened the beneficiary and has approved the services requested. Telephone screening must be followed-up by the written certification.

PIHP responsibilities include:

- Pre-admission screening to determine whether alternative services are appropriate and available. Severity of Illness and Intensity of Service clinical criteria will be used for such pre-screening. Inpatient pre-screening services must be available 24-hours-a-day, seven-days-a-week.
- Provision of notice regarding rights to a second opinion in the case of denials.
- Coordination with substance abuse treatment providers, when appropriate.
- Provision of, or referral to and linkage with, alternative services, when appropriate.
- Communication with the treating and/or referring provider.
- Communication with the primary care physician or health plan.
- Planning in conjunction with hospital personnel for the beneficiary's after-care services.

In most instances, the beneficiary will receive services in a community-based psychiatric unit in the PIHP service area where he resides. There may be instances when a PIHP is responsible for a resident that they have placed into a community program in another county or state. In these cases, the responsible PIHP, i.e., the one managing the case, is responsible for authorizing admission and/or continuing stay.

If a beneficiary experiences psychiatric crisis in another county, the PIHP in that county should provide crisis intervention/services as needed and contact the PIHP for the county of the beneficiary's residence for disposition.

8.1 ADMISSIONS

The PIHPs will make authorization and approval decisions for these services according to Level of Care guidelines established by MDHHS and appearing in this section. All admission and continuing stay responsibilities and procedures must be conducted in accordance with the terms of the contract between the hospital and the PIHP.

Emergency Room Services	When necessary, the beneficiary may seek services through the emergency room. Disposition of the psychiatric emergency will be the responsibility of the PIHP and may result in: ▪ Inpatient admission; ▪ Referral to an alternative service when appropriate and available; or ▪ Disposition of the crisis through provision of immediate services/interventions, with follow-up as necessary. The PIHP is involved in the psychiatric aspect of the emergency situation. Any medical treatment needed by the beneficiary is beyond the general purview of the PIHP.
Admissions to In-State Out-of-Area Hospitals	Medicaid beneficiaries may seek inpatient psychiatric services from hospitals located outside their county of residence/PIHP catchment area. If the out-of-area hospital has a contract with the beneficiary's county/catchment area PIHP, the hospital should contact that PIHP to obtain the required pre-admission authorization/approval for the beneficiary. If the out-of-area hospital does not have a contract with the beneficiary's designated county/catchment area PIHP, the hospital must contact the PIHP that serves the county in which the hospital is located to obtain pre-admission approval/authorization. The hospital-area PIHP will conduct the pre-admission review and will consult with the designated county/catchment area PIHP to determine the appropriate disposition of the request for admission authorization/approval. Payment responsibility for authorized days of care will rest with the PIHP that authorized the services.
Admission to Out-of-State Non-Borderland Inpatient Psychiatric Hospitals	The PIHP for the beneficiary's county of residency must prior authorize the admission for psychiatric inpatient care as medically necessary, as with in-state hospitals. The PIHP is responsible for continued stay reviews and payment to these hospitals.

8.2 APPEALS

PIHPs will make authorization and approval decisions for services according to Level of Care guidelines. If the hospital disagrees with the decision of the PIHP, regarding either admission authorization/approval or the number of authorized days of care, the hospital may appeal to the PIHP according to the terms of its contract with the PIHP. If the hospital does not have a contract or agreement with the PIHP, any appeals by the hospital will be conducted through the usual and customary procedures that the PIHP employs in its contracts with other enrolled hospital providers.

If a beneficiary or his legal representative disagrees with a PIHP decision related to admission authorization/approval or approved days of care, he may request a reconsideration and second opinion from the PIHP. If the PIHP's initial decision is upheld, the beneficiary has further redress through the Medicaid fair hearing process. Medicaid beneficiaries can request the Medicaid fair hearing without going through local review processes.

8.3 BENEFICIARIES WHO DO NOT HAVE MEDICAID ELIGIBILITY UPON ADMISSION

For beneficiaries whose enrollment in Medicaid is determined after the end of an episode of inpatient psychiatric or partial hospitalization care (eligibility extends back and encompasses the dates of the episode of care), the PIHP will conduct a retrospective review of the episode of care to determine if services were medically necessary and appropriate for Medicaid reimbursement, unless the PIHP has previously reviewed and certified the admission and authorized days of care under other contractual and

payment arrangements with the hospital. If the PIHP has conducted the pre-admission authorization and continuing stay reviews for these beneficiaries during the episode of care, this will be considered as a certification that authorized services are eligible for reimbursement by the PIHP under the Medicaid program once the beneficiary's retroactive Medicaid eligibility has been established.

As noted above, the purpose of a retrospective review is to determine if services rendered were medically necessary and hence qualify for Medicaid reimbursement. Since the hospital will not receive reimbursement for any care rendered which does not meet the test of medical necessity, it is advantageous for hospitals to involve PIHPs during the episode of care for any beneficiary that the facility believes may be eligible for Medicaid.

8.4 MEDICARE

For Medicare-covered services, the PIHP may only pay up to a Medicare-enrolled beneficiary's obligation to pay (i.e., coinsurance and deductibles). (Refer to the Coordination of Benefits Chapter in this manual for more information.)

8.5 ELIGIBILITY CRITERIA

8.5.A. INPATIENT PSYCHIATRIC AND PARTIAL HOSPITALIZATION SERVICES

Medicaid requires that hospitals providing inpatient psychiatric services or partial hospitalization services obtain authorization and certification of the need for admission and continuing stay from PIHPs. A PIHP reviewer determines authorization and certification by applying criteria outlined in this document. The hospital or attending physician may request a reconsideration of adverse authorization/certification determinations made by the initial PIHP reviewer.

The criteria described below employ the concepts of Severity of Illness (SI) and Intensity of Service (IS) to assist reviewers in determinations regarding whether a particular care setting or service intensity is appropriately matched to the beneficiary's current condition.

- Severity of Illness (SI) refers to the nature and severity of the signs, symptoms, functional impairments and risk potential related to the beneficiary's psychiatric disorder.
- Intensity of Service (IS) refers to the setting of care, to the types and frequency of needed services and supports, and to the degree of restrictiveness necessary to safely and effectively treat the beneficiary.

Medicaid coverage for inpatient psychiatric services is limited to beneficiaries with a current primary psychiatric diagnosis, as described in the criteria below. It is recognized that some beneficiaries will have other conditions or disorders (e.g., developmental disabilities or substance abuse) that coexist with a psychiatric disturbance. In regard to developmental disabilities, if a person with developmental disabilities presents with signs or symptoms of a significant, serious, concomitant mental illness, the mental illness will take precedence for purposes of care and placement decisions, and the beneficiary may be authorized/certified for inpatient psychiatric care under these guidelines.

For beneficiaries who present with psychiatric symptoms associated with current active substance abuse, it may be difficult to determine whether symptoms exhibited are due to

a primary mental illness or represent a substance-induced disorder, and to make an informed level of care placement decision. A beneficiary exhibiting a psychiatric disturbance in the context of current active substance use or intoxication may require acute detoxification services before an accurate assessment of the need for psychiatric inpatient services can be made. In these situations, the hospital and the PIHP must confer to determine the appropriate location (acute medical setting or psychiatric unit) for the detoxification services.

The crucial consideration in initial placement decisions for a beneficiary with psychiatric symptoms associated with current active substance abuse is whether the beneficiary's immediate treatment needs are primarily medical or psychiatric. If the beneficiary's primary need is medical (e.g., life-threatening substance-induced toxic conditions requiring acute medical care and detoxification), then detoxification in an acute medical setting (presuming the beneficiary's condition meets previously published acute care detoxification criteria) is indicated. If the beneficiary's primary need is psychiatric care (the person meets the SI/IS criteria for inpatient psychiatric care), they should be admitted to the psychiatric unit and acute medical detoxification provided in that setting.

Hospitals are reminded that they must obtain PIHP admission authorization and certification for all admissions to a distinct part psychiatric unit or freestanding psychiatric hospital.

8.5.B. Inpatient Admission Criteria: Adults

Inpatient psychiatric care may be used to treat a person with mental illness who requires care in a 24-hour medically structured and supervised facility. The SI/IS criteria for admission are based upon the assumption that the beneficiary is displaying signs and symptoms of a serious psychiatric disorder, demonstrating functional impairments, and manifesting a level of clinical instability (risk) that, either individually or collectively, are of such severity that treatment in an alternative setting would be unsafe or ineffective.

Medicaid coverage is dependent upon active treatment being provided at the medically necessary level of care.

The individual must meet all three criteria outlined in the following table:

Diagnosis	The beneficiary must be suffering from a mental illness reflected in a primary, validated, current version of DSM or ICD diagnosis (not including ICD-9 V-codes and ICD-10 Z-codes).
Severity of Illness (signs, symptoms, functional impairments and risk potential)	At least **one** of the following manifestations is present: ▪ Severe Psychiatric Signs and Symptoms ➢ Psychiatric symptoms - features of intense cognitive/perceptual/affective disturbance (hallucinations, delusions, extreme agitation, profound depression) severe enough to cause seriously disordered and/or bizarre behavior (e.g., catatonia, mania, incoherence) or prominent psychomotor retardation, resulting in extensive interference with activities of daily living, so that the person cannot function at a lower level of care.

- Disorientation, seriously impaired reality testing, defective judgment, impulse control problems and/or memory impairment severe enough to endanger the welfare of the person and/or others.
- A severe, life-threatening psychiatric syndrome or an atypical or unusually complex psychiatric condition exists that has failed, or is deemed unlikely, to respond to less intensive levels of care, and has resulted in substantial current dysfunction.

- Disruptions of Self-Care and Independent Functioning
  - The person is unable to attend to basic self-care tasks and/or to maintain adequate nutrition, shelter, or other essentials of daily living due to psychiatric disorder.
  - There is evidence of serious disabling impairment in interpersonal functioning (e.g., withdrawal from relationships; repeated conflictual interactions with family, employer, co-workers, neighbors) and/or extreme deterioration in the person's ability to meet current educational/occupational role performance expectations.
- Harm to Self
  - Suicide: Attempt or ideation is considered serious by the intention, degree of lethality, extent of hopelessness, degree of impulsivity, level of impairment (current intoxication, judgment, psychological symptoms), history of prior attempts, and/or existence of a workable plan.
  - Self-Mutilation and/or Reckless Endangerment: There is evidence of current behavior, or recent history. There is a verbalized threat of a need or willingness to self-mutilate, or to become involved in other high-risk behaviors; and intent, impulsivity, plan and judgment would suggest an inability to maintain control over these ideations.
  - Other Self-Injurious Activity: The person has a recent history of drug ingestion with a strong suspicion of overdose. The person may not need detoxification but could require treatment of a substance-induced psychiatric disorder.
- Harm to Others
  - Serious assaultive behavior has occurred, and there is a risk of escalation or repetition of this behavior in the near future.
  - There is expressed intention to harm others and a plan and/or means to carry it out, and the level of impulse control is non-existent or impaired (due to psychotic symptoms, especially command or verbal hallucinations, intoxication, judgment, or psychological symptoms, such as persecutory delusions and paranoid ideation).
- Drug/Medication Complications or Coexisting General Medical Condition Requiring Care
  - There has been significant destructive behavior toward property that endangers others.
  - The person has experienced severe side effects from using therapeutic psychotropic medications.

	➢ The person has a known history of psychiatric disorder that requires psychotropic medication for stabilization of the condition, and the administration, adjustment or reinitiation of medications requires close and continuous observation and monitoring, and this cannot be accomplished at a lower level of care due to the beneficiary's condition or to the nature of the procedures involved. ➢ There are concurrent significant physical symptoms or medical disorders which necessitate evaluation, intensive monitoring and/or treatment during medically necessary psychiatric hospitalization, and the coexisting general medical condition would complicate or interfere with treatment of the psychiatric disorder at a less intensive level of care. **Special Consideration: Concomitant Substance Abuse -** The underlying or existing psychiatric diagnosis must be the primary cause of the beneficiary's current symptoms or represent the primary reason observation and treatment is necessary in the psychiatric unit or hospital setting.
Intensity of Service	The person meets the intensity of service requirements if inpatient services are considered medically necessary for the beneficiary's treatment/diagnosis, and if the person requires at least **one** of the following: ▪ Close and continuous skilled medical observation and supervision are necessary to make significant changes in psychotropic medications. ▪ Close and continuous skilled medical observation is necessary due to otherwise unmanageable side effects of psychotropic medications. ▪ Continuous observation and control of behavior (e.g., isolation, restraint, closed unit, suicidal/homicidal precautions) is needed to protect the beneficiary, others, and/or property, or to contain the beneficiary so that treatment may occur. ▪ A comprehensive multi-modal therapy plan is needed, requiring close medical supervision and coordination, due to its complexity and/or the severity of the beneficiary's signs and symptoms.

8.5.C. Inpatient Admission Criteria: Children Through Age 21

Inpatient psychiatric care may be used to treat a child or adolescent with mental illness or serious emotional disturbance who requires care in a 24-hour medically structured and supervised facility. The SI/IS criteria for admission are based on the assumption that the beneficiary is displaying signs and symptoms of a serious psychiatric disorder, demonstrating functional impairments and manifesting a level of clinical instability (risk) that are, either individually or collectively, of such severity that treatment in an alternative setting would be unsafe or ineffective.

Medicaid coverage is dependent upon active treatment being provided at the medically necessary level of care.

The individual must meet all three criteria outlined in the table below:

Diagnosis	The beneficiary must be suffering from a mental illness reflected in a primary, validated, current version of DSM or ICD diagnosis (not including ICD-9 V-codes and ICD-10 Z-codes).

Severity of Illness (signs, symptoms, functional impairments and risk potential)	At least **one** of the following manifestations is present: ▪ Severe Psychiatric Signs and Symptoms ➢ Psychiatric symptoms - features of intense cognitive/perceptual/affective disturbance (hallucinations, delusions, extreme agitation, profound depression) - severe enough to cause disordered and/or bizarre behavior (e.g., catatonia, mania, incoherence) or prominent psychomotor retardation, resulting in extensive interference with activities of daily living, so that the person cannot function at a lower level of care. ➢ Disorientation, impaired reality testing, defective judgment, impulse control problems and/or memory impairment severe enough to endanger the welfare of the person and/or others. ➢ Severe anxiety, phobic symptoms or agitation, or ruminative/obsessive behavior that has failed, or is deemed unlikely, to respond to less intensive levels of care and has resulted in substantial current dysfunction. ▪ Disruptions of Self-Care and Independent Functioning ➢ Beneficiary is unable to maintain adequate nutrition or self care due to a severe psychiatric disorder. ➢ The beneficiary exhibits significant inability to attend to age-appropriate responsibilities, and there has been a serious deterioration/impairment of interpersonal, familial, and/or educational functioning due to an acute psychiatric disorder or severe developmental disturbance. ▪ Harm to Self ➢ A suicide attempt has been made which is serious by degree of lethal intent, hopelessness, or impulsivity. ➢ There is a specific plan to harm self with clear intent and/or lethal potential. ➢ There is self-harm ideation or threats without a plan, which are considered serious due to impulsivity, current impairment or a history of prior attempts. ➢ There is current behavior or recent history of self-mutilation, severe impulsivity, significant risk-taking or other self-endangering behavior. ➢ There is a verbalized threat of a need or willingness to self-mutilate, or to become involved in other high-risk behaviors; and intent, impulsivity, plan and judgment would suggest an inability to maintain control over these ideations. ➢ There is a recent history of drug ingestion with a strong suspicion of intentional overdose. The person may not need detoxification but could require treatment of a substance-induced psychiatric disorder. ▪ Harm to Others ➢ Serious assaultive behavior has occurred and there is a clear risk of escalation or repetition of this behavior in the near future.

	➢ There is expressed intention to harm others and a plan and means to carry it out; the level of impulse control is non-existent or impaired. ➢ There has been significant destructive behavior toward property that endangers others, such as setting fires. ➢ The person has experienced severe side effects from using therapeutic psychotropic medications. ▪ Drug/Medication Complications or Coexisting General Medical Condition Requiring Care ➢ The person has a known history of psychiatric disorder that requires psychotropic medication for stabilization of the condition, and the administration, adjustment or reinitiation of medications requires close and continuous observation and monitoring, and this cannot be accomplished at a lower level of care due to the beneficiary's condition or to the nature of the procedures involved. ➢ There are concurrent significant physical symptoms or medical disorders which necessitate evaluation, intensive monitoring and/or treatment during medically necessary psychiatric hospitalization, and the coexisting general medical condition would complicate or interfere with treatment of the psychiatric disorder at a less intensive level of care. **Special Consideration: Concomitant Substance Abuse -** The underlying psychiatric diagnosis must be the primary cause of the beneficiary's current symptoms or represents the primary reason observation and treatment are necessary in the hospital setting.
Intensity of Service	The person meets the intensity of service requirements if inpatient services are considered medically necessary and if the person requires at least **one** of the following: ▪ Close and continuous skilled medical observation and supervision are necessary to make significant changes in psychotropic medications. ▪ Close and continuous skilled medical observation is needed due to otherwise unmanageable side effects of psychotropic medications. ▪ Continuous observation and control of behavior (e.g., isolation, restraint, closed unit, suicidal/homicidal precautions) to protect the beneficiary, others, and/or property, or to contain the beneficiary so that treatment may occur. ▪ A comprehensive multi-modal therapy plan is needed, requiring close medical supervision and coordination, due to its complexity and/or the severity of the beneficiary's signs and symptoms.

8.5.D. Inpatient Psychiatric Care – Continuing Stay Criteria: Adults, Adolescents and Children

After a beneficiary has been certified for admission to an inpatient psychiatric setting, services must be reviewed at regular intervals to assess the current status of the treatment process and to determine the continued necessity for care in an inpatient setting. Treatment within an inpatient psychiatric setting is directed at stabilization of incapacitating signs or symptoms, amelioration of severely disabling functional impairments, arrestment of potentially life-threatening self/other harm inclinations, management of adverse biologic reactions to treatment and/or regulation of complicated

medication situations. The continuing stay recertification process is designed to assess the efficacy of the treatment regime in addressing these concerns, and to determine whether the inpatient setting remains the most appropriate, least restrictive, level of care for treatment of the beneficiary's problems and dysfunctions.

Continuing treatment in an inpatient setting may be certified when signs, symptoms, behaviors, impairments, harm inclinations or biologic/medication complications, similar to those which justified the beneficiary's admission certification, remain present, and continue to be of such a nature and severity that inpatient psychiatric treatment is still medically necessary. It is anticipated that in those reviews which fall near the end of an episode of care, these problems and dysfunctions will have stabilized or diminished.

Discharge planning must begin at the onset of treatment in the inpatient unit. Payment cannot be authorized for continued stays that are due solely to placement problems or the unavailability of aftercare services.

The individual must meet all three criteria outlined in the following table:

Diagnosis	The beneficiary has a validated current version of DSM or ICD mental disorder (excluding ICD-9 V-codes and ICD-10 Z-codes) that remains the principal diagnosis for purposes of care during the period under review.
Severity of Illness (signs, symptoms, functional impairments and risk potential)	▪ Persistence/intensification of signs/symptoms, impairments, harm inclinations or biologic/medication complications which necessitated admission to this level of care, and which cannot currently be addressed at a lower level of care. ▪ Continued severe disturbance of cognition, perception, affect, memory, behavior or judgment. ▪ Continued gravely disabling or incapacitating functional impairments or severely and pervasively impaired personal adjustment. ▪ Continued significant self/other harm risk. ▪ Use of psychotropic medication at dosage levels necessitating medical supervision, dosage titration of medications requiring skilled observation, or adverse biologic reactions requiring close and continuous observation and monitoring. ▪ Emergence of new signs/symptoms, impairments, harm inclinations or medication complications meeting admission criteria.
Intensity of Service	▪ The beneficiary requires close observation and medical supervision due to the severity of signs and symptoms, to control risk behaviors or inclinations, to assure basic needs are met or to manage biologic/medication complications. ▪ The beneficiary is receiving active, timely, treatment delivered according to an individualized plan of care. ▪ Active treatment is directed toward stabilizing or diminishing those symptoms, impairments, harm inclinations or biologic/medication complications that necessitated admission to inpatient care.

	▪ The beneficiary is making progress toward treatment goals as evidenced by a measurable reduction in signs/symptoms, impairments, harm inclinations or biologic/medication complications or, if no progress has been made, there has been a modification of the treatment plan and therapeutic program, and there is a reasonable expectation of a positive response to treatment.

Discharge criteria and aftercare planning are documented in the beneficiary's record.

SECTION 9 – INTENSIVE CRISIS STABILIZATION SERVICES

9.1 ADULT SERVICES

Intensive crisis stabilization services are structured treatment and support activities provided by a multidisciplinary team and designed to provide a short-term alternative to inpatient psychiatric services. Services may be used to avert a psychiatric admission or to shorten the length of an inpatient stay when clinically indicated.

A crisis situation means a situation in which an individual is experiencing a serious mental illness or a developmental disability and one of the following applies:

- The individual can reasonably be expected within the near future to physically injure himself or another individual, either intentionally or unintentionally.
- The individual is unable to provide himself clothing, or shelter, or to attend to basic physical activities such as eating, toileting, bathing, grooming, dressing, or ambulating, and this inability may lead in the near future to harm to the individual or to another individual.
- The individual's judgment is so impaired that he is unable to understand the need for treatment and, in the opinion of the mental health professional, his continued behavior, as a result of the mental illness, developmental disability, or emotional disturbance, can reasonably be expected in the near future to result in physical harm to the individual or to another individual.

9.1.A. APPROVAL

The PIHP must seek and maintain MDHHS approval for the intensive crisis stabilization services in order to use Medicaid funds for program services.

9.1.B. POPULATION

These services are for beneficiaries who have been assessed to meet criteria for psychiatric hospital admissions but who, with intense interventions, can be stabilized and served in their usual community environments. These services may also be provided to beneficiaries leaving inpatient psychiatric services if such services will result in a shortened inpatient stay.

Beneficiaries must have a diagnosis of mental illness or mental illness with a co-occurring substance use disorder or developmental disability.

9.1.C. SERVICES

Intensive crisis services are intensive treatment interventions delivered by an intensive crisis stabilization treatment team under the supervision of a psychiatrist. Component services include:

- Intensive individual counseling/psychotherapy;
- Assessments (rendered by the treatment team);

- Family therapy;
- Psychiatric supervision; and
- Therapeutic support services by trained paraprofessionals.

9.1.D. Qualified Staff

Intensive crisis services must be provided by a treatment team of mental health professionals under the supervision of a psychiatrist. The psychiatrist need not provide on-site supervision at all times, but must be available by telephone at all times. The treatment team providing intensive crisis stabilization services must be mental health professionals. Nursing services/consultation must be available.

The treatment team may be assisted by trained paraprofessionals under appropriate supervision. The trained paraprofessionals must have at least one year of satisfactory work experience providing services to beneficiaries with serious mental illness. Activities of the trained paraprofessionals include assistance with therapeutic support services. In addition, the team may include one or more peer support specialists.

9.1.E. Location of Services

Intensive crisis stabilization services may be provided where necessary to alleviate the crisis situation, and to permit the beneficiary to remain in, or return more quickly to, his usual community environment. Intensive crisis stabilization services must not be provided exclusively or predominantly at residential programs.

Exceptions: Intensive crisis stabilization services may not be provided in:

- Inpatient settings;
- Jails or other settings where the beneficiary has been adjudicated; or
- Crisis residential settings.

9.1.F. Individual Plan of Service

Intensive crisis stabilization services may be provided initially to alleviate an immediate or serious psychiatric crisis. However, following resolution of the immediate situation (and within no more than 48 hours), an intensive crisis stabilization services treatment plan must be developed. The intensive crisis stabilization treatment plan must be developed through a person-centered planning process in consultation with the psychiatrist. Other professionals may also be involved if required by the needs of the beneficiary. The case manager (if the beneficiary receives case management services) must be involved in the treatment and follow-up services.

The individual plan of service must contain:

- Clearly stated goals and measurable objectives, derived from the assessment of immediate need, and stated in terms of specific observable changes in behavior, skills, attitudes, or circumstances, structured to resolve the crisis.

- Identification of the services and activities designed to resolve the crisis and attain his goals and objectives.
- Plans for follow-up services (including other mental health services where indicated) after the crisis has been resolved. The role of the case manager must be identified, where applicable.

9.2 CHILDREN'S SERVICES

Intensive crisis stabilization services are structured treatment and support activities provided by a mobile intensive crisis stabilization team that are designed to promptly address a crisis situation in order to avert a psychiatric admission or other out of home placement or to maintain a child or youth in their home or present living arrangement who has recently returned from a psychiatric hospitalization or other out of home placement. These services must be available to children or youth with serious emotional disturbance (SED) and/or intellectual/developmental disabilities (I/DD), including autism, or co-occurring SED and substance use disorder (SUD).

A crisis situation means a situation in which at least one of the following applies:

- The parent/caregiver has identified a crisis and reports that their capacity to manage the crisis is limited at this time and they are requesting assistance.
- The child or youth can reasonably be expected within the near future to physically injure self or another individual, either intentionally or unintentionally.
- The child or youth exhibits risk behaviors and/or behavioral/emotional symptoms which are impacting their overall functioning; and/or the current functional impairment is a clearly observable change compared with previous functioning.
- The child or youth requires immediate intervention in order to be maintained in their home or present living arrangement or to avoid psychiatric hospitalization or other out of home placement.

The goals of intensive crisis stabilization services are as follows:

- To rapidly respond to any non-imminently life threatening emotional symptoms and/or behaviors that are disrupting the child's or youth's functioning;
- To provide immediate intervention to assist children and youth and their parents/caregivers in de-escalating behaviors, emotional symptoms and/or dynamics impacting the child's or youth 's functioning ability;
- To prevent/reduce the need for care in a more restrictive setting (e.g., inpatient psychiatric hospitalization, detention, etc.) by providing community-based intervention and resource development;
- To effectively engage, assess, deliver and plan for appropriate interventions to minimize risk, aid in stabilization of behaviors, and improve functioning; and
- To enhance the child's or youth's and parent's/caregiver's ability to access any identified community-based supports, resources and services.

9.2.A. Approval

The PIHP must seek and receive MDHHS approval, initially and every three years thereafter, for the intensive crisis stabilization services in order to use Medicaid funds for program services.

9.2.B. Population

These services are for children or youth ages 0 to 21 with SED and/or I/DD, including autism or co-occurring SED and SUD, and their parents/caregivers who are currently residing in the catchment area of the approved program, and are in need of intensive crisis stabilization services in the home or community as defined in this section. Mobile intensive crisis stabilization teams must be able to travel to the child or youth in crisis for a face to face contact in one hour or less in urban counties, and in two hours or less in rural counties, from the time of the request for intensive crisis stabilization services.

9.2.C. Services

Component services include:

- Assessments (rendered by the treatment team)
- De-escalation of the crisis
- Family-driven and youth-guided planning
- Crisis and safety plan development
- Intensive individual counseling/psychotherapy
- Family therapy
- Skill building
- Psychoeducation
- Referrals and connections to additional community resources
- Collaboration and problem solving with other child- or youth-serving systems, as applicable
- Psychiatric consult, as needed

9.2.D. Qualified Staff [Change Made 7/1/18]

Intensive crisis stabilization services must be provided by a mobile intensive crisis stabilization team consisting of at least two staff who travel to the child or youth in crisis. One team member must be a Master's prepared Child Mental Health Professional (or Master's prepared Qualified Intellectual Disabilities Professional [QIDP], if applicable) and the second team member may be another professional or paraprofessional under appropriate supervision. Paraprofessionals must have at least one year of satisfactory work experience providing services to children with serious emotional disturbance and/or intellectual/developmental disabilities, as applicable. **(text added 7/1/18)** Team members

must have access to an on-call psychiatrist by telephone, as needed. At minimum, all team members must be trained in crisis intervention and de-escalation techniques.

9.2.E. Location of Services

Intensive crisis stabilization services must be provided where necessary to alleviate the crisis situation, and to permit the child or youth to remain in their usual home and community environment.

Exceptions: Intensive crisis stabilization services may not be provided in:

- Inpatient settings;
- Jails or detention centers; or
- Residential settings (e.g., Child Caring Institutions, Crisis Residential).

9.2.F. Individual Plan of Service

Intensive crisis stabilization services may be provided initially to alleviate an immediate crisis. However, following resolution of the immediate situation, an existing individual plan of service and crisis and safety plan must be updated or, for children or youth who are not yet recipients of CMHSP services but are eligible for such services, a family-driven and youth-guided follow-up plan must be developed.

If the child or youth is a current recipient of CMHSP services, mobile intensive crisis stabilization team members are responsible for notifying the primary therapist, case manager, or wraparound facilitator, as applicable, of the contact with the mobile intensive crisis stabilization team the next business day. It is the responsibility of the primary therapist, case manager, or wraparound facilitator to follow-up with the child or youth and parent/caregiver. The child or youth, parent/caregiver and the relevant treatment team members must revisit the current individual plan of service and crisis and safety plan and make adjustments where necessary to address current treatment needs.

If the child or youth is not yet a recipient of CMHSP services but is eligible for such services, the follow-up plan must include appropriate referrals to mental health assessment and treatment resources and any other resources the child or youth and parent/caregiver may require. The mobile intensive crisis stabilization team is responsible for providing necessary information and referrals. The follow-up plan must also include the next steps for obtaining needed services, timelines for those activities, and identify the responsible parties. Mobile intensive crisis stabilization team members must contact the parent/caregiver by phone or face-to-face within seven business days to determine the status of the stated goals in the follow-up plan.

SECTION 10 – OUTPATIENT PARTIAL HOSPITALIZATION SERVICES

The PIHP is responsible for authorizing and paying for Medicaid admissions and continued stays in partial hospitalization programs by Medicaid beneficiaries.

- Admissions - beneficiaries may be referred to a partial hospitalization program from psychiatric inpatient hospitals or psychiatric units, referring providers, or PIHPs, or they may present themselves at the outpatient hospital without a referral.
- Continued stays must be authorized by the PIHP.

Authorization for the partial hospitalization admission and continued stay includes authorization for all services related to that admission/stay, including laboratory, pharmacy, and radiology services. The outpatient partial hospitalization program must bill the PIHP for authorized services according to procedures and rates established between the facility and the PIHP.

10.1 PARTIAL HOSPITALIZATION ADMISSION CRITERIA: ADULT

Partial hospitalization services may be used to treat a person with mental illness who requires intensive, highly coordinated, multi-modal ambulatory care with active psychiatric supervision. Treatment, services and supports are provided for six or more hours per day, five days a week. The use of partial hospitalization as a setting of care presumes that the beneficiary does not currently need treatment in a 24-hour protective environment. Conversely, the use of partial hospitalization implies that routine outpatient treatment is of insufficient intensity to meet the beneficiary's present treatment needs. The SI/IS criteria for admission assume that the beneficiary is displaying signs and symptoms of a serious psychiatric disorder, demonstrating significant functional impairments in self-care, daily living skills, interpersonal/social and/or educational/vocational domains, and is exhibiting some evidence of clinical instability. However, the level of symptom acuity, extent of functional impairments and/or the estimation of risk (clinical instability) do not justify or necessitate treatment at a more restrictive level of care.

Medicaid coverage is dependent upon active treatment being provided at the medically necessary level of care.

The individual must meet all three criteria outlined in the table below:

Diagnosis	The beneficiary must be suffering from a mental illness, reflected in a primary, validated, current version of DSM or ICD Diagnosis (not including ICD-9 V-codes and ICD-10 Z-codes).

Severity of Illness (signs, symptoms, functional impairments and risk potential)	At least **two** of the following manifestations are present: ▪ Psychiatric Signs and Symptoms ➢ Some prominent disturbance of thought processes, perception, affect, memory, consciousness, somatic functioning (due to a mental illness) or behavior exists (intermittent hallucinations, transient delusions, panic reactions, agitation, obsessions/ruminations, severe phobias, depression, etc.) and is serious enough to cause disordered or aberrant conduct, impulse control problems, questionable judgment, psychomotor acceleration or retardation, withdrawal or avoidance, compulsions/rituals, impaired reality testing and/or impairments in functioning and role performance. The disordered or aberrant conduct or activity and/or the level of agitation are not so severe, extreme or unstable so as to require frequent restraints or to pose a danger to others. ▪ Disruptions of Self-Care and Independent Functioning ➢ The person seriously neglects self-care tasks (hygiene, grooming, etc.) and/or does not sufficiently attend to essential aspects of daily living (does not shop, prepare meals, maintain adequate nutrition, pay bills, complete housekeeping chores, etc.) due to a mental disorder. ➢ Beneficiary is able to maintain adequate nutrition, shelter or other essentials of daily living only with structure and supervision for a significant portion of the day, and with family/community support when away from the partial hospitalization program. ➢ The person's interpersonal functioning is significantly impaired (seriously dysfunctional communication, extreme social withdrawal, etc.). ➢ There has been notable recent deterioration in meeting educational/occupational responsibilities and role performance expectations. ▪ Danger to Self ➢ There is modest danger to self, reflected in: intermittent self-harm ideation, expressed ambivalent inclinations without a plan, non-intentional threats, mild and infrequent self-harm gestures (low lethality/intent) or self-mutilation, passive death wishes, or slightly self-endangering activities. ➢ The beneficiary has not made any recent significant (by intent or lethality) suicide attempts, nor is there any well-defined plan for such activity or, if there have been recent significant actions, these inclinations/behaviors are now clearly under control and the person no longer needs/requires 24-hour supervision to contain self-harm risk. ▪ Danger to Others ➢ Where assaultive tendencies exist, there have been no overt actions and there is reasonable expectation, based upon history and recent behavior, that the beneficiary will be able to curb these inclinations. ➢ There have been destructive fantasies described and mild threats verbalized, but the beneficiary appears to have impulse control, judgment, and reality orientation sufficient to suppress urges to act on these imaginings or expressions.

	➢ There has been minor destructive behavior toward property without endangerment of others. ▪ Drug/Medication Complications ➢ The beneficiary has experienced side effects of atypical complexity resulting from psychotropic drugs, and regulation/correction/monitoring of these circumstances cannot be accomplished at a lower level of care due to the beneficiary's condition or to the nature of the procedures involved. ➢ The beneficiary needs evaluation and monitoring due to significant changes in medication or because of problems with medication regimen compliance.
Intensity of Service	The person meets the intensity of service requirements if partial hospitalization services are considered medically necessary and the person requires at least **one** of the following: ▪ The person requires intensive, structured, coordinated, multi-modal treatment and supports with active psychiatric supervision to arrest regression and forestall the need for inpatient care. ▪ The beneficiary has reached a level of clinical stability (diminished risk) obviating the need for continued care in a 24-hour protective environment but continues to require active, intensive treatment and support to relieve/reverse disabling psychiatric symptomatology and/or residual functional impairments. ▪ Routine medical observation and supervision is required to effect significant regulation of psychotropic medications and/or to minimize serious side effects.

10.2 PARTIAL HOSPITALIZATION ADMISSION CRITERIA: CHILDREN AND ADOLESCENTS

Partial hospitalization services may be used to treat a child or adolescent with mental illness or serious emotional disturbance who requires intensive, highly coordinated, multi-modal ambulatory care with active psychiatric supervision. Treatment, services and supports are provided for six or more hours per day, five days a week. The use of partial hospitalization as a setting of care presumes that the beneficiary does not currently need treatment in a 24-hour protective environment. Conversely, the use of partial hospitalization implies that routine outpatient treatment is of insufficient intensity to meet the beneficiary's present treatment needs. The SI/IS criteria for admission assume that the beneficiary is displaying signs and symptoms of a serious psychiatric disorder, demonstrating significant functional impairments in self-care, daily living skill, interpersonal/social and/or educational/vocational domains, and is exhibiting some evidence of clinical instability. However, the level of symptom acuity, extent of functional impairments and/or the estimation of risk (clinical instability) does not justify or necessitate treatment at a more restrictive level of care.

Medicaid coverage is dependent upon active treatment being provided at the medically necessary level of care.

The individual must meet all three criteria outlined in the following table:

Diagnosis	The beneficiary must be suffering from a mental illness, reflected in a primary, validated, current version of DSM or ICD diagnosis (not including ICD-9 V-codes and ICD-10 Z-codes).

Severity of Illness (signs, symptoms, functional impairments and risk potential)	At least **two** of the following manifestations are present: ▪ Psychiatric Signs and Symptoms ➢ Some prominent disturbance of thought processes, perception, affect, memory, consciousness, somatic functioning (due to a mental illness) or behavior exists (intermittent hallucinations, transient delusions, panic reactions, agitation, obsessions/ruminations, severe phobias, depression, etc.) and is serious enough to cause disordered or aberrant conduct, impulse control problems, questionable judgment, psychomotor acceleration or retardation, withdrawal or avoidance, compulsions/rituals, impaired reality testing and/or impairments in functioning and role performance. The disordered or aberrant conduct or activity and/or the level of agitation is not so severe, extreme or unstable so as to require frequent restraints or to pose a danger to others. ▪ Disruptions of Self-Care and Independent Functioning ➢ The child/adolescent exhibits significant impairments in self-care skills (feeding, dressing, toileting, hygiene/bathing/grooming, etc.), in the ability to attend to age-appropriate responsibilities, or in self-regulation capabilities, due to a mental disorder or emotional illness. ➢ The child/adolescent is able to maintain adequate self-care and self-regulation only with structure and supervision for a significant portion of the day, and with family/community support when away from the partial hospitalization program. ➢ There is recent evidence of serious impairment/incapacitation in the child's/adolescent's interpersonal and social functioning (seriously dysfunctional communication, significant social withdrawal and isolation, repeated disruptive, inappropriate or bizarre behavior in social settings, etc.). ➢ There is recent evidence of considerable deterioration in functioning within the family and/or significant decline in occupational/educational role performance due to a mental disorder or emotional illness. ▪ Danger to Self ➢ There is modest danger to self, reflected in: non-accidental self-harm gestures or self-mutilation actions which are not life-threatening in either intent or lethal potential, intermittent self-harm ideation, expressed ambivalent inclinations without a plan, non-intentional threats, passive death wishes, or slightly self-endangering activities. ➢ The beneficiary has not made any recent significant (by intent or lethality) suicide attempts, nor is there any well-defined plan for such activity or, if there have been recent significant actions, these inclinations/behaviors are now clearly under control and the person no longer needs/requires 24-hour supervision to contain self-harm risk.

	▪ Danger to Others ➢ Assaultive tendencies exist, and some assaultive behavior may have occurred, but any overt actions have been without any serious or significant injury to others, and there is reasonable expectation, based upon history and recent behavior, that the beneficiary will be able to curb any serious expression of these inclinations. ➢ There have been destructive fantasies described and mild threats verbalized, but the beneficiary appears to have adequate impulse control, judgment, and reality orientation sufficient to suppress urges to act on these imaginings or expressions. ➢ There has been minor destructive behavior toward property without endangerment of others. ▪ Drug/Medication Complications ➢ The beneficiary has experienced side effects of atypical complexity resulting from psychotropic drugs and regulation/correction/monitoring of these circumstances cannot be accomplished at a lower level of care due to the beneficiary's condition or to the nature of the procedures involved. ➢ The beneficiary needs evaluation and monitoring due to significant changes in medication or because of problems with medication regimen compliance.
Intensity of Service	The person meets the intensity of service requirements if partial hospitalization services are considered medically necessary and the person requires at least **one** of the following: ▪ The person requires intensive, structured, coordinated, multi-modal treatment and supports with active psychiatric supervision to arrest regression and forestall the need for inpatient care. ▪ The beneficiary has reached a level of clinical stability (diminished risk) obviating the need for continued care in a 24-hour protective environment but continues to require active, intensive treatment and support to relieve/reverse disabling psychiatric symptomatology and/or residual functional impairments. ▪ Routine medical observation and supervision is required to effect significant regulation of psychotropic medications and/or to minimize serious side effects.

10.3 Partial Hospitalization Continuing Stay Criteria for Adults, Adolescents and Children

After a beneficiary has been certified for admission to a partial hospitalization program, services will be reviewed at regular intervals to assess the current status of the treatment process and to determine the continued necessity for care in a partial hospitalization setting. Treatment within a partial hospitalization program is directed at resolution or stabilization of acute symptoms, elimination or amelioration of disabling functional impairments, maintenance of self/other safety and/or regulation of precarious or complicated medication situations. The continuing stay recertification process is designed to assess the efficacy of the treatment regime in addressing these concerns, and to determine whether the partial program remains the most appropriate, least restrictive, level of care for treatment of the beneficiary's problems and dysfunctions.

Continuing treatment in the partial program may be certified when symptoms, impairments, harm inclinations or medication complications, similar to those which justified the beneficiary's admission

certification, remain present, and continue to be of such a nature and severity that partial hospitalization treatment is still medically necessary. It is anticipated that in those reviews which fall near the end of an episode of care, these problems and dysfunctions will have stabilized or diminished.

Discharge planning must begin at the onset of treatment in the program. Payment cannot be authorized for continued stays that are due solely to placement problems or the unavailability of aftercare services.

The individual must meet all three criteria outlined in the following table:

Diagnosis	The beneficiary has a validated current version of DSM or ICD mental disorder (excluding ICD-9 V-codes and ICD-10 Z-codes), which remains the principal diagnosis for purposes of care during the period under review.
Severity of Illness (signs, symptoms, functional impairments and risk potential)	▪ Persistence of symptoms, impairments, harm inclinations or medication complications which necessitated admission to this level of care, and which cannot currently be addressed at a lower level of care. ▪ Emergence of new symptoms, impairments, harm inclinations or medication complications meeting admission criteria. ▪ Progress has been made in ameliorating admission symptoms or impairments, but the treatment goals have not yet been fully achieved and cannot currently be addressed at a lower level of care.
Intensity of Service	▪ The beneficiary is receiving active, timely, intensive, structured multi-modal treatment delivered according to an individualized plan of care. ▪ Active treatment is directed toward stabilizing or diminishing those symptoms, impairments, harm inclinations or medication complications that necessitated admission to the program. ▪ The beneficiary is making progress toward treatment goals or, if no progress has been made, the treatment plan and therapeutic program have been revised accordingly and there is a reasonable expectation of a positive response to treatment.

Discharge criteria and aftercare planning are documented in the beneficiary's record.

SECTION 11 – PERSONAL CARE IN LICENSED SPECIALIZED RESIDENTIAL SETTINGS

Personal care services are those services provided in accordance with an individual plan of service to assist a beneficiary in performing his own personal daily activities. Services may be provided only in a licensed foster care setting with a specialized residential program certified by the state. These personal care services are distinctly different from the state plan Home Help program administered by MDHHS.

Personal care services are covered when authorized by a physician or other health care professional in accordance with an individual plan of services, and rendered by a qualified person. Supervision of personal care services must be provided by a health care professional who meets the qualifications contained in this chapter.

11.1 SERVICES

Personal care services include assisting the beneficiary to perform the following:

- Assistance with food preparation, clothing and laundry, and housekeeping beyond the level required by facility licensure, (e.g., a beneficiary requires special dietary needs such as pureed food);
- Eating/feeding;
- Toileting;
- Bathing;
- Grooming;
- Dressing;
- Transferring (between bed, chair, wheelchair, and/or stretcher);
- Ambulation; and
- Assistance with self-administered medications.

"Assisting" means staff performs the personal care tasks for the individual; or performs the tasks along with the individual (i.e., some hands-on); or otherwise assists the individual to perform the tasks himself/herself by prompting, reminding, or by being in attendance while the beneficiary performs the task(s).

11.2 PROVIDER QUALIFICATIONS

Personal care may be rendered to a Medicaid beneficiary in an Adult Foster Care setting licensed and certified by the state under the 1987 Department of Mental Health Administrative Rule R330.1801-09 (as amended in 1995).

11.3 DOCUMENTATION

The following documentation is required in the beneficiary's file in order for reimbursement to be made:

- An assessment of the beneficiary's need for personal care.
- An individual plan of services that includes the specific personal care services and activities, including the amount, scope and duration to be delivered that is reviewed and approved at least once per year during person-centered planning.
- Documentation of the specific days on which personal care services were delivered consistent with the beneficiary's individual plan of service.

SECTION 12 – SUBSTANCE ABUSE SERVICES

12.1 COVERED SERVICES - OUTPATIENT CARE

Medicaid-covered services and supports must be provided, based on medical necessity, to eligible beneficiaries who reside in the specified region and request services.

Outpatient treatment is a non-residential treatment service that can take place in an office-based location with clinicians educated/trained in providing professionally directed alcohol and other drug (AOD) treatment or a community-based location with appropriately educated/trained staff. The treatment occurs in regularly scheduled sessions, usually totaling fewer than nine contact hours per week but, when medically necessary, can total over 20 hours in a week. Individual, family or group treatment services may be provided individually or in combination.

Treatment must be individualized based on a bio-psycho-social assessment, diagnostic impression and beneficiary characteristics, including age, gender, culture, and development. Authorized decisions on length of stay, including continued stay, change in level of care, and discharge, must be based on the American Society of Addiction Medicine (ASAM) Criteria. Beneficiary participation in referral and continuing care planning must occur prior to discharge and should be based on the needs of the beneficiary in order to support sustained recovery.

12.1.A. ELIGIBILITY

Outpatient care may be provided only when:

- The service meets medical necessity criteria.
- The current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) is used to determine an initial diagnostic impression (also known as provisional diagnosis). The diagnostic impression must include all five axes.
- The service is based on individualized determination of need.
- The service is cost effective.
- The American Society of Addiction Medicine (ASAM) Criteria are used to determine substance abuse treatment placement/admission and/or continued stay needs.
- The service is based on a level of care determination using the six assessment dimensions of the current ASAM Criteria:
  - Withdrawal potential
  - Medical conditions and complications
  - Emotional, behavioral or cognitive conditions and complications
  - Readiness to change
  - Relapse, continued use or continued problem potential
  - Recovery/living environment.

This service is limited to those beneficiaries who will benefit from treatment and have been determined to have:

- an acceptable readiness to change level;
- minimal or manageable medical conditions;
- minimal or manageable withdrawal risks;
- emotional, behavioral and cognitive conditions that will not prevent the beneficiary benefiting from this level of care;
- minimal or manageable relapse potential; and
- a minimally to fully supportive recovery environment.

12.1.B. COVERED SERVICES

Once the above criteria have been satisfied and the beneficiary has demonstrated a willingness to participate in treatment, the following services can be provided in the outpatient setting:

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

Early Intervention	Includes stage-based interventions for individuals with substance use disorders and individuals who may not meet the threshold of abuse or dependence but are experiencing functional/social impairment as a result of use.
Detoxification/ Withdrawal Monitoring	For the purpose of preventing/alleviating medical complications as they relate to no longer using a substance.
Division of Pharmacologic Therapies/Center for Substance Abuse Treatment (DPT/ CSAT) Approved Pharmacological Supports	Refer to the Treatment (DPT/CSAT) Approved Pharmacological Supports subsection.
Substance Abuse Treatment Services	Services that are required to include assessment, treatment planning, stage-based interventions, referral linking and monitoring, recovery support preparation, recovery support services, and treatment based on medical necessity. They may include individual, group and family treatment. These services are provided under the supervision of a SATS or SATP.

12.1.C. ADMISSION CRITERIA

Outpatient services should be authorized based on the number of hours and/or types of services that are medically necessary. Reauthorization or continued treatment should take place when it has been demonstrated that the beneficiary is benefiting from treatment but additional covered services are needed for the beneficiary to be able to sustain recovery independently.

Reauthorization of services can be denied in situations where the beneficiary has:

- not been actively involved in their treatment, as evidenced by repeatedly missing appointments;
- not been participating/refusing to participate in treatment activities;
- continued use of substances and other behavior that is deemed to violate the rules and regulations of the program providing the services.

Beneficiaries may also be terminated from treatment services based on these violations.

12.1.D. Service Intensity

The medically necessary outpatient services correspond to the frequency and duration of services established by the ASAM levels of care and are referred to as follows:

- Level 0.5 – Early Intervention
- Level 1.0 – Outpatient
- Level 2.1 – Intensive Outpatient
- Level 2.5 – Expanded Intensive Outpatient

Outpatient services can include any variety of the covered services and are dependent on the individual needs of the beneficiary. The assessment, treatment plan and recovery support preparations are the only components that are consistent throughout the outpatient levels of care as each beneficiary must have these as part of the authorized treatment services. As a beneficiary's needs increase, more services and/or frequency/ duration of services may be utilized if these are medically necessary. The ASAM levels correspond with established hours of services that take place during a week.

ASAM Level 0.5	Services are not subdivided by the number of hours received during a week. The amount and type of services provided are based on individual needs based on the beneficiary's motivation to change and other risk factors that may be present.
ASAM Level 1.0	Services from one hour to eight hours during a week.
ASAM Level 2.1	Services from nine to 19 hours in a week. The services are offered at least three days a week to fulfill the minimum nine-hour commitment.
ASAM Level 2.5	Services that are offered 20 or more hours in a week.

12.2 Treatment (DPT/CSAT) Approved Pharmacological Supports

12.2.A. Provision of Services

Opiate-dependent beneficiaries may be provided chemotherapy using methadone as an adjunct to a treatment service. Provision of such services must meet the following criteria:

- Services must be provided under the supervision of a physician licensed to practice medicine in Michigan.
- The physician must be licensed to prescribe controlled substances, as well as licensed to work at a methadone program.
- The methadone component of the substance abuse treatment program must be:
  - licensed as such by the state;
  - certified by the Division of Pharmacologic Therapies/Center for Substance Abuse Treatment (DPT/CSAT);
  - licensed by the Drug Enforcement Administration (DEA); and

- accredited by a DPT/CSAT and state-approved accrediting organization (The Joint Commission (TJC) and the Commission on Accreditation of Rehabilitation Facilities (CARF)).

- Methadone must be administered by an appropriately-licensed MD/DO, physician's assistant, nurse practitioner, registered nurse, licensed practical nurse, or pharmacist.

12.2.B. Covered Services

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

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

12.2.C. Eligibility Criteria

Medical necessity requirements shall be used to determine the need for methadone as an adjunct treatment and recovery service.

All six dimensions of the American Society of Addiction Medicine (ASAM) Criteria must be addressed:

- Acute intoxication and/or withdrawal potential
- Biomedical conditions and complications.
- Emotional/behavioral conditions and complications (e.g., psychiatric conditions, psychological or emotional/behavioral complications of known or unknown origin, poor impulse control, changes in mental status, or transient neuropsychiatric complications)
- Treatment acceptance/resistance
- Relapse/continued use potential
- Recovery/living environment

12.2.D. Admission Criteria

Decisions to admit an individual for methadone maintenance must be based on medical necessity criteria, satisfy the LOC determination using the six dimensions of the ASAM Criteria, and have an initial diagnostic impression of opioid dependency for at least one year based on current DSM criteria.

Admission procedures require a physical examination. This examination must include a medical assessment to confirm the current DSM diagnosis of opioid dependency of at least one year, as was identified during the screening process. The physician may refer the individual for further medical assessment as indicated.

Consistent with the LOC determination, individuals requesting methadone must be presented with all appropriate options for substance use disorder treatment, such as:

- Medical Detoxification
- Sub-acute Detoxification
- Residential Care
- Buprenorphine/Naloxone
- Non-Medication Assisted Outpatient Treatment

12.2.D.1. Special Circumstances for Admissions

There are special circumstances for the admission of pregnant women, pregnant adolescents, and adolescents.

Pregnant Women	▪ Pregnant women requesting treatment are considered a priority for admission and must be screened and referred for services within 24 hours. ▪ Pregnant individuals who have a documented history of opioid addiction, regardless of age or length of opioid dependency, may be admitted to an Opioid Treatment Program (OTP) provided the pregnancy is certified by the OTP physician and treatment is found to be justified. ▪ For pregnant individuals, evidence of current physiological dependence is not necessary. ▪ Pregnant opioid-dependent individuals must be referred for prenatal care and other pregnancy-related services and supports, as necessary. ▪ OTPs must obtain informed consent from pregnant women, and all women admitted to methadone treatment who may become pregnant, stating that they will not knowingly put themselves and their fetus in jeopardy by leaving the OTP against medical advice. ▪ Because methadone and opiate withdrawal are not recommended during pregnancy due to the increased risk to the fetus, the OTP shall not discharge pregnant women without making documented attempts to facilitate a referral for continued treatment with another provider.
Pregnant Adolescents	▪ For an individual under 18 years of age, a parent, legal guardian, or responsible adult designated by the relevant state authority, must provide consent for

	treatment in writing. (In Michigan, the relevant state authority is Children's Protective Services.) ➢ A copy of this signed informed consent statement must be placed in the individual's medical record. ➢ This signed consent is in addition to the general consent that is signed by all individuals receiving methadone, and must be filed in the medical record.
Non-Pregnant Adolescents	▪ An individual under 18 years of age is required to have had at least two documented unsuccessful attempts at short-term detoxification and/or drug-free treatment within a 12-month period to be eligible for maintenance treatment. ▪ No individual under 18 years of age may be admitted to maintenance treatment unless a parent, legal guardian, or responsible adult (designated by the relevant state authority) consents, in writing, to such treatment. Minors under 15 years of age must also have the permission of the State Opioid Treatment Authority and the Drug Enforcement Administration. (Refer to Administrative Rules for Substance Use Disorder Service Programs in Michigan, R 325.14409(5).) ➢ A copy of this signed informed consent statement must be placed in the individual's medical record. ➢ This signed consent is in addition to the general consent that is signed by all individuals receiving methadone and must be filed in their medical record. (Refer to 42CFR subpart 8.12(e)(2).)

12.2.E. MEDICAL MAINTENANCE PHASE

When the maximum therapeutic benefit of counseling has been achieved, it may be appropriate for the individual to enter the medical maintenance (methadone only) phase of treatment and recovery; that is if it has been determined that ongoing use of the medication is medically necessary and appropriate for the individual. The following criteria are to be considered when making the decision to move to medical maintenance:

- Two years of continuous treatment.
- Abstinence from illicit drugs and from abuse of prescription drugs for the period indicated by federal and state regulations (at least two years for a full 30-day maintenance dosage).
- No alcohol use problem.
- Stable living conditions in an environment free of substance use.
- Stable and legal source of income.
- Involvement in productive activities (e.g., employment, school, volunteer work).
- No criminal or legal involvement for at least three years and no current parole or probation status.
- Adequate social support system and absence of significant non-stabilized co-occurring disorders.

12.2.F. Discontinuation/Termination Criteria

Discontinuation/termination from methadone treatment refers to the following situations:

- Beneficiaries must discontinue treatment with methadone when treatment is completed with respect to both the medical necessity for the medication and for counseling services.
- Beneficiaries may be terminated from services if there is clinical and/or behavioral non-compliance.
- If a beneficiary is terminated,:
  - The OTP must attempt to make a referral for another LOC assessment or for placing the beneficiary at another OTP.
  - The OTP must make an effort to ensure that the beneficiary follows through with the referral.
  - These efforts must be documented in the medical record.
  - The OTP must follow the procedures of the funding authority in coordinating these referrals.
- Any action to terminate treatment of a Medicaid beneficiary requires a "notice of action" be given to the beneficiary and the parent, legal guardian, or responsible adult (designated by the relevant state authority/CPS). The beneficiary and the parent, legal guardian, or responsible adult (designated by the relevant state authority/CPS) has a right to appeal this decision. Services must continue and dosage levels maintained while the appeal is in process, unless the action is being carried out due to administrative discontinuation criteria outlined in the subsection titled Administrative Discontinuation.

Services are discontinued/terminated, either by Completion of Treatment or through Administrative Discontinuation. Refer to the following subsections for additional information.

12.2.F.1. Completion of Treatment

The decision to discharge a beneficiary must be made by the OTP's physician, with input from clinical staff, the beneficiary, and the parent, legal guardian, or responsible adult (designated by the relevant state authority/CPS). Completion of treatment is determined when the beneficiary has fully or substantially achieved the goals listed in their individualized treatment and recovery plan and no longer needs methadone as a medication. As part of this process, a reduction of the dosage to a medication-free state (tapering) should be implemented within safe and appropriate medical standards.

12.2.F.2. Administrative Discontinuation

Administrative discontinuation relates to non-compliance with treatment and recovery recommendations, and/or engaging in activities or behaviors that impact the safety of the OTP environment or other individuals who are receiving treatment. The OTP must work with the beneficiary and the parent, legal guardian, or responsible adult (designated by the relevant state authority/CPS) to explore and implement methods to facilitate compliance.

Non-compliance is defined as actions exhibited by the beneficiary which include, but are not limited to:

- The repeated or continued use of illicit opioids and non-opioid drugs (including alcohol).
- Toxicology results that do not indicate the presence of methadone metabolites. (The same actions are taken as if illicit drugs, including non-prescribed medication, were detected.)

  In both of the aforementioned circumstances, OTPs must perform toxicology tests for methadone metabolites, opioids, cannabinoids, benzodiazepines, cocaine, amphetamines, and barbiturates (Administrative Rules for Substance Use Disorder Service Programs in Michigan, R 325.14406).

  OTPs must test the beneficiary for alcohol if use is prohibited under their individualized treatment and recovery plan or the beneficiary appears to be using alcohol to a degree that would make dosing unsafe.
- Repeated failure to submit to toxicology sampling as requested.
- Repeated failure to attend scheduled individual and/or group counseling sessions, or other clinical activities such as psychiatric or psychological appointments.
- Failure to manage medical concerns/conditions, including adherence to physician treatment and recovery services and use of prescription medications that may interfere with the effectiveness of methadone and may present a physical risk to the individual.
- Repeated failure to follow through on other treatment and recovery plan related referrals. (Repeated failure should be considered on an individual basis and only after the OTP has taken steps to assist beneficiaries to comply with activities.)

The commission of acts by the beneficiary that jeopardize the safety and well-being of staff and/or other individuals, or negatively impact the therapeutic environment, is not acceptable and can result in immediate discharge. Such acts include, but are not limited to, the following:

- Possession of a weapon on OTP property
- Assaultive behavior against staff and/or other individuals
- Threats (verbal or physical) against staff and/or other individuals
- Diversion of controlled substances, including methadone
- Diversion and/or adulteration of toxicology samples
- Possession of a controlled substance with intent to use and/or sell on agency property or within a one-block radius of the clinic
- Sexual harassment of staff and/or other individuals
- Loitering on the clinic property or within a one-block radius of the clinic

Administrative discontinuation of services can be carried out by two methods:

- **Immediate Termination -** This involves the discontinuation of services at the time of one of the above safety-related incidents or at the time an incident is brought to the attention of the OTP.
- **Enhanced Tapering Discontinuation -** This involves an accelerated decrease of the methadone dose (usually by 10 mg or 10 percent a day). The manner in which methadone is discontinued is at the discretion of the OTP physician to ensure the safety and well-being of the beneficiary.

It may be necessary for the OTP to refer beneficiaries who are being administratively discharged to the local access management system for evaluation for another level of care. Justification for non-compliance termination must be documented in the beneficiary's chart.

12.3 SUB-ACUTE DETOXIFICATION

Sub-acute detoxification is defined as supervised care for the purpose of managing the effects of withdrawal from alcohol and/or other drugs as part of a planned sequence of addiction treatment. Detoxification is limited to the stabilization of the medical effects of the withdrawal and to the referral to necessary ongoing treatment and/or support services. Licensure as a sub-acute detoxification program is required.

Sub-acute detoxification is part of a continuum of care for substance use disorders and does not constitute the end goal in the treatment process. The detoxification process consists of three essential components: evaluation, stabilization, and fostering client readiness for, and entry into, treatment. A detoxification process that does not incorporate all three components is considered incomplete and inadequate.

Detoxification can take place in both residential and outpatient settings, and at various levels of intensity within these settings. Client placement to setting and to level of intensity must be based on ASAM Criteria and individualized determination of client need.

The following combinations of sub-acute detoxification settings and levels of intensity correspond to the LOC determination based on the ASAM Criteria.

- Outpatient Setting
  - Ambulatory Detoxification without extended on-site monitoring corresponding to ASAM Level 1-WM, or ambulatory detoxification with extended on-site monitoring (ASAM Level 2-WM).
  - Outpatient setting sub-acute detoxification must be provided under the supervision of a Substance Abuse Treatment Specialist. Services must have arrangements for access to licensed medical personnel as needed. ASAM Level 2-WM ambulatory detoxification services must be monitored by appropriately credentialed and licensed nurses.

- Residential Setting
  - Clinically Managed Residential Detoxification - Non-Medical or Social Detoxification Setting: Emphasizes peer and social support for persons who warrant 24-hour support (ASAM Level 3.2-WM). These services must be provided under the supervision of a Substance Abuse Treatment Specialist. Services must have arrangements for access to licensed medical personnel as needed.
  - Medically Managed Residential Detoxification - Freestanding Detoxification Center: These services must be staffed 24-hours-per-day, seven-days-per-week by a licensed physician or by the designated representative of a licensed physician (ASAM Level 3.7-WM).

This service is limited to stabilization of the medical effects of the withdrawal, and referral to necessary ongoing treatment and/or support services. This service, when clinically indicated, is an alternative to acute medical care provided by licensed health care professionals in a hospital setting.

Authorization requirements:

- Symptom alleviation is not sufficient for purposes of admission. There must be documentation of current beneficiary status that provides evidence the admission is likely to directly assist the beneficiary in the adoption and pursuit of a plan for further appropriate treatment and recovery.
- Admission to sub-acute detoxification must be made based on:
  - Medical necessity criteria
  - LOC determination based on an evaluation of the six assessment dimensions of the current ASAM Criteria.
- Initial length-of-stay authorizations may be for up to three days, with additional days authorized if there is clinical evidence that detoxification is not successful or complete and authorization requirements continue to be met.

12.4 Residential Treatment

Residential Treatment is defined as intensive therapeutic service which includes overnight stay and planned therapeutic, rehabilitative or didactic counseling to address cognitive and behavioral impairments for the purpose of enabling the beneficiary to participate and benefit from less intensive treatment. A program director is responsible for the overall management of the clinical program, and treatment is provided by appropriate credentialed professional staff, including substance abuse specialists. Residential treatment must be staffed 24-hours-per-day. The clinical program must be provided under the supervision of a Substance Abuse Treatment Specialist with either full licensure or limited licensure as a psychologist, master's social worker, professional counselor, marriage and family therapist or physician. Services may be provided by a Substance Abuse Treatment Specialist or a non-degreed staff.

This intensive therapeutic service is limited to those beneficiaries who, because of specific cognitive and behavioral impairments, need a safe and stable environment in order to benefit from treatment.

Authorization requirements:

- The effects of the substance use disorder must be so significant and the resulting impairment so great that outpatient and intensive outpatient treatments have not been effective or cannot be safely provided, and when the beneficiary provides evidence of willingness to participate in treatment.
- Admissions to Residential Treatment must be based on:
  - Medical necessity criteria
  - LOC determination based on an evaluation of the six assessment dimensions of the current ASAM Criteria
- Additional days may be authorized when authorization requirements continue to be met, if there is evidence of progress in achieving treatment plan goals, and reauthorization is necessary to resolve cognitive and behavioral impairments which prevent the beneficiary from benefiting from less intensive treatment.

12.5 Excluded Services

- Room and board;
- All other services not addressed within Covered or Allowable Services; and
- Medicaid Substance Abuse Services funded Outside the PIHP Plan.

Some Medicaid-covered services are available to substance abuse beneficiaries, but are provided outside of the PIHP Plan. The PIHPs are not responsible to pay for the following:

- Acute detoxification;
- Laboratory services related to substance abuse (with the exception of lab services required for Methadone);
- Medications used in the treatment/management of addictive disorders;
- Emergency medical care;
- Emergency transportation;
- Substance abuse prevention and treatment that occurs routinely in the context of providing primary health care; and
- Routine transportation to substance abuse treatment services which is the responsibility of the local MDHHS office.

SECTION 13 – TARGETED CASE MANAGEMENT

Targeted case management is a covered service that assists beneficiaries to design and implement strategies for obtaining services and supports that are goal-oriented and individualized. Services include assessment, planning, linkage, advocacy, coordination and monitoring to assist beneficiaries in gaining access to needed health and dental services, financial assistance, housing, employment, education, social services, and other services and natural supports developed through the person-centered planning process. Targeted case management is provided in a responsive, coordinated, effective and efficient manner focusing on process and outcomes.

Targeted case management services must be available for all children with serious emotional disturbance, adults with serious mental illness, persons with a developmental disability, and those with co-occurring substance use disorders who have multiple service needs, have a high level of vulnerability, require access to a continuum of mental health services from the PIHP, and/or are unable to independently access and sustain involvement with needed services.

Beneficiaries must be provided choice of available, qualified case management staff upon initial assignment and on an ongoing basis.

13.1 PROVIDER QUALIFICATIONS

Providers must demonstrate the capacity to provide all core requirements specified below and have a sufficient number of staff to meet the needs of the target population.

Providers must document initial and ongoing training for case managers related to the core requirements and applicable to the target population served.

Caseload size and composition must be realistic for the case manager to complete the core requirements as identified in the individual plan of service developed through the person-centered planning process.

13.2 DETERMINATION OF NEED

The determination of the need for case management must occur at the completion of the intake process and through the person-centered planning process for beneficiaries receiving services and supports. Justification as to whether case management is needed or not must be documented in the beneficiary's record.

13.3 CORE REQUIREMENTS

- Assuring that the person-centered planning process takes place and that it results in the individual plan of service.
- Assuring that the plan of service identifies what services and supports will be provided, who will provide them, and how the case manager will monitor (i.e., interval of face-to-face contacts) the services and supports identified under each goal and objective.
- Overseeing implementation of the individual plan of service, including supporting the beneficiary's dreams, goals, and desires for optimizing independence; promoting recovery; and assisting in the development and maintenance of natural supports.

- Assuring the participation of the beneficiary on an ongoing basis in discussions of his plans, goals, and status.
- Identifying and addressing gaps in service provision.
- Coordinating the beneficiary's services and supports with all providers, making referrals, and advocating for the beneficiary.
- Assisting the beneficiary to access programs that provide financial, medical, and other assistance such as Home Help and Transportation services.
- Assuring coordination with the beneficiary's primary and other health care providers to assure continuity of care.
- Coordinating and assisting the beneficiary in crisis intervention and discharge planning, including community supports after hospitalization.
- Facilitating the transition (e.g., from inpatient to community services, school to work, dependent to independent living) process, including arrangements for follow-up services.
- Assisting beneficiaries with crisis planning.
- Identifying the process for after-hours contact.

Assessment	The provider must have the capacity to perform an initial written comprehensive assessment addressing the beneficiary's needs/wants, barriers to needs/wants, supports to address barriers, and health and welfare issues. Assessments must be updated when there is significant change in the condition or circumstances of the beneficiary. The individual plan of services must also reflect such changes.
Documentation	The beneficiary's record must contain sufficient information to document the provision of case management, including the nature of the service, the date, and the location of contacts between the case manager and the beneficiary, including whether the contacts were face-to-face. The frequency of face-to-face contacts must be dependent on the intensity of the beneficiary's needs. The case manager must review services at intervals defined in the individual plan of service. The plan shall be kept current and modified when indicated (reflecting the intensity of the beneficiary's health and welfare needs). A beneficiary or his/her guardian or authorized representative may request and review the plan at any time. A formal review of the plan shall not occur less often than annually to review progress toward goals and objectives and to assess beneficiary satisfaction.
Monitoring	The case manager must determine, on an ongoing basis, if the services and supports have been delivered, and if they are adequate to meet the needs/wants of the beneficiary. Frequency and scope (face-to-face and telephone) of case management monitoring activities must reflect the intensity of the beneficiary's health and welfare needs identified in the individual plan of services.

Targeted case management shall not include direct delivery of ongoing day-to-day supports and/or training, or provision of other Medicaid services. Targeted case managers are prohibited from exercising the agency's authority to authorize or deny the provision of services. Targeted case management shall not duplicate services that are the responsibility of another program.

13.4 STAFF QUALIFICATIONS

A primary case manager must be a qualified mental health or intellectual disability professional (QMHP or QIDP) or, if the case manager has only a bachelor's degree but without the specialized training or experience, they must be supervised by a QMHP or QIDP who does possess the training or experience. Services to a child with serious emotional disturbance must be provided by a QMHP who is also a child mental health professional. Services to children with developmental disabilities must be provided by a QIDP.

SECTION 14 – CHILDREN'S HOME AND COMMUNITY-BASED SERVICES WAIVER (CWP)

The Children's Home and Community Based Services Waiver Program (CWP) provides services that are enhancements or additions to regular Medicaid coverage to children up to age 18 who are enrolled in the CWP.

The Children's Waiver is a fee-for-service program administered by the CMHSP. The CMHSP will be held financially responsible for any costs incurred on behalf of the CWP beneficiary that were authorized by the CMHSP and exceed the Medicaid fee screens or amount, duration and scope parameters.

Services, equipment and Environmental Accessibility Adaptations (EAAs) that require prior authorization from MDHHS must be submitted to the CWP Clinical Review Team at MDHHS. The team is comprised of a physician, registered nurse, psychologist, and licensed master's social worker with consultation by a building specialist and an occupational therapist.

14.1 KEY PROVISIONS

The CWP enables Medicaid to fund necessary home- and community-based services for children with developmental disabilities who reside with their birth or legally adoptive parent(s) or with a relative who has been named legal guardian under the laws of the State of Michigan, regardless of their parent's income.

The CMHSP is responsible for assessment of potential waiver candidates. The CMHSP is also responsible for referring potential waiver candidates by completing the CWP "pre-screen" form and sending it to the MDHHS to determine priority rating.

Application for the CWP is made through the CMHSP. The CMHSP is responsible for the coordination of the child's waiver services. The case manager, the child and his family, friends, and other professional members of the planning team work cooperatively to identify the child's needs and to secure the necessary services. All services and supports must be included in the Individual Plan of Services (IPOS). The IPOS must be reviewed, approved and signed by the physician.

A CWP beneficiary must receive at least one children's waiver service per month in order to retain eligibility.

14.2 ELIGIBILITY

The following eligibility requirements must be met:

- The child must have a developmental disability (as defined in Michigan state law), be less than 18 years of age and in need of habilitation services.
- The child must have a score on the Global Assessment of Functioning (GAF) Scale of 50 or below.
- The child must reside with his birth or legally adoptive parent(s) or with a relative who has been named the legal guardian for that child under the laws of the State of Michigan, provided that the relative is not paid to provide foster care for that child.

- The child is at risk of being placed into an ICF/IID facility because of the intensity of the child's care and the lack of needed support, or the child currently resides in an ICF/IID facility but, with appropriate community support, could return home.
- The child must meet, or be below, Medicaid income and asset limits when viewed as a family of one (the parent's income is waived).
- The child's intellectual or functional limitations indicate that he would be eligible for health, habilitative and active treatment services provided at the ICF/IID level of care. Habilitative services are designed to assist individuals in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings. Active treatment includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services. Active treatment is directed toward the acquisition of the behaviors necessary for the beneficiary to function with as much self-determination and independence as possible, and the prevention or deceleration of regression or loss of current optimal functional status.

14.3 Covered Waiver Services

Covered Medicaid services that continue to be available to CWP beneficiaries are listed in the Covered Services Section of this chapter. Refer to the Children's Waiver Community Living Support Services Appendix of this chapter for criteria for determining number of hours. Services covered under CWP include:

Community Living Supports	Community Living Supports (CLS) provides assistance to a family in the care of their child while facilitating the child's independence and integration into the community. This service provides skill development related to activities of daily living, such as bathing, eating, dressing, personal hygiene, household chores and safety skills; skill development to achieve or maintain mobility, sensory-motor, communication, socialization and relationship-building skills, and participation in leisure and community activities. These supports must be provided directly to, or on behalf of, the child. The supports, as identified in the individual plan of services, are provided in the child's home and may be provided in community settings when integration into the community is an identified goal. These supports may serve to reinforce skills or lessons taught in school, therapy or other settings, but are not intended to supplant services provided in school or other settings. Individuals who are identified in the individual plan of services to provide CLS to the child and family must meet provider qualifications. The CMHSP must maintain the following documentation: ▪ A log of the CLS must be maintained in the child's record, documenting the provision of activities outlined in the plan. ▪ Provider qualifications and standards must be maintained for all staff providing services and supports to the child and family. All service costs must be maintained in the child's file for audit purposes.

Enhanced Transportation	Transportation costs may be reimbursed when separately specified in the individual plan of services and provided by people other than staff performing CLS, in order to enable a child served by the CWP to gain access to waiver and other community services, activities and resources. Transportation is limited to local distances, where local is defined as within the child's county or a bordering county. This service is an enhancement of transportation services covered under Medicaid. Family, neighbors, friends, or community agencies that can provide this service without charge must be utilized before seeking funding through the CWP. The availability and use of natural supports should be documented in the record. Parents of children served by the waiver are not entitled to enhanced transportation reimbursement.
Environmental Accessibility Adaptations (EAAs)	Environmental Accessibility Adaptations (EAAs) include those physical adaptations to the home, specified in the individual plan of services, which are necessary to ensure the health, welfare and safety of the child, or enable him to function with greater independence in the home and without which the child would require institutionalization. Home adaptations may include the installation of ramps, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems that are essential to support the child's medical equipment. Requests for EAAs must be prior authorized by the CWP Clinical Review Team following denial by all applicable insurance sources, e.g., private insurance, Children's Special Health Care Services (CSHCS), Medicaid. All services shall be provided in accordance with applicable state or local building codes. A prescription is required and is valid for one year from the date of signature. Standards of value purchasing must be followed. The EAA must be the most reasonable alternative, based on the results of a review of all options, including a change in the use of rooms within the home or alternative housing. The existing structure must have the capability to accept and support the proposed changes. The infrastructure of the home involved in the funded EAA (e.g., electrical system, plumbing, well/septic, foundation, heating/cooling, smoke detector systems, roof) must be in compliance with any applicable local codes. EAAs shall exclude costs for improvements exclusively required to meet local building codes. The EAA must incorporate reasonable and necessary construction standards, excluding cosmetic improvements. The adaptation cannot result in valuation of the structure significantly above comparable neighborhood real estate values. The EAA must demonstrate cost-effectiveness. The family must apply, with the assistance of the case manager if needed, to all applicable funding sources, such as housing commission grants, MSHDA, and community development block grants, for assistance. Acceptances or denials by these funding sources must be documented in the child's records. The CWP is a funding source of last resort. Excluded are those adaptations or improvements to the home that are of general utility, are considered to be standard housing obligations of parents, and are not of direct medical or remedial benefit to the child. EAAs that are required to support proper functioning of medical equipment, such as electrical upgrades, are limited to the requirements for safe operation of the specified equipment and are not intended to correct existing code violations in a child's home.

	All work must be completed while the child is enrolled in the CWP. Adaptations may be made to rental properties when the landowner agrees to the adaptation in writing. A written agreement between the landowner and the child's family must specify any requirements for restoration of the property to its original condition if the occupants move and must indicate that the CWP and MDHHS are not obligated for any restoration costs. If a family purchases a home, or builds a home or addition while the child is receiving waiver services, it is the family's responsibility to assure that the home will meet the child's basic needs, such as having a ground floor bath/bedroom if the child has mobility limitations. The CWP does not cover construction costs in a new home or addition, or a home purchased after the beneficiary is enrolled in the waiver. The CWP funds may be authorized to assist with the adaptation noted above (e.g., ramps, grab bars, widening doorways) for a home recently purchased. Additional square footage may be prior authorized following a MDHHS specialized housing consultation if it is determined that adding square footage is the only alternative available to make the home accessible and the most cost-effective alternative for housing. Additional square footage is limited to the space necessary to make the home wheelchair-accessible for a child with mobility impairments to prevent institutionalization; the amount will be determined by the direct medical or remedial need of the beneficiary. The family must exhaust all applicable funding options, such as the family's ability to pay, housing commission grants, MSHDA and community development block grants. Acceptances or denials by these funding sources must be documented in the child's records.
Family Training	This provides for training and counseling services for the families of children served on the CWP. For purposes of this service, "family" is defined as the people who live with or provide care to a child served on the CWP, and may include a parent or siblings. Family does not include individuals who are employed to care for the child. Training includes instruction about treatment regimens and use of equipment specified in the plan of services, and must include updates as necessary to safely maintain the child at home. Family training is also a counseling service directed to the family and designed to improve and develop the family's skills in dealing with the life circumstances of parenting a child with special needs. All family training must be included in the child's individual plan of services and must be provided on a face-to-face basis.
Non-Family Training	This service provides coaching, supervision and monitoring of CLS staff by professional staff (LLP, MSW, or QIDP). The professional staff will work with parents and CLS staff to implement the plan that addresses services designed to improve the child's social interactions and self-control by instilling positive behaviors in the place of behaviors that are socially disruptive, injurious to the child or others, or that cause property damage.
Fencing	Fencing may be approved with documentation that it is essential to achieve the outcomes specified in the child's individual plan of services and necessary to meet a child's health and safety needs. Authorization for fencing is for a maximum of 200 feet of standard chain link fence and one gate. If it is determined that chain link fencing will not meet the child's health and safety needs, a standard stockade fence may be considered.

Financial Management Services/Fiscal Intermediary Services	Healthcare Common Procedure Coding System (HCPCS) code "T2025" should be used to bill for this service. This is a "per month" service with a maximum unit of one per month. Financial Management Services/Fiscal Intermediary Services include, but are not limited to,: ▪ Facilitation of the employment of service workers by the child's parent or guardian acting as the consumer's representative, including federal, state and local tax withholding/payments, unemployment compensation fees, wage settlements, and fiscal accounting; ▪ Assuring adherence to federal and state laws and regulations; and ▪ Ensuring compliance with documentation requirements related to management of public funds. The fiscal intermediary may also perform other supportive functions that enable the consumer – through his/her parent or guardian - to self-direct needed services. These functions may include helping the consumer's representative recruit staff (e.g., developing job descriptions, placing ads, assisting with interviewing); contracting with or employing providers of services; verification of provider qualifications (including reference and background checks); and assisting the consumer and his/her representative to understand billing and documentation requirements. This is a service that handles the financial flow-through of Medicaid dollars for children enrolled in the CWP who are using Choice Voucher arrangements. This CWP waiver service is available only to CWP consumers whose parent or guardian, serving as the consumer's representative, chooses to self-direct selected services through Choice Voucher arrangements. A CMHSP may terminate self-direction of services (and therefore Financial Management Services) when the health and welfare of the consumer is in jeopardy due to the failure of the consumer's representative to direct services and supports or when the consumer's representative consistently fails to comply with contractual requirements. A fiscal intermediary is an independent legal entity – organization or individual - that acts as the fiscal agent of the CMHSP for the purpose of assuring fiduciary accountability for the funds authorized to purchase specific services identified in the consumer's individual plan of service (IPOS). The fiscal intermediary receives funds from the CMHSP and makes payments authorized by the consumer's parent or guardian, as the consumer's representative. The fiscal intermediary acts as an employer agent when the consumer's representative directly employs staff or other service providers. The fiscal intermediary can be an agency or organization (e.g., financial management services agency, accounting firm, local ARC or other advocacy organization) or individual (e.g., accountant, financial advisor/manager, attorney). The fiscal intermediary must meet requirements as identified in the MDHHS/CMHSP Managed Mental Health Supports and Services Contract – Attachment C3.4.4 Medicaid Managed Specialty Supports and Services Concurrent 1915(b)(c) Waiver Program FY12 (and subsequent years) – Attachment P3 4.4.

Respite Care	Respite care services are provided to the child on an intermittent or short-term basis because of the absence or need for relief of the parent. Respite is intended to support the parent who is the primary caregiver. This service can be provided by a qualified provider under contract with the CMHSP in the child's home, foster home, group home, licensed respite care facility, licensed camp, or the home of a friend or relative. A parent or guardian may not be considered a provider, nor be reimbursed for this service. All respite services are billed under HCPCS code T1005 – Respite Care Service 15 Min. – with modifiers as appropriate. The maximum respite allocation is 4,608 units (1,152 hours) per fiscal year. The cost of room and board cannot be included as part of respite care, unless provided as part of the respite care in a facility that is not a private residence. Respite provided in an institution (i.e., ICF/IID, nursing facility, or hospital) is not covered by the CWP. When a child requires skilled nursing interventions for 24 hours, the maximum daily amount that one nurse can provide is 16 hours. When the family is not available to provide the additional eight hours of care, a second nurse will be required to provide services for the remainder of the 24-hour period. If a nurse provides respite to more than one child at the same time, the nurse can only provide skilled nursing interventions to one child at a time. Therefore, service for that child would be covered as RN or LPN respite, and services to the other child(ren) would be covered as aide-level respite.
Specialized Medical Equipment and Supplies	Specialized medical equipment and supplies includes durable medical equipment, environmental safety and control devices, adaptive toys, activities of daily living (ADL) aids, and allergy control supplies that are specified in the child's individual plan of services. This service is intended to enable the child to increase his abilities to perform ADLs or to perceive, control, or communicate with the environment in which the child lives. Generators may be covered for a beneficiary who is ventilator-dependent or requires daily use of oxygen via a concentrator. The size of a generator will be limited to the wattage required to provide power to essential life-sustaining equipment. This service also includes vehicle modifications, van lifts and wheelchair tie-downs. Specialized medical equipment and supplies includes items necessary for life support, ancillary supplies and equipment necessary for the proper functioning of such items, and durable and non-durable medical equipment not covered by Medicaid or through other insurance. (Refer to the Medical Supplier Chapter for information regarding Medicaid-covered equipment and supplies.) Equipment and supplies must be of direct medical or remedial benefit to the child. "Direct medical or remedial benefit" is a prescribed specialized treatment and its associated equipment or environmental accessibility adaptation that is essential to the implementation of the child's individual plan of services. The plan must include documentation that, as a result of the treatment and its associated equipment or adaptation, institutionalization of the child will be prevented. A prescription is required and is valid for one year from the date of signature. All items must be determined to be essential to the health, safety, welfare, and independent functioning of the child as specified in the individual plan of services. There must be documented evidence that the item is the most cost-effective alternative to meet the child's need following value purchasing standards. All items must meet applicable standards of manufacture, design and installation. The CMHSP, or its contract agency, must maintain documentation to support that the best value in warranty coverage (e.g., the most coverage for the least cost, per industry standards) was obtained for the item at the time of purchase.

The following are examples of items not covered under this service:

- Items that are not of direct medical or remedial benefit or that are considered to be experimental. "Experimental" means that the validity of use of the item has not been supported in one or more studies in a preferred professional journal.
- Furniture, appliances, bedding, storage cabinets, whirlpool tubs, and other non-custom items that may routinely be found in a home.
- Items that would normally be available to any child and would ordinarily be provided by the family.
- Items that are considered family recreational choices (outdoor play equipment, swimming pools, pool decks and hot tubs).
- The purchase or lease of vehicles and any repairs or routine maintenance to the vehicle.
- Educational supplies and equipment expected to be provided by the school.

1. Local Authorization of Specialized Medical Equipment and Supplies

As defined below under the various Healthcare Common Procedure Coding System (HCPCS) codes, the CMHSP may locally authorize selected medical equipment and supplies covered under this service category. Medicaid payment will not be made for items that exceed quantity/frequency limits or established Medicaid fee screens as published in the MDHHS CMHSP Children's Waiver Database in effect at the time the equipment or supply is authorized.

- **Miscellaneous therapeutic items and supplies, retail purchases, not otherwise classified; identify product in "Remarks" (HCPCS T1999)**

  This code is used to bill Medicaid for age-appropriate adaptive toys identified in the child's individual plan of services to address the adaptive or therapeutic need for the item and the specific habilitative outcome.

  Items that are typically available in a home and ordinarily provided by families, schools, etc. (e.g., crayons, coloring books, regular board games, educational or non-adaptive toys/software, CD/DVD players, camera, film, computers) are not covered.

- **Personal care item, not otherwise specified, each; identify product in "Remarks" (HCPCS S5199)**

  This code is used to bill Medicaid for ADL aids that enable the child to be as independent as possible in areas of self-care. The child's individual plan of services must describe the purpose and use of the ADL aid and any training that the child requires for its use. ADL aids must not be similar in function to items previously billed to Medicaid.

- **Specialized supply, not otherwise specified, waiver; identify product in "Remarks" (HCPCS T2028)**

  This code is used to bill Medicaid for allergy control supplies used for the on-going management of a diagnosed severe reaction to airborne irritants and must be specified in the child's individual plan of services. Household items routinely found in a home are not covered (e.g., bed linens, mattress, pillow, vacuum cleaner).

2. State-Level Prior Authorization of Specialized Medical Equipment and Supplies

All other items and services covered under this category must be prior authorized by the MDHHS CWP Clinical Review Team following denial by all applicable insurance sources, e.g., private insurance, CSHCS, Medicaid. (Refer to the Children's Waiver Program [CWP] Prior Authorization subsection for details regarding the prior authorization process.) Prior authorization will not be given for items and services that exceed quantity/frequency limits as published in the MDHHS CMHSP Children's Waiver Database in effect at the time the service is authorized. Pursuant to prior authorization by the MDHHS CWP Clinical Review Team and provision of the items or service, Medicaid payment will be at the rate prior authorized.

- **Specialized medical equipment, not otherwise specified, waiver (HCPCS T2029)**

  This code is used to bill Medicaid for environmental safety and control devices that enable the child to be as independent as possible. These devices may assist in controlling the environment or assuring safety in conjunction with programs designed to teach safety awareness or skills. The child's individual plan of services must address the use of the device and include any training that the child requires for its use. Environmental safety and control devices do not include items of general utility such as standard smoke detectors, fire extinguishers, home security systems, and storage cabinets.

  This service is limited to five environmental safety and control devices or sets of devices per quarter. A set is considered a group of like items that must be purchased in a quantity to meet the child's needs, e.g., outlet plug covers.

- **Repair or non-routine service for durable medical equipment other than oxygen requiring the skill of a technician, labor component, per 15 minutes (HCPCS K0739)**

  This code is used to bill Medicaid for repairs to specialized medical equipment that are not covered benefits through other insurances. There must be documentation in the child's individual plan of services that the specialized medical equipment continues to be of direct medical or remedial benefit to the child. All applicable warranty and insurance coverage must be sought and denied before requesting funding for repairs through the CWP. The CMHSP must document that the repair is the most cost-effective solution when compared with replacement or purchase of a new item. If the equipment requires repairs due to misuse or abuse, the CMHSP must provide evidence of training in the use of the equipment to prevent future incidents.

- **Vehicle modifications, waiver; per service (HCPCS T2039)**

  This code is used to bill Medicaid for modifications to full-size vans, van lifts and wheelchair tie-down systems. Modifications to the family-owned van must be necessary to ensure the accessibility of the child with mobility impairments, and the vehicle must be the child's primary means of transportation. The individual plan of services must specify the child's accessibility needs that will be addressed by these modifications.

Prior authorization for a van lift will be considered no more frequently than once every five years, which is the minimum life expectancy of a lift.

When purchasing new vehicles, many automobile manufacturers offer a rebate of up to $1,000 to reimburse documented expenditures for modification of a vehicle for accessibility. The CMHSP must request that the family purchasing the vehicle obtain information regarding any rebate programs and apply the rebate toward the cost of the modifications.

Other modifications to a full-size van, such as raised doors, which are necessary to meet the child's accessibility needs will be considered. It is expected that the CMHSP will use prudence in considering and processing beneficiary requests for modifications to newly purchased vehicles (e.g., providing evidence that the child's needs were considered in purchasing a full-size van; purchasing a vehicle that has a raised roof). Conversions to mini-vans are limited to the same modification and would not include additional costs required to modify the frame (e.g., lower the floor) to accommodate a lift. Excluded are items such as automatic door openers, remote car starters, custom interiors, etc. The purchase of a vehicle or maintenance to the vehicle is the family's responsibility.

If the vehicle is stolen or damaged beyond repair within five years of the purchase, replacement would only be considered with documentation that the existing lift cannot be transferred to a new van and that no other funding source (e.g., automobile insurance, homeowner's insurance, personal liability, judgment settlement, etc.) is available to cover the replacement.

- **Durable medical equipment, miscellaneous (HCPCS E1399)**

  This code is used to bill Medicaid for durable medical equipment as described below:

  - Window air-conditioning unit for the room where the child spends the majority of his time (e.g., sleeping area). The child must have a documented medical diagnosis of one of the following specific medical diagnoses or conditions:
    - temperature regulation dysfunction due to brain injury or other medical diagnosis;
    - severe respiratory distress secondary to asthma, permanent lung damage, or other medical conditions which are exacerbated by heat and humidity;
    - severe dehydration resulting from a medical diagnosis (e.g., diabetes insipidus) which may result in hospitalization; or
    - severe cardiac problems which may result in hospitalization unless the environmental temperature is carefully controlled.

	➢ Generator for a child who is ventilator-dependent or requires daily use of oxygen via a concentrator. The size of a generator will be limited to the wattage required to provide power to essential life-sustaining equipment (typically 5,000 watts) and is not intended to provide power for the entire home. The request for prior approval of a generator must include a documented history of power outages, including frequency and duration. The local power company must be notified in writing of the need to restore power on a priority basis due to the child's needs. ➢ Therapeutic items, assistive technology, and other durable medical equipment for a child who has sensory, communication, or mobility needs when the item is reasonably expected to enable the child to perceive, control or communicate with the environment in which the child lives, to have a greater degree of independence than would be possible without the item or device, or to benefit maximally from a program designed to meet physical or behavioral needs.
Specialty Services	Specialty Services include: ▪ Music Therapies; ▪ Recreation Therapies; ▪ Art Therapies; and ▪ Massage Therapies. Specialty Services may include the following activities: Child and family training; coaching and supervision of staff; monitoring of progress related to goals and objectives; and recommending changes in the plan. This may be used in addition to the traditional professional therapy model included in Medicaid. Services must be directly related to an identified goal in the individual plan of service and approved by the physician. Service providers must meet the CMHSP provider qualifications, including appropriate licensure/certification. Services are limited to four sessions per therapy per month. The CMHSP must maintain a record of all Specialty Service costs for audit purposes. Hourly care services are not covered under Specialty Services.

14.4 CHILDREN'S WAIVER PROGRAM (CWP) PRIOR AUTHORIZATION

To determine if a specific service requires MDHHS CWP prior authorization, refer to the Covered Waiver Services subsection above. The CMHSP must complete and submit to the MDHHS CWP an original Prior Review and Approval Request (PRAR) form and the following documentation for each prior authorization request:

- Original current (within 365 days) prescription signed by a physician.
- Narrative justification of need completed by an appropriate professional.
- Documentation that the requested item, device, or modification is essential to the implementation of the child's individual plan of services and is of direct medical or remedial benefit to the child.
- A copy of the habilitation program (i.e., goals, objectives and methodologies) as related to the request and identified in the individual plan of services.

- Written denial of funding from other sources, including private insurance, Medicaid or CSHCS when applicable, charitable or community organizations, and housing grant programs. If the private insurance carrier requires prior authorization to determine coverage, a request for prior authorization must be submitted to the carrier before submitting the PRAR to the MDHHS CWP.
- Three similar bids for requests costing equal to or more than $1,000; only one bid is required for requests costing less than $1,000. If fewer than three bids are obtained for requests costing equal to or more than $1,000, documentation must describe what efforts were made to secure the bids, and why fewer than three bids were obtained.

The completed PRAR and supporting documentation must be submitted to the MDHHS Children's Waiver Program. (Refer to the Directory Appendix for contact information.)

14.5 Provider Qualifications

14.5.A. Individuals Who Provide Respite and CLS

Individuals who provide respite and CLS must:

- Be at least 18 years of age.
- Be able to practice prevention techniques to reduce transmission of any communicable diseases from themselves to others in the environment where they are providing support.
- Have a documented understanding and skill in implementing the individual plan of services and report on activities performed.
- Be in good standing with the law (i.e., not a fugitive from justice, a convicted felon, or an illegal alien).
- Be able to perform basic first aid and emergency procedures.
- Be trained in recipient rights.
- Be an employee of the CMHSP or its contract agency, or an employee of the parent who is paid through a Choice Voucher arrangement. The Choice Voucher System is the designation or set of arrangements that facilitate and support accomplishing self-determination through the use of an individual budget, a fiscal intermediary and direct consumer-provider contracting.

14.5.B. Individuals Performing Case Management Functions

Individuals performing case management functions must meet the requirements for a Qualified Intellectual Disability Professional (QIDP) and have:

- A minimum of a Bachelor's degree in a human services field.
- One year of experience working with people with developmental disabilities.

SECTION 15 – HABILITATION SUPPORTS WAIVER FOR PERSONS WITH DEVELOPMENTAL DISABILITIES

Beneficiaries with developmental disabilities may be enrolled in Michigan's Habilitation Supports Waiver (HSW) and receive the supports and services as defined in this section. HSW beneficiaries may also receive other Medicaid state plan or additional/B3 services. A HSW beneficiary must receive at least one HSW service per month in order to retain eligibility. Medical necessity criteria should be used in determining the amount, duration, and scope of services and supports to be used. The beneficiary's services and supports that are to be provided under the auspices of the PIHP must be specified in his individual plan of services developed through the person-centered planning process.

HSW beneficiaries must be enrolled through the MDHHS enrollment process completed by the PIHP. The enrollment process must include annual verification that the beneficiary:

- Has a developmental disability (as defined by Michigan law);
- Is Medicaid-eligible;
- Is residing in a community setting;
- If not for HSW services, would require ICF/IID level of care services; and
- Chooses to participate in the HSW in lieu of ICF/IID services.

The enrollment process also includes confirmation of changes in the beneficiary's enrollment status, including termination from the waiver, changes of residence requiring transfer of the waiver to another PIHP, and death. Termination from the HSW may occur when the beneficiary no longer meets one or more of the eligibility criteria specified above as determined by the PIHP, or does not receive at least one HSW service per month, or withdraws from the program voluntarily, or dies. Instructions for beneficiary enrollments and annual re-certification may be obtained from the MDHHS Bureau of Community Based Services. (Refer to the Directory Appendix for contact information.)

The PIHP shall use value purchasing for HSW services and supports. The PIHP shall assist beneficiaries to examine their first- and third-party resources to pursue all reimbursements to which they may be entitled, and to make use of other community resources for non-PIHP covered activities, supports or services.

Reimbursement for services rendered under the HSW is included in the PIHP capitation rate.

Beneficiaries enrolled in the HSW may not be enrolled simultaneously in any other §1915(c) waiver.

Habilitation services under the HSW are not otherwise available to the beneficiary through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973.

15.1 Waiver Supports and Services [Change Made 7/1/18]

Community Living Supports (CLS)	Community Living Supports (CLS) facilitate an individual's independence, productivity, and promote inclusion and participation. The supports can be provided in the beneficiary's residence (licensed facility, family home, own home or apartment) and in community settings (including, but not limited to, libraries, city pools, camps, etc.), and may not supplant other waiver or state plan covered services (e.g., out-of-home non-vocational habilitation, Home Help Program, personal care in specialized residential, respite). The supports are: ▪ Assisting (that exceeds state plan for adults), prompting, reminding, cueing, observing, guiding and/or training the beneficiary with: ➢ Meal preparation; ➢ Laundry; ➢ Routine, seasonal, and heavy household care and maintenance (where no other party, such as a landlord or licensee, has responsibility for provision of these services); ➢ Activities of daily living, such as bathing, eating, dressing, personal hygiene; and ➢ Shopping for food and other necessities of daily living. ▪ Assisting, supporting and/or training the beneficiary with: ➢ Money management; ➢ Non-medical care (not requiring nurse or physician intervention); ➢ Socialization and relationship building; ➢ Transportation (excluding to and from medical appointments that are the responsibility of Medicaid through MDHHS or health plan) from the beneficiary's residence to community activities, among community activities, and from the community activities back to the beneficiary's residence); ➢ Leisure choice and participation in regular community activities; ➢ Attendance at medical appointments; and ➢ Acquiring goods and/or services other than those listed under shopping and non-medical services. ▪ Reminding, observing, and/or monitoring of medication administration. The CLS do not include the costs associated with room and board. Payments for CLS may not be made, directly or indirectly, to responsible relatives (i.e., spouses or parents of minor children) or the legal guardian. For beneficiaries living in unlicensed homes, CLS assistance with meal preparation, laundry, routine household care and maintenance, ADLs, and/or shopping may be used to complement Home Help or Expanded Home Help services when the individual's needs for this assistance have been officially determined to exceed DHS's allowable parameters. Reminding, observing, guiding, and/or training of these activities are CLS coverages that do not supplant Home Help or Expanded Home Help. CLS may be provided in a licensed specialized residential setting as a complement to, and in conjunction with, State Plan coverage of Personal Care in Specialized Residential Settings.

	If beneficiaries living in unlicensed homes need assistance with meal preparation, laundry, routine household care and maintenance, ADLs, and/or shopping, the beneficiary must request Home Help and, if necessary, Expanded Home Help from MDHHS. CLS may be used for those activities while the beneficiary awaits determination by MDHHS of the amount, scope and duration of Home Help or Expanded Home Help. If the beneficiary requests it, the PIHP must assist with applying for Home Help or submitting a request for a Fair Hearing when the beneficiary believes that the MDHHS authorization of amount, scope and duration of Home Help does not accurately reflect his or her needs. CLS may also be used for those activities while the beneficiary awaits the decision from a Fair Hearing of the appeal of a MDHHS decision. Community Living Supports (CLS) provides support to a beneficiary younger than 18, and the family in the care of their child, while facilitating the child's independence and integration into the community. This service provides skill development related to activities of daily living, such as bathing, eating, dressing, personal hygiene, household chores and safety skills; and skill development to achieve or maintain mobility, sensory-motor, communication, socialization and relationship-building skills, and participation in leisure and community activities. These supports must be provided directly to, or on behalf of, the child. These supports may serve to reinforce skills or lessons taught in school, therapy, or other settings. For children and adults up to age 26 who are enrolled in school, CLS services are not intended to supplant services provided in school or other settings or to be provided during the times when the child or adult would typically be in school but for the parent's choice to home-school.
Enhanced Medical Equipment and Supplies	Enhanced medical equipment and supplies include devices, supplies, controls, or appliances that are not available under regular Medicaid coverage or through other insurances. (Refer to the Medical Supplier Chapter of this manual for more information about Medicaid-covered equipment and supplies.) All enhanced medical equipment and supplies must be specified in the plan of service, and must enable the beneficiary to increase his abilities to perform activities of daily living; or to perceive, control, or communicate with the environment. Items that are not of direct medical or remedial benefit, or that are considered to be experimental to the beneficiary, are excluded from coverage. ▪ "Direct medical or remedial" benefit is a prescribed specialized treatment and its associated equipment or environmental accessibility adaptation that are essential to the implementation of the individual plan of service. ▪ "Experimental" means that the validity of the use of the item has not been supported in one or more studies in a refereed professional journal. The plan must document that, as a result of the treatment and its associated equipment or adaptation, institutionalization of the beneficiary will be prevented. There must be documented evidence that the item is the most cost-effective alternative to meet the beneficiary's need. All items must be ordered on a prescription as defined in the General Information Section of this chapter. An order is valid one year from the date it was signed. This coverage includes: ▪ Adaptations to vehicles; ▪ Items necessary for life support;

	▪ Ancillary supplies and equipment necessary for proper functioning of such items; and ▪ Durable and non-durable medical equipment not available under the Medicaid state plan. Generators may be covered for an individual who is ventilator dependent or requires daily use of an oxygen concentrator. The size of a generator will be limited to the wattage required to provide power to essential life-sustaining equipment. Assessments and specialized training needed in conjunction with the use of such equipment, as well as warranted upkeep and repair, shall be considered as part of the cost of the services. Furnishings (e.g., furniture, appliances, bedding) and other non-custom items (e.g., wall and floor coverings, and decorative items) that are routinely found in a home are not included. Items that are considered family recreational choices are not covered. The purchase or lease of a vehicle, as well as any repairs or routine maintenance to the vehicle, is not covered. Educational equipment and supplies are expected to be provided by the school as specified in the Individualized **(revised 7/1/18)** Education Plan and are not covered. Eyeglasses, hearing aids, and dentures are not covered. Covered items must meet applicable standards of manufacture, design, and installation. There must be documentation that the best value in warranty coverage was obtained for the item at the time of purchase. The PIHP should have a process in place that gives notice to a medical equipment supplier that purchase of the equipment or supply has been authorized. Repairs to enhanced medical equipment that are not covered benefits through other insurances may be covered. There must be documentation in the individual plan of services that the enhanced medical equipment continues to be of direct medical or remedial benefit. All applicable warranty and insurance coverage must be sought and denied before paying for repairs. The PIHP must document the repair is the most cost-effective solution when compared with replacement or purchase of a new item. If the equipment requires repairs due to misuse or abuse, the PIHP must provide evidence of training in the use of the equipment to prevent future incidents. The PIHP must assure that all applicable private insurance, Medicare and/or Medicaid requirements for the procurement of durable medical equipment and supplies have been met. The PIHP may not use the waiver service to purchase equipment or supplies that would have been covered by another program if the program's rules were followed, including using providers who participate with that program.
Enhanced Pharmacy	Physician-ordered, nonprescription "medicine chest" items as specified in the beneficiary's support plan. Items that are not of direct medical or remedial benefit to the beneficiary are not allowed. Only the following items are allowable: ▪ Cough, cold, pain, headache, allergy, and/or gastrointestinal distress remedies; ▪ Vitamins and minerals; ▪ Special dietary juices and foods that augment, but do not replace, a regular diet;

	▪ Thickening agents for safe swallowing when the beneficiary has a diagnosis of dysphagia and either: ➢ A history of aspiration pneumonia, or ➢ Documentation that the beneficiary is at risk of insertion of a feeding tube without thickening agents for safe swallowing; ▪ First aid supplies (e.g., band-aids, iodine, rubbing alcohol, cotton swabs, gauze, antiseptic cleansing pads); ▪ Special oral care products to treat specific oral conditions beyond routine mouth care (e.g., special toothpaste, toothbrushes, anti-plaque rinses, antiseptic mouthwashes); and ▪ Special items (i.e., accommodating common disabilities -- longer, wider handles), tweezers and nail clippers. Routine cosmetic products (e.g., make-up base, aftershave, mascara, and similar products) are not included. However, products necessary to ameliorate negative visual impact of serious facial disfigurements (e.g., massive scarring) and/or skin conditions (including exposed area eczema, psoriasis, and/or acne) will be covered. Refer to the Pharmacy Chapter in this manual for information about Medicaid-covered prescriptions. HSW funds cannot be used to pay for copays for other prescription plans the beneficiary may have.
Environmental Modifications	Physical adaptations to the home and/or workplace required by the beneficiary's support plan that are necessary to ensure the health, safety, and welfare of the beneficiary, or enable him to function with greater independence within the environment(s) and without which the beneficiary would require institutionalization. Adaptations may include: ▪ The installation of ramps and grab bars; ▪ Widening of doorways; ▪ Modification of bathroom facilities; ▪ Installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies necessary for the welfare of the beneficiary; and ▪ Environmental control devices that replace the need for paid staff and increase the beneficiary's ability to live independently, such as automatic door openers. Excluded are those adaptations or improvements to the home that are of general utility, are considered to be standard housing obligations of the beneficiary, and are not of direct medical or remedial benefit. Examples of exclusions include, but are not limited to, carpeting, roof repair, sidewalks, driveways, heating, central air conditioning (except under exceptions noted in the service definition), garages, raised garage doors, storage and organizers, hot tubs, whirlpool tubs, swimming pools, landscaping and general home repairs. The HSW does not cover construction costs in a new home or additions to a home purchased after the beneficiary is enrolled in the waiver.

	"Direct medical or remedial" benefit is a prescribed specialized treatment and its associated equipment or environmental accessibility adaptation that are essential to the implementation of the individual plan of service. The plan must document that, as a result of the treatment and its associated equipment or adaptation, institutionalization of the beneficiary will be prevented. There must be documented evidence that the item is the most cost-effective alternative to meet the beneficiary's need. An example of a reasonable alternative, based on the results of a review of all options, may include changing the purpose, use, or function of a room within the home or finding alternative housing. Assessments and specialized training needed in conjunction with the use of such environmental modifications are included as a part of the cost of the service. All items must be ordered on a prescription as defined in the General Information Section of this chapter. An order is valid for one year from the date it was signed. Central air-conditioning is included only when prescribed by a physician and specified with extensive documentation in the plan as to how it is essential in the treatment of the beneficiary's illness or condition. This supporting documentation must demonstrate the cost-effectiveness of central air compared to the cost of window units in all rooms that the beneficiary must use. Environmental modifications that are required to support proper functioning of medical equipment, such as electrical upgrades, are limited to the requirements for safe operation of the specified equipment and are not intended to correct existing code violations in a beneficiary's home. The PIHP must assure there is a signed contract or bid proposal with the builder prior to the start of an environmental modification. It is the responsibility of the PIHP to work with the beneficiary and builder to ensure that the work is completed as outlined in the contract or bid proposal. Adaptations may be made to rental properties when the landowner agrees to the adaptation in writing. A written agreement between the landowner, the beneficiary, and the PIHP must specify any requirements for restoration of the property to its original condition if the occupant moves. If a beneficiary or his family purchases or builds a home while receiving waiver services, it is the beneficiary's or family's responsibility to assure that the home will meet basic needs, such as having a ground floor bath/bedroom if the beneficiary has mobility limitations. HSW funds may be authorized to assist with the adaptations noted above (e.g., ramps, grab bars, widening doorways, etc.) for a home recently purchased. If modifications are needed to a home under construction that require special adaptation to the plan (e.g., roll-in shower), the HSW may be used to fund the difference between the standard fixture and the modification required to accommodate the beneficiary's need. Environmental modifications for **licensed settings** includes only the remaining balance of previous environmental modification costs that accommodate the specific needs of current waiver beneficiaries, and will be limited to the documented portion being amortized in the mortgage, or the lease cost per bed. Environmental modifications exclude the cost of modifications required for basic foster care licensure or to meet local building codes. The existing structure must have the capability to accept and support the proposed changes. The infrastructure of the home involved in the funded modifications (e.g., electrical system, plumbing, well/septic, foundation, heating/cooling, smoke detector systems, roof) must be in compliance with any applicable local codes. Environmental modifications shall exclude costs for improvements exclusively required to meet local building codes.

	The environmental modification must incorporate reasonable and necessary construction standards, excluding cosmetic improvements. The adaptation cannot result in valuation of the structure significantly above comparable neighborhood real estate values. The beneficiary, with the direct assistance by the PIHP supports coordinator when necessary, must make a reasonable effort to access all available funding sources, such as housing commission grants, Michigan State Housing Development Authority (MSHDA), and community development block grants, for assistance. A record of efforts to apply for alternative funding sources must be documented in the beneficiary's records, as well as acceptances or denials by these funding sources. The HSW is a funding source of last resort. Adaptations to the **work environment** are limited to those necessary to accommodate the person's individualized needs, and cannot be used to supplant the requirements of Section 504 of the Rehabilitation Act, the Americans with Disabilities Act (ADA), or covered by Michigan Rehabilitation Services (MRS) or the Bureau of Services for Blind Persons (BSBP). All services must be provided in accordance with applicable state or local building codes.
Family Training	Training and counseling services for the families of beneficiaries served on the waiver. For purposes of this service, "family" is defined as the family members who live with or provide care to the beneficiary in the HSW, and may include parent, spouse, children, relatives, foster family, unpaid caregivers, or in-laws. Training includes instructions about treatment regimens and use of equipment specified in the individual plan of services, and includes updates as needed to safely maintain the person at home. Family training goals, and the content, frequency, and duration of the training and/or counseling, should be identified in the beneficiary's individual plan of services. Not included are individuals who are employed to provide waiver services for the beneficiary.

Goods and Services	The purpose of Goods and Services is to promote individual control over, and flexible use of, the individual budget by the HSW beneficiary using arrangements that support self-determination and facilitate creative use of funds to accomplish the goals identified in the individual plan of services (IPOS) through achieving better value or an improved outcome. Goods and services must increase independence, facilitate productivity, or promote community inclusion and substitute for human assistance (such as personal care in the Medicaid State Plan and community living supports and other one-to-one support as described in the HSW or §1915(b)(3) Additional Service definitions) to the extent that individual budget expenditures would otherwise be made for the human assistance. A Goods and Services item must be identified using a person-centered planning process, meet medical necessity criteria, and be documented in the IPOS. Purchase of a warranty may be included when it is available for the item and is financially reasonable. Goods and Services are available only to individuals participating in arrangements of self-determination whose individual budget is lodged with a fiscal intermediary. This coverage may not be used to acquire goods or services that are prohibited by federal or state laws or regulations, e.g., purchase or lease or routine maintenance of a vehicle.
Out-of-Home Nonvocational Habilitation	Assistance with acquisition, retention, or improvement in self-help, socialization, and adaptive skills; and the supports services, including transportation to and from, incidental to the provision of that assistance that takes place in a non-residential setting, separate from the home or facility in which the beneficiary resides. Examples of incidental support include: ▪ Aides helping the beneficiary with his mobility, transferring, and personal hygiene functions at the various sites where habilitation is provided in the community. ▪ When necessary, helping the person to engage in the habilitation activities (e.g., interpreting). Services must be furnished four or more hours per day on a regularly scheduled basis for one or more days per week unless provided as an adjunct to other day activities included in the beneficiary's plan of service. These supports focus on enabling the person to attain or maintain his maximum functioning level, and should be coordinated with any physical, occupational, or speech therapies listed in the plan of services. Services may serve to reinforce skills or lessons taught in school, therapy, or other settings.
Personal Emergency Response Systems (PERS)	Electronic devices that enable beneficiaries to secure help in the event of an emergency. The beneficiary may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once the button is activated. The response center is staffed by trained professionals. This service includes a one-time installation and up to twelve monthly monitoring services per year. PERS coverage should be limited to beneficiaries living alone (or living with a roommate who does not provide supports), or who are alone for significant parts of the day; who have no regular support or service provider for those parts of the day; and who would otherwise require extensive routine support and guidance.

Prevocational Services	Prevocational services involve the provision of learning and work experiences where a beneficiary can develop general, non-job-task-specific strengths and skills that contribute to employability in paid employment in integrated, community settings. Services are expected to occur over a defined period of time and provided in sufficient amount and scope to achieve the outcome, as determined by the beneficiary and his/her care planning team in the ongoing person-centered planning process. Services are expected to specifically involve strategies that enhance a beneficiary's employability in integrated, community settings. Competitive employment and supported employment are considered successful outcomes of prevocational services. However, participation in prevocational services is not a required prerequisite for competitive employment or receiving supported employment services. Prevocational services should enable each beneficiary to attain the highest possible wage and work which is in the most integrated setting and matched to the beneficiary's interests, strengths, priorities, abilities, and capabilities. Services are intended to develop and teach general skills that lead to employment including, but not limited to: ▪ ability to communicate effectively with supervisors, co-workers and customers; ▪ generally accepted community workplace conduct and dress; ▪ ability to follow directions; ▪ ability to attend to tasks; ▪ workplace problem solving skills and strategies; ▪ general workplace safety; and ▪ mobility training. Support of employment outcomes is a part of the person-centered planning process and emphasizes informed consumer choice. This process specifies the beneficiary's personal outcomes toward a goal of productivity, identifies the services and items, including prevocational services and other employment-related services that advance achievement of the beneficiary's outcomes, and addresses the alternatives that are effective in supporting his or her outcomes. From the alternatives, the beneficiary selects the most cost-effective approach that will help him or her achieve the outcome. Beneficiaries who receive prevocational services during some days or parts of days may also receive other waiver services, such as supported employment, out-of-home non-vocational habilitation, or community living supports, at other times. Beneficiaries who are still attending school may receive prevocational training and other work-related transition services through the school system and may also participate in prevocational services designed to complement and reinforce the skills being learned in the school program during portions of their day that are not the educational system's responsibility, e.g., after school or on weekends and school vacations. Prevocational services may be provided in a variety of community locations. Beneficiaries participating in prevocational services may be compensated in accordance with applicable Federal laws and regulations, but the provision of prevocational services is intended to lead to a permanent integrated employment situation. Documentation must be maintained by the PIHP that the beneficiary is not currently eligible for supported employment services provided by Michigan Rehabilitation Services (MRS) or the Bureau of Services for Blind Persons (BSBP). Information must be updated when MRS or BSBP eligibility conditions change.

	Prevocational services may be provided to supplement, but may not duplicate, services provided under supported employment or out-of-home non-vocational habilitation services. Coordination with the beneficiary's school is necessary to assure that prevocational services provided in the waiver do not duplicate or supplant transition services that are the responsibility of the educational program. Transportation provided between the beneficiary's place of residence and the site of the prevocational services, or between habilitation sites, is included as part of the prevocational and/or habilitation services. Assistance with personal care or other activities of daily living that are provided to a beneficiary during the receipt of prevocational services may be included as part of prevocational services or may be provided as a separate State Plan Home Help service or community living supports service under the waiver, but the same activity cannot be reported as being provided to more than one service. Only activities that contribute to the beneficiary's work experience, work skills, or work-related knowledge can be included in prevocational services.
Private Duty Nursing (PDN)	Private Duty Nursing (PDN) services are skilled nursing interventions provided to individuals age 21 and older, up to a maximum of 16 hours per day, to meet an individual's health needs that are directly related to his developmental disability. PDN includes the provision of nursing assessment, treatment and observation provided by licensed nurses within the scope of the State's Nurse Practice Act, consistent with physician's orders and in accordance with the written health care plan which is part of the beneficiary's individual plan of services (IPOS). PDN services are for beneficiaries who require more individual and continuous care than periodic or intermittent nursing available through state plan services, e.g., Home Health. The individual receiving PDN must also require at least one of the following habilitative services, whether being provided by natural supports or through the waiver. ▪ Community living supports ▪ Out-of-home non-vocational habilitation ▪ Prevocational or supported employment To be determined eligible for PDN services, the PIHP must find that the beneficiary meets Medical Criteria I as well as Medical Criteria III, or meets Medical Criteria II as well as Medical Criteria III. Regardless of whether the beneficiary meets Medical Criteria I or II, the beneficiary must also meet Medical Criteria III. **Medical Criteria I** – The beneficiary is dependent daily on technology-based medical equipment to sustain life. "Dependent daily on technology-based medical equipment" means: ▪ Mechanical rate-dependent ventilation (four or more hours per day), or assisted rate-dependent respiration (e.g., some models of Bi-PAP); or ▪ Deep oral (past the tonsils) or tracheostomy suctioning eight or more times in a 24-hour period; or ▪ Nasogastric tube feedings or medications when removal and insertion of the nasogastric tube is required, associated with complex medical problems or medical fragility; or

- Total parenteral nutrition delivered via a central line, associated with complex medical problems or medical fragility; or
- Continuous oxygen administration (eight or more hours per day), in combination with a pulse oximeter and a documented need for skilled nursing assessment, judgment, and intervention in the rate of oxygen administration. This would not be met if oxygen adjustment is done only according to a written protocol with no skilled assessment, judgment or intervention required. Continuous use of oxygen therapy is a covered Medicaid benefit for beneficiaries age 21 and older when tested at rest while breathing room air and the oxygen saturation rate is 88 percent or below, or the PO2 level is 55 mm HG or below.

Medical Criteria II – Frequent episodes of medical instability within the past three to six months, requiring skilled nursing assessments, judgments or interventions (as described in III below) due to a substantiated medical condition directly related to the developmental disability.

Definitions:

- "Frequent" means at least 12 episodes of medical instability related to the progressively debilitating physical disorder within the past six months, or at least six episodes of medical instability related to the progressively debilitating physical disorder within the past three months. "Medical instability" means emergency medical treatment in a hospital emergency room or inpatient hospitalization related to the underlying progressively debilitating physical disorder.
- "Emergency medical treatment" means covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish such services and are needed to evaluate or stabilize an emergency medical condition. "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention would result in placing the health of the individual in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

For beneficiaries described in II above, the requirement for frequent episodes of medical instability is applicable only to the initial determination for private duty nursing. A determination of need for continued private duty nursing services is based on the continuous skilled nursing care.

- "Directly related to the developmental disability" means an illness, diagnosis, or syndrome occurred during the developmental period prior to age 22, is likely to continue indefinitely, and results in significant functional limitations in 3 or more areas of life activity. Illnesses or disability acquired after the developmental period, such as stroke or heart conditions, would not be considered directly related to the developmental disability.
- "Substantiated" means documented in the clinical/medical record, including the nursing notes.

Medical Criteria III – The beneficiary requires continuous skilled nursing care on a daily basis during the time when a licensed nurse is paid to provide services.

Definitions:

- "Continuous" means at least once every 3 hours throughout a 24-hour period, and/or when delayed interventions may result in further deterioration of health status, in loss of function or death, in acceleration of the chronic condition, or in a preventable acute episode.
- Equipment needs alone do not create the need for skilled nursing services.
- "Skilled nursing" means assessments, judgments, interventions, and evaluations of interventions requiring the education, training, and experience of a licensed nurse. Skilled nursing care includes, but is not limited to:
  - performing assessments to determine the basis for acting or a need for action, and documentation to support the frequency and scope of those decisions or actions;
  - managing mechanical rate-dependent ventilation or assisted rate-dependent respiration (e.g., some models of Bi-PAP) that is required by the beneficiary four or more hours per day;
  - deep oral (past the tonsils) or tracheostomy suctioning;
  - injections when there is a regular or predicted schedule, or prn injections that are required at least once per month (insulin administration is not considered a skilled nursing intervention);
  - nasogastric tube feedings or medications when removal and insertion of the nasogastric tube is required, associated with complex medical problems or medical fragility;
  - total parenteral nutrition delivered via a central line and care of the central line;
  - continuous oxygen administration (eight or more hours per day), in combination with a pulse oximeter, and a documented need for adjustments in the rate of oxygen administration requiring skilled nursing assessments, judgments and interventions. This would not be met if oxygen adjustment is done only according to a written protocol with no skilled assessment, judgment or intervention required. Continuous use of oxygen therapy is a covered Medicaid benefit for beneficiaries age 21 and older when tested at rest while breathing room air and the oxygen saturation rate is 88 percent or below, or the PO2 level is 55 mm HG or below;

- monitoring fluid and electrolyte balances where imbalances may occur rapidly due to complex medical problems or medical fragility. Monitoring by a skilled nurse would include maintaining strict intake and output, monitoring skin for edema or dehydration, and watching for cardiac and respiratory signs and symptoms. Taking routine blood pressure and pulse once per shift that does not require any skilled assessment, judgment or intervention at least once every three hours during a 24-hour period, as documented in the nursing notes, would not be considered skilled nursing.

Once the Medical Criteria eligibility for PDN has been established, and as part of determining the amount of PDN a beneficiary is eligible for, the Intensity of Care category must be determined. This is a clinical judgment based on the following factors:

- The beneficiary's medical condition;
- The type and frequency of needed nursing assessments, judgments and interventions; and
- The impact of delayed nursing interventions.

Equipment needs alone do not determine intensity of care. Other aspects of care (e.g., administering medications) are important when developing a plan for meeting the overall needs of the beneficiary but do not determine the amount of hours of nursing for which the beneficiary is eligible.

High Category	Medium Category	Low Category
Beneficiaries requiring nursing assessments, judgments and interventions by a licensed nurse (RN/LPN) at least one time each hour throughout a 24-hour period when delayed nursing interventions could result in further deterioration of health status, in loss of function, death, or in acceleration of the chronic condition.	Beneficiaries requiring nursing assessments, judgments and interventions by a licensed nurse (RN/LPN) at least one time every three hours throughout a 24-hour period, or at least one time each hour for at least 12 hours per day, when delayed nursing interventions could result in further deterioration of health status, in loss of function, death, or in acceleration of the chronic condition. This category also includes beneficiaries with a higher need for nursing assessments and judgments due to an inability to communicate and direct their own care.	Beneficiaries requiring nursing assessments, judgments and interventions by a licensed nurse (RN/LPN) at least one time every three hours for at least 12 hours per day, as well as those beneficiaries who can participate in and direct their own care.

The amount of PDN hours authorized represents a monthly total determined by calculating an average amount of PDN per day multiplied by the number of days in the month. The beneficiary has the flexibility to use the hours as needed during the month, not to exceed the total monthly authorized amount.

	The amount of PDN (i.e., the number of hours that can be authorized for a beneficiary) is determined through the person-centered planning process to address the individual's unique needs and circumstances. Factors to be considered should include the beneficiary's care needs which establish medical necessity for PDN; the beneficiary's and family's circumstances (e.g., the availability of natural supports); and other resources for daily care (e.g., private health insurance, trusts, bequests). Although the person-centered planning process is used to determine the exact amount of PDN specified in the IPOS, in general, a beneficiary who has Low Category PDN needs would require eight or fewer hours per day, a beneficiary who has Medium Category PDN needs would require 12 or fewer hours per day, and a beneficiary who has High Category PDN needs would require 16 or fewer hours per day. The nurse may provide personal care only when incidental to the delivery of PDN, e.g., diaper changes, but may not provide routine personal care. The provision of personal care in unlicensed homes is through Home Help, a state plan service. If the beneficiary receiving PDN services demonstrates the need for Home Help services, the IPOS must document coordination of Home Help and PDN to assure no duplication of services. Licensed nurses provide the nursing treatments, observation, and/or teaching as ordered by a physician, and that are consistent with the written individual plan of services. These services should be provided to a beneficiary at home or in the community. A physician's prescription is required. The PIHP must assess and document the availability of all private health care coverage (e.g., private or commercial health insurance, Medicare, health maintenance organization, preferred provider organization, Champus, Worker's Compensation, an indemnity policy, automobile insurance) for private duty nursing and will assist the beneficiary in selecting a private duty nursing provider in accordance with available third-party coverage. This includes private health coverage held by, or on behalf of, a beneficiary. If a beneficiary is attending school and the Individualized Education **(revised 7/1/18)** Plan (IEP) identifies the need for PDN during transportation to and from school and/or in the classroom, the school is responsible for providing PDN during school hours. For adults up to age 26 who are enrolled in school, PDN services are not intended to supplant services provided in school or other settings or to be provided during the times when the beneficiary would typically be in school but for the parent's choice to home-school. An exception process to ensure the beneficiary's health, safety and welfare is available if the beneficiary's needs exceed the 16-hours-per-day maximum for a time-limited period not to exceed six months. Factors underlying the need for additional PDN must be identified in the beneficiary's plan, including strategies directed toward resolving the factors necessitating the exception, if applicable. Documentation must substantiate all of the following: ▪ Current medical necessity for the exception; and ▪ Additional PDN services are essential to the successful implementation of the beneficiary's written plan of care, and are essential to maintain the beneficiary within the least restrictive, safe, and humane environment suitable to his condition.

Exceptions must be based on the increased identified medical needs of the beneficiary or the impact on the beneficiary's needs due to the unavailability of the primary unpaid caregiver. Consideration for an exception is limited to situations outside the beneficiary's or family's control that place the beneficiary in jeopardy of serious injury or significant deterioration of health status. Exceptions may be considered for either of the following general situations:

- A temporary alteration in the beneficiary's care needs, resulting in one or both of the following:
  - A temporary increase in the intensity of required assessments, judgments, and interventions.
  - A temporary need for additional training to enable the primary caregiver(s) to identify and meet the beneficiary's care needs.

  The total number of additional PDN hours per day will be based on the physician's documentation of the extent and duration of the beneficiary's increased medical needs for a maximum of six months.
- The temporary inability of the primary unpaid caregiver(s) to provide the required care, as the result of one of the following:
  - In the event the caregiver is hospitalized, a maximum of 24 hours per day can be authorized for each day the caregiver is hospitalized. Upon discharge from the hospital, or in the event of an acute illness or injury of the caregiver, the total number of additional PDN hours per day will be based on the physician's documentation of the extent and duration of the caregiver's limitations and the needs of the beneficiary as it relates to those limitations, not to exceed six months.
  - The death of the primary caregiver. The initial amount of hours allowable under this exception is 24 hours per day for 14 days. Subsequent exceptions can be approved up to an additional 60 days, with monthly reviews thereafter by the PIHP/CMHSP.
  - The death of an immediate family member. "Immediate family member" is defined as the caregiver's spouse, partner, parent, sibling, or child. The maximum number of hours allowable under this exception criterion is 24 hours per day for a maximum of seven days.

  "Inability" is defined as the caregiver is either unable to provide care, or is prevented from providing care.

  "Primary caregiver" is defined as the caregiver who provides the majority of unpaid care.

  "Unpaid care" is defined as care provided by a caregiver where no reimbursement is received for those services, e.g., is not being paid as a Home Help provider or Community Living Supports staff.

  This exception is not available if the beneficiary resides in a licensed setting or in a home where all care is provided by paid caregivers.

	In the event that a transition plan has been developed wherein PDN services are to be reduced or eliminated based on a determination of medical necessity, the PIHP may provide PDN for a period of time (not to exceed three months) for the purpose of training the CLS or respite aides or family and assuring a smooth transition. In those cases, the transition plan, including amount, scope, frequency and duration of the training by nurses to aides, must be documented in the IPOS. A transition process is not intended to provide two-to-one (nurse and aide) staffing for any purpose other than for training (with limitations on duration and frequency noted in the IPOS) while the aide or family member becomes familiar with the beneficiary's care needs. This transition period is only permitted when it has been determined that PDN is not medically necessary and the beneficiary's care needs can be met by a trained CLS or respite aide. **Private Duty Nursing is a Medicaid coverage for beneficiaries under age 21 who meet the medical criteria for eligibility. Refer to the Private Duty Nursing Chapter of this manual for additional information.**
Respite Care	Respite care services are provided to a waiver eligible beneficiary on a short-term, intermittent basis to relieve the beneficiary's family or other primary caregiver(s) from daily stress and care demands during times when they are providing unpaid care. Relief needs of hourly or shift staff workers should be accommodated by staffing substitutions, plan adjustments, or location changes and not by respite care. ▪ "Short-term" means the respite service is provided during a limited period of time (e.g., a few hours, a few days, weekends, or for vacations). ▪ "Intermittent" means the respite service does not occur regularly or continuously. The service stops and starts repeatedly or with periods in between. ▪ "Primary" caregivers are typically the same people who provide at least some unpaid supports daily. ▪ "Unpaid" means that respite may only be provided during those portions of the day when no one is being paid to provide the care, i.e., not a time when the beneficiary is receiving a paid State Plan (e.g., home help) or waiver service (e.g., community living supports) or service through other programs (e.g., school). Since adult beneficiaries living at home typically receive home help services and hire their family members, respite is not available when the family member is being paid to provide the home help service, but may be available at other times throughout the day when the caregiver is not paid.

	Respite is not intended to be provided on a continuous, long-term basis where it is a part of daily services that would enable an unpaid caregiver to work full-time. In those cases, community living supports or other services of paid support or training staff should be used. The beneficiary's record must clearly differentiate respite hours from community living support services. Decisions about the methods and amounts of respite are decided during the person-centered planning process. Respite care may not be provided by a parent of a minor beneficiary receiving the service, the spouse of the beneficiary, the beneficiary's legal guardian, or the primary unpaid caregiver.
	
	Respite services may be provided in the following settings:
	
	▪ Waiver beneficiary's home or place of residence.
	▪ Licensed foster care home.
	▪ Facility approved by the State that is not a private residence, such as:
	  ➢ Group home; or
	  ➢ Licensed respite care facility.
	▪ Home of a friend or relative (not the parent of a minor beneficiary or the spouse of the beneficiary served or the legal guardian) chosen by the beneficiary; licensed camp; in community settings with a respite worker training, if needed, by the beneficiary or family. These sites are approved by the beneficiary and identified in the IPOS.
	
	Cost of room and board must not be included as part of the respite care unless provided as part of the respite care in a facility that is not a private residence. Respite provided in an institution (i.e., ICF/IID, nursing facility, or hospital) or MDHHS approved day program site is not covered by the HSW. The beneficiary's record must clearly differentiate respite hours from community living support services.

Supports Coordination	Supports coordination works with the waiver beneficiary to assure all necessary supports and services are provided to enable the beneficiary to achieve community inclusion and participation, productivity, and independence in home- and community-based settings. Without the supports and services, the beneficiary would otherwise require the level of care services provided in an ICF/IID. Supports coordination involves the waiver beneficiary and others identified by the beneficiary (i.e., family member(s)) in developing a written individual plan of services (IPOS) through the person-centered planning process. The waiver beneficiary may choose to work with a supports coordinator through the provider agency, an independent supports coordinator, a supports coordinator assistant, or a services and supports broker. Functions performed by a supports coordinator, supports coordinator assistant, or services and supports broker include an assurance of the following: ▪ Assistance with access to entitlements and/or legal representation. ▪ Brokering of providers of services/supports. ▪ Developing an IPOS using the person-centered planning process, including revisions to the IPOS at the beneficiary's request or as the beneficiary's changing circumstances may warrant. ▪ Linking to, coordinating with, follow-up of, and advocacy with all supports and services, including the Medicaid Health Plan, Medicaid fee-for-service, or other health care providers.

- Monitoring of Habilitation Supports Waiver and other mental health services.
- Planning and/or facilitating planning using person-centered principles. This function may be delegated to an independent facilitator chosen by the beneficiary.

The role of the supports coordinator assistant is to perform the functions listed above, as they are needed, when the beneficiary selects an assistant in lieu of a supports coordinator. When a supports coordinator assistant is used, a qualified supports coordinator must supervise the assistant.

The beneficiary may select a services and supports broker to perform supports coordination functions. However, parents of a minor-aged beneficiary, spouse or legal guardian of an adult beneficiary may not provide services and supports broker services to the beneficiary. The primary roles are to assist the beneficiary in making informed decisions about what will work best for him, are consistent with his needs and reflect the beneficiary's circumstances. The services and supports broker helps the beneficiary explore the availability of community services and supports, housing, and employment and then makes the necessary arrangements to link the beneficiary with those supports. Services and supports brokerage services offer practical skills training to enable beneficiaries to remain independent, including the provision of information on recruiting/hiring/managing workers, effective communication and problem solving.

Whenever services and supports brokers perform any of the supports coordination functions, it is expected that the beneficiary will also have a supports coordinator or supports coordinator assistant employed by the PIHP or its provider network that assures the other functions above are in place, and that the functions assigned to the services and supports broker are being performed. The IPOS must clearly identify which functions are the responsibility of the supports coordinator, the supports coordinator assistant and the services and supports broker. The services and supports broker must work under the supervision of a qualified supports coordinator.

Many beneficiaries choose a services and supports broker rather than traditional case management services or supports coordination provided directly by a supports coordinator. If a beneficiary does not want case management or supports coordination services, the PIHP will assist the beneficiary to identify who will assist him in performing each of the functions, including the use of natural supports or other qualified providers, to assure the supports coordination functions are provided. The IPOS must reflect the beneficiary's choices, the responsible person(s) for each of the functions listed in this section, and the frequency at which each will occur.

When the beneficiary chooses a supports coordinator assistant, a services and supports broker, or a natural support to perform any of the functions, the IPOS must clearly identify which functions are the responsibility of the supports coordinator, the supports coordinator assistant, the services and supports broker or the natural support. The PIHP must assure that it is not paying for the supports coordinator or supports coordinator assistant and the services and supports broker to perform the same function. Likewise, when a supports coordinator or supports coordinator assistant facilitates a person-centered planning meeting, it is expected that the PIHP would not "double count" the time of any services and supports broker who also attends. During its on-site visits, MDHHS will review the IPOS to verify that there is no duplication of service provision when both a supports coordinator or supports coordinator assistant and a services and supports broker are assigned supports coordination responsibilities in a beneficiary's plan of service.

	Supports strategies will incorporate the principles of empowerment, community inclusion, health and safety assurances, and the use of natural supports. Support coordinators, supports coordinator assistants, or services and supports brokers will work closely with the beneficiary to assure his ongoing satisfaction with the process and outcomes of the supports, services, and available resources. Supports Coordination is reported only when there is face-to-face contact with the beneficiary. Related activities, such as telephone calls to schedule appointments or arrange supports, are functions that are performed by a supports coordinator but not reported separately. Supports coordination functions must assure: ▪ Activities are documented. ▪ Appointments and meetings are scheduled. ▪ Housing and employment issues are addressed. ▪ Income/benefits are maximized. ▪ Information is provided to assure the beneficiary (and his representative(s), if applicable) is informed about self-determination. ▪ Monitoring of individual budgets (when applicable) for over- or under-utilization of funds is provided. ▪ Natural and community supports are used. ▪ Person-centered planning is provided and independent facilitation of person-centered planning is made available. ▪ Persons chosen by the beneficiary are involved in the planning process. ▪ Plans of supports/services are reviewed at such intervals as are indicated during planning. ▪ Social networks are developed. ▪ The desires and needs of the beneficiary are determined. ▪ The quality of the supports and services, as well as the health and safety of the beneficiary, is monitored. ▪ The supports and services desired and needed by the beneficiary are identified and implemented. Additionally, the supports coordinator, supports coordinator assistant, or services and supports broker coordinates with, and provides information as needed to, the qualified intellectual disability professional (QIDP) on the process of evaluation and reevaluation of beneficiary level of care (e.g., supply status and update information, summarize input from supports providers, planning committee members, etc.).

	While supports coordination as part of the overall plan implementation and/or facilitation may include initiation of other coverages and/or short-term provision of supports, it shall not include direct delivery of ongoing day-to-day supports and/or training, or provision of other Medicaid services. Supports coordination does not include any activities defined as Out-of-Home Non-Vocational Habilitation, Prevocational Services, Supported Employment, or CLS. Supports coordinators, supports coordinator assistants, and services and supports brokers are prohibited from exercising the agency's authority to authorize or deny the provision of services. Supports coordination may not duplicate services that are the responsibility of another program. The supports coordination functions to be performed and the frequency of face-to-face and other contacts are specified in the beneficiary's plan. The beneficiary's record must contain sufficient information to document the provision of supports coordination, including the nature of the service, the date, and the location of contacts, including whether the contacts were face-to-face. The frequency and scope of supports coordination contacts must take into consideration health and safety needs of the beneficiary.
Supported Employment	Supported employment is the combination of ongoing support services and paid employment that enables the beneficiary to work in the community. For purposes of this waiver, the definition of "supported employment" is: ▪ Community-based, taking place in integrated work settings where workers with disabilities work alongside people who do not have disabilities. ▪ For beneficiaries with severe disabilities who require ongoing intensive supports such as job coach, employment specialist, or personal assistant. ▪ For beneficiaries who require intermittent or diminishing amounts of supports from a job coach, employment specialist or personal assistant. Supported employment includes activities needed to sustain paid work by individuals receiving waiver services, including supervision and training, job coach, employment specialist services, personal assistance and consumer-run businesses. Supported employment services cannot be used for capital investment in a consumer-run business. When supported employment services are provided at a work site in which persons without disabilities are employed, payment will be made only for the adaptations, supervision and training required by individuals receiving waiver services as a result of their disabilities, and will not include payment for the supervisory activities rendered as a normal part of the business setting or for any services that are the responsibility of another agency, such as Michigan Rehabilitation Services (MRS) or the Bureau of Services for Blind Persons (BSBP). FFP may not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as: ▪ Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program; ▪ Payments that are passed through to users of supported employment programs; or ▪ Payments for vocational training that is not directly related to an individual's supported employment program.

	Transportation provided between the beneficiary's place of residence and the site of the supported employment service, or between habilitation sites (in cases where the beneficiary receives habilitation services in more than one place), is included as part of the supported employment and/or habilitation service. Documentation must be maintained by the PIHP that the beneficiary is not currently eligible for supported employment services provided by MRS or BSBP. Information must be updated when MRS or BSBP eligibility conditions change.

15.2 Supports and Services Provider Qualifications

Providers of Habilitation Supports Waiver supports and services are chosen by the beneficiary and others assisting him during the person-centered planning process, and must meet the staffing qualifications contained in Michigan's 1915(c) Waiver.

15.2.A. Supports Coordinator Qualifications

The Supports Coordinator must be:

- a QIDP;
- Selected by the beneficiary.

15.2.B. Trained Supports Coordinator Assistant Qualifications

- Minimum of equivalent experience (i.e., provides knowledge, skills and abilities similar to supports coordinator qualifications).
- Functions under the supervision of a supports coordinator.
- Selected by the beneficiary.
- At least 18 years of age.

15.2.C. Aide Qualifications

Minimum qualifications are noted below for aide level work (chore, respite, CLS, and out-of-home habilitation). The planning team should also identify other competencies that will assure the best possible outcomes for the beneficiary. Aide level staff who provide services and supports must be:

- At least 18 years of age.
- Able to prevent transmission of any communicable disease from self to others in the environment in which they are providing supports.
- Able to communicate expressively and receptively in order to follow individual plan requirements and beneficiary-specific emergency procedures, and report on activities performed.
- In good standing with the law (i.e., not a fugitive from justice, not a convicted felon who is either still under jurisdiction or one whose felony relates to the kind of duty he/she would be performing, not an illegal alien).

- Able to perform basic first aid procedures, as evidenced by completion of a first aid training course, self-test, or other method determined by the PIHP to demonstrate competence in basic first aid procedures.
- Has received training in the beneficiary's IPOS.

15.2.D. Services and Supports Broker Qualifications

- Selected by the beneficiary.
- Demonstrates competence in areas of job responsibilities for services and supports broker.
- Functions under the supervision of a supports coordinator.
- At least 18 years of age.

SECTION 16 – MENTAL HEALTH AND SCHOOL BASED SERVICES

This section is applicable to all PIHP programs/provider requirements and pertains to beneficiaries with mental illness and/or developmental disabilities.

The School-Based Services (SBS) policy requires cooperative agreements between the PIHP and the SBS provider. These agreements are not changed by the policies in this chapter. Any required releases of information are part of the existing requirements of the SBS provider.

The quality assurance standards for SBS also requires the coordination of care with other human service agencies where appropriate, including local public health departments, community mental health agencies and the beneficiary's physician or managed care providers. In addition, enrolled SBS providers are required to cooperate with other human service agencies operating within the same service area and are not expected to replace or substitute services already provided by other agencies.

When a beneficiary receives active treatment from a SBS provider, the services must be coordinated with the PIHP. If the PIHP provides mental health services for a special education student with serious emotional disturbance or a developmental disability, PIHP must coordinate such services and information with special education and other human services agencies serving the student.

(Refer to the School Based Services Chapter of this manual for additional information.)

SECTION 17 – ADDITIONAL MENTAL HEALTH SERVICES (B3S)

PIHPs must make certain Medicaid-funded mental health supports and services available, in addition to the Medicaid State Plan Specialty Supports and Services or Habilitation Waiver Services, through the authority of 1915(b)(3) of the Social Security Act (hereafter referred to as B3s). The intent of B3 supports and services is to fund medically necessary supports and services that promote community inclusion and participation, independence, and/or productivity when identified in the individual plan of service as one or more goals developed during person-centered planning. NOTE: Certain services found in this section are State Plan EPSDT services when delivered to children birth-21 years, which include community living supports, family support and training (Parent-to-Parent/Parent Support Partner) peer-delivered services, prevention/direct models of parent education and services for children of adults with mental illness, skill building, supports coordination, and supported employment.

17.1 DEFINITIONS OF GOALS THAT MEET THE INTENTS AND PURPOSE OF B3 SUPPORTS AND SERVICES

The goals (listed below) and their operational definitions will vary according to the individual's needs and desires. However, goals that are inconsistent with least restrictive environment (i.e., most integrated home, work, community that meet the individual's needs and desires) and individual choice and control cannot be supported by B3 supports and services unless there is documentation that health and safety would otherwise be jeopardized; or that such least restrictive arrangements or choice and control opportunities have been demonstrated to be unsuccessful for that individual. Care should be taken to insure that these goals are those of the individual first, not those of a parent, guardian, provider, therapist, or case manager, no matter how well intentioned. The services in the plan, whether B3 supports and services alone, or in combination with state plan or Habilitation Supports Waiver services, must reasonably be expected to achieve the goals and intended outcomes identified. The configuration of supports and services should assist the individual to attain outcomes that are typical in his community; and without such services and supports, would be impossible to attain.

Community Inclusion and Participation	The individual uses community services and participates in community activities in the same manner as the typical community citizen. Examples are recreation (parks, movies, concerts, sporting events, arts classes, etc.), shopping, socialization (visiting friends, attending club meetings, dining out) and civic (volunteering, voting, attending governmental meetings, etc.) activities. A beneficiary's use of, and participation in, community activities are expected to be integrated with that of the typical citizen's (e.g., the beneficiary would attend an "integrated" yoga class at the community center rather than a special yoga class for persons with intellectual disability).
Independence	"Freedom from another's influence, control and determination." (Webster's New World College Dictionary, 1996). Independence in the B3 context means how the individual defines the extent of such freedom for him/herself during person-centered planning. For example, to some beneficiaries, "freedom" could be living on their own, controlling their own budget, choosing an apartment as well as the persons who will live there with them, or getting around the community on their own. To others, "freedom" could be control over what and when to eat, what and when to watch television, when and how to bathe, or when to go to bed and arise. For children under 18 years old, independence may mean the support given by parents and others to help children achieve the skills they need to be successful in school, enter adulthood and live independently.

Productivity	Engaged in activities that result in or lead to maintenance of or increased self-sufficiency. Those activities are typically going to school and work. The operational definition of productivity for an individual may be influenced by age-appropriateness. For example, a person who is 76 years old may choose to volunteer or participate in other community or senior center activities rather than have any productivity goals. For children under the age of five years, productivity may be successful participation in home, pre-school, or child care activities. Children under 18 would be expected to attend school, but may choose to work in addition. In order to use B3 supports and services, individuals would be expected to prepare for, or go to, school or work in the same places that the typical citizen uses.

17.2 Criteria for Authorizing B3 Supports and Services

The authorization and use of Medicaid funds for any of the B3 supports and services, as well as their amount, scope and duration, are dependent upon:

- The Medicaid beneficiary's eligibility for specialty services and supports as defined in this Chapter;
- The service(s) having been identified during person-centered planning;
- The service(s) being medically necessary as defined in the Medical Necessity Criteria subsection of this chapter;
- The service(s) being expected to achieve one or more of the above-listed goals as identified in the beneficiary's plan of service; and
- Additional criteria indicated in certain B3 service definitions, as applicable.

Decisions regarding the authorization of a B3 service (including the amount, scope and duration) must take into account the PIHP's documented capacity to reasonably and equitably serve other Medicaid beneficiaries who also have needs for these services. The B3 supports and services are not intended to meet all the individual's needs and preferences, as some needs may be better met by community and other natural supports. Natural supports mean unpaid assistance provided to the beneficiary by people in his/her network (family, friends, neighbors, community volunteers) who are willing and able to provide such assistance. It is reasonable to expect that parents of minor children with disabilities will provide the same level of care they would provide to their children without disabilities. MDHHS encourages the use of natural supports to assist in meeting an individual's needs to the extent that the family or friends who provide the natural supports are willing and able to provide this assistance. PIHPs may not require a beneficiary's natural support network to provide such assistance as a condition for receiving specialty mental health supports and services. The use of natural supports must be documented in the beneficiary's individual plan of service.

Provider qualifications and service locations that are not otherwise identified in this section must meet the requirements identified in the General Information and Program Requirement sections of this chapter.

17.3 B3 Supports and Services

The B3 supports and services defined below are the supports and services that PIHPs are to provide from their Medicaid capitation.

17.3.A. Assistive Technology

Assistive technology is an item or set of items that enable the individual to increase his ability to perform activities of daily living with a greater degree of independence than without them; to perceive, control, or communicate with the environment in which he lives. These are items that are not available through other Medicaid coverage or through other insurances. These items must be specified in the individual plan of service. All items must be ordered by a physician on a prescription as defined in the General Information section of this chapter. An order is valid for one year from the date it was signed.

Coverage includes:

- Adaptations to vehicles
- Items necessary for independent living (e.g., Lifeline, sensory integration equipment)
- Communication devices
- Special personal care items that accommodate the person's disability (e.g., reachers, full-spectrum lamp)
- Prostheses necessary to ameliorate negative visual impact of serious facial disfigurements and/or skin conditions
- Ancillary supplies and equipment necessary for proper functioning of assistive technology items
- Repairs to covered assistive technology that are not covered benefits through other insurances

Assessments by an appropriate health care professional, specialized training needed in conjunction with the use of the equipment, and warranted upkeep will be considered as part of the cost of the services.

Coverage excludes:

- Furnishings (e.g., furniture, appliances, bedding) and other non-custom items (e.g., wall and floor coverings, decorative items) that are routinely found in a home.
- Items that are considered family recreational choices.
- The purchase or lease of a vehicle, and any repairs or routine maintenance to the vehicle.
- Educational supplies required to be provided by the school as specified in the child's Individualized Education Plan.

Covered items must meet applicable standards of manufacture, design, and installation. There must be documentation that the best value in warranty coverage was obtained for the item at the time of purchase.

In order to cover repairs of assistive technology items, there must be documentation in the individual plan of services that the assistive technology continues to meet the criteria

for B3 supports and services as well as those in this subsection. All applicable warranty and insurance coverages must be sought and denied before paying for repairs. The PIHP must document that the repair is the most cost-effective solution when compared with replacement or purchase of a new item. If the equipment requires repairs due to misuse or abuse, the PIHP must provide evidence of training in the use of the equipment to prevent future incidents.

17.3.B. COMMUNITY LIVING SUPPORTS

NOTE: This service is a State Plan EPSDT service when delivered to children birth-21 years.

Community Living Supports are used to increase or maintain personal self-sufficiency, facilitating an individual's achievement of his goals of community inclusion and participation, independence or productivity. The supports may be provided in the participant's residence or in community settings (including, but not limited to, libraries, city pools, camps, etc.).

Coverage includes:

- Assisting (that exceeds state plan for adults), prompting, reminding, cueing, observing, guiding and/or training in the following activities:
  - meal preparation
  - laundry
  - routine, seasonal, and heavy household care and maintenance
  - activities of daily living (e.g., bathing, eating, dressing, personal hygiene)
  - shopping for food and other necessities of daily living

  CLS services may not supplant services otherwise available to the beneficiary through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973 or state plan services, e.g., Personal Care (assistance with ADLs in a certified specialized residential setting) and Home Help or Expanded Home Help (assistance in the individual's own, unlicensed home with meal preparation, laundry, routine household care and maintenance, activities of daily living and shopping). If such assistance appears to be needed, the beneficiary must request Home Help and, if necessary, Expanded Home Help from MDHHS. CLS may be used for those activities while the beneficiary awaits determination by MDHHS of the amount, scope and duration of Home Help or Expanded Home Help. If the beneficiary requests it, the PIHP case manager or supports coordinator must assist him/her in requesting Home Help or in filling out and sending a request for Fair Hearing when the beneficiary believes that the MDHHS authorization of amount, scope and duration of Home Help does not appear to reflect the beneficiary's needs based on the findings of the MDHHS assessment.
- Staff assistance, support and/or training with activities such as:
  - money management
  - non-medical care (not requiring nurse or physician intervention)

- socialization and relationship building
- transportation from the beneficiary's residence to community activities, among community activities, and from the community activities back to the beneficiary's residence (transportation to and from medical appointments is excluded)
- participation in regular community activities and recreation opportunities (e.g., attending classes, movies, concerts and events in a park; volunteering; voting)
- attendance at medical appointments
- acquiring or procuring goods, other than those listed under shopping, and non-medical services

- Reminding, observing and/or monitoring of medication administration
- Staff assistance with preserving the health and safety of the individual in order that he/she may reside or be supported in the most integrated, independent community setting.

CLS may be provided in a licensed specialized residential setting as a complement to, and in conjunction with, state plan coverage Personal Care in Specialized Residential Settings. Transportation to medical appointments is covered by Medicaid through MDHHS or the Medicaid Health Plan. Payment for CLS services may not be made, directly or indirectly, to responsible relatives (i.e., spouses, or parents of minor children), or guardian of the beneficiary receiving community living supports.

CLS assistance with meal preparation, laundry, routine household care and maintenance, activities of daily living and/or shopping may be used to complement Home Help or Expanded Home Help services when the individual's needs for this assistance have been officially determined to exceed the DHS's allowable parameters. CLS may also be used for those activities while the beneficiary awaits the decision from a Fair Hearing of the appeal of a MDHHS decision. Reminding, observing, guiding, and/or training of these activities are CLS coverages that do not supplant Home Help or Expanded Home Help.

Community Living Supports (CLS) provides support to a beneficiary younger than 18, and the family in the care of their child, while facilitating the child's independence and integration into the community. This service provides skill development related to activities of daily living, such as bathing, eating, dressing, personal hygiene, household chores and safety skills; and skill development to achieve or maintain mobility, sensory-motor, communication, socialization and relationship-building skills, and participation in leisure and community activities. These supports must be provided directly to, or on behalf of, the child. These supports may serve to reinforce skills or lessons taught in school, therapy, or other settings. For children and adults up to age 26 who are enrolled in school, CLS services are not intended to supplant services provided in school or other settings or to be provided during the times when the child or adult would typically be in school but for the parent's choice to home-school.

17.3.C. Enhanced Pharmacy

Enhanced pharmacy items are physician-ordered, nonprescription "medicine chest" items as specified in the individual's plan of service. There must be documented evidence that the item is not available through Medicaid or other insurances, and is the most cost-effective alternative to meet the beneficiary's need.

The following items are covered only for adult beneficiaries living in independent settings (i.e., own home, apartment where deed or lease is signed by the beneficiary):

- Cough, cold, pain, headache, allergy, and/or gastrointestinal distress remedies
- First aid supplies (e.g., band-aids, iodine, rubbing alcohol, cotton swabs, gauze, antiseptic cleansing pads)

The following items are covered for beneficiaries living in independent settings, with family, or in licensed dependent care settings:

- Special oral care products to treat specific oral conditions beyond routine mouth care (e.g., special toothpaste, tooth brushes, anti-plaque rinses, antiseptic mouthwashes)
- Vitamins and minerals
- Special dietary juices and foods that augment, but do not replace, a regular diet
- Thickening agents for safe swallowing when the beneficiary has a diagnosis of dysphagia and either:
  - A history of aspiration pneumonia, or
  - Documentation that the beneficiary is at risk of insertion of a feeding tube without the thickening agents for safe swallowing.

Coverage excludes:

- Routine cosmetic products (e.g., make-up base, aftershave, mascara, and similar products)

17.3.D. Environmental Modifications

Physical adaptations to the beneficiary's own home or apartment and/or work place. There must be documented evidence that the modification is the most cost-effective alternative to meet the beneficiary's need/goal based on the results of a review of all options, including a change in the use of rooms within the home or alternative housing, or in the case of vehicle modification, alternative transportation. All modifications must be prescribed by a physician. Prior to the environmental modification being authorized, PIHP may require that the beneficiary apply to all applicable funding sources (e.g., housing commission grants, MSHDA, and community development block grants), for assistance. It is expected that the PIHP case manager/supports coordinator will assist the beneficiary in his pursuit of these resources. Acceptances or denials by these funding sources must be documented in the beneficiary's records. Medicaid is a funding source of last resort.

Coverage includes:

- The installation of ramps and grab-bars.
- Widening of doorways.
- Modification of bathroom facilities.
- Special floor, wall or window covering that will enable the beneficiary more independence or control over his environment, and/or ensure health and safety.
- Installation of specialized electrical and plumbing systems that are necessary to accommodate the medical equipment and supplies necessary for the welfare of the beneficiary.
- Assessments by an appropriate health care professional and specialized training needed in conjunction with the use of such environmental modifications.
- Central air conditioning when prescribed by a physician and specified as to how it is essential in the treatment of the beneficiary's illness or condition. This supporting documentation must demonstrate the cost-effectiveness of central air compared to the cost of window units in all rooms that the beneficiary must use.
- Environmental modifications that are required to support proper functioning of medical equipment, such as electrical upgrades, limited to the requirements for safe operation of the specified equipment.
- Adaptations to the work environment limited to those necessary to accommodate the beneficiary's individualized needs.

Coverage excludes:

- Adaptations or improvements to the home that are not of direct medical or remedial benefit to the beneficiary, or do not support the identified goals of community inclusion and participation, independence or productivity.
- Adaptations or improvements to the home that are of general utility or cosmetic value and are considered to be standard housing obligations of the beneficiary. Examples of exclusions include, but are not limited to, carpeting (see exception above), roof repair, sidewalks, driveways, heating, central air conditioning, garages, raised garage doors, storage and organizers, landscaping and general home repairs.
- Cost for construction of a new home or new construction (e.g., additions) in an existing home.
- Environmental modifications costs for improvements exclusively required to meet local building codes.
- Adaptations to the work environment that are the requirements of Section 504 of the Rehabilitation Act, the Americans with Disabilities Act, or are the responsibilities of Michigan Rehabilitation Services (MRS) or the Bureau of Services for Blind Persons (BSBP).

The PIHP must assure there is a signed contract with the builder for an environmental modification and the homeowner. It is the responsibility of the PIHP to work with the

beneficiary and the builder to ensure that the work is completed as outlined in the contract and that issues are resolved among all parties. In the event that the contract is terminated prior to the completion of the work, Medicaid capitation payments may not be used to pay for any additional costs resulting from the termination of the contract.

The existing structure must have the capability to accept and support the proposed changes. The "infrastructure" of the home (e.g., electrical system, plumbing, well/septic, foundation, heating/cooling, smoke detector systems, roof) must be in compliance with all local codes. If the home is not code compliant, other funding sources must be secured to bring the home into compliance.

The environmental modification must incorporate reasonable and necessary construction standards and comply with applicable state or local building codes. The adaptation cannot result in valuation of the structure significantly above comparable neighborhood real estate values.

Adaptations may be made to rental properties when the landowner agrees to the adaptation in writing. A written agreement between the landowner and the beneficiary must specify any requirements for restoration of the property to its original condition if the occupant moves, and must indicate that Medicaid is not obligated for any restoration costs.

If a beneficiary purchases an existing home while receiving Medicaid services, it is the beneficiary's responsibility to assure that the home will meet basic needs, such as having a ground floor bath/bedroom if the beneficiary has mobility limitations. Medicaid funds may be authorized to assist with the adaptations noted above (e.g., ramps, grab bars, widening doorways) for a recently purchased existing home.

17.3.E. Family Support and Training [Change Made 4/1/18]

NOTE: This service is a State Plan EPSDT service when delivered to children birth-21 years.

Family-focused services provided to family (natural or adoptive parents, spouse, children, siblings, relatives, foster family, in-laws, and other unpaid caregivers) of persons with serious mental illness, serious emotional disturbance or developmental disability for the purpose of assisting the family in relating to and caring for a relative with one of these disabilities. The services target the family members who are caring for and/or living with an individual receiving mental health services. The service is to be used in cases where the beneficiary is hindered or at risk of being hindered in his ability to achieve goals of:

- performing activities of daily living;
- perceiving, controlling, or communicating with the environment in which he lives; or
- improving his inclusion and participation in the community or productive activity, or opportunities for independent living.

The training and counseling goals, content, frequency and duration of the training must be identified in the beneficiary's individual plan of service, along with the beneficiary's goal(s) that are being facilitated by this service.

Coverage includes:

- Education and training, including instructions about treatment regimens, and use of assistive technology and/or medical equipment needed to safely maintain the person at home as specified in the individual plan of service.
- Counseling and peer support provided by a trained counselor or peer one-on-one or in group for assistance with identifying coping strategies for successfully caring for or living with a person with disabilities.
- Family Psycho-Education (SAMHSA model -- specific information is found in the GUIDE TO FAMILY PSYCHOEDUCATION, Requirements for Certification, Sustainability, and Fidelity) for individuals with serious mental illness and their families. This evidence-based practice includes family educational groups, skills workshops, and joining.
- Parent-to-Parent Support is designed to support parents/family of children with serious emotional disturbance or intellectual/developmental disabilities, including autism, as part of the treatment process to be empowered, confident and have knowledge and skills that will enable the parent/family to improve their child's and family's functioning. Utilizing their lived experience, the trained parent support partner, who has or had a child with special mental health needs, provides education, coaching, and support and enhances the assessment and mental health treatment process. The parent support partner provides these services to the parents/caregivers. These activities are provided in the home and in the community. The parent support partner is an active member of the treatment team and participates in team consultation with the treating professionals. The parent support partner is to be provided regular supervision. **(revised 4/1/18)**

17.3.F. Housing Assistance

Housing assistance is assistance with short-term, interim, or one-time-only expenses (not including room and board costs) for beneficiaries transitioning from restrictive settings and homelessness into more independent, integrated living arrangements while in the process of securing other benefits (e.g., SSI) or public programs (e.g., governmental rental assistance and/or home ownership programs) that will become available to assume these obligations and provide needed assistance.

Additional criteria for housing assistance:

- The beneficiary must have in his individual plan of services a goal of independent living, and either live in a home/apartment that he/she owns, rents, or leases; or be in the process of transitioning to such a setting; and
- Documentation of the beneficiary's control (i.e., beneficiary-signed lease, rental agreement, deed) of his living arrangement in the individual plan of service; and
- Documentation of efforts (e.g., the person is on a waiting list) under way to secure other benefits, such as SSI or public programs (e.g., governmental rental assistance, community housing initiatives and/or home ownership programs) so when these become available they will assume these obligations and provide the needed assistance.

Coverage includes:

- Assistance with utilities, insurance, and moving expenses where such expenses would pose a barrier to a successful transition to owning or leasing/renting a dwelling.
- Limited term or temporary assistance with living expenses for beneficiaries transitioning from restrictive settings and homelessness. Limited term or temporary assistance is defined as a total of six (6) occurrences of a funding need.
- Interim assistance with utilities, insurance or living expenses when the beneficiary already living in an independent setting experiences a temporary reduction or termination of his own or other community resources. Interim assistance is defined as a total of three (3) occurrences of a funding need.
- Home maintenance when, without a repair to the home or replacement of a necessary appliance, the individual would be unable to move there, or if already living there, would be forced to leave for health and safety reasons.

Coverage excludes:

- Funding for on-going housing costs. Ongoing is defined as longer than a total of six (6) occurrences of a funding need.
- Funding for any room and board costs (i.e., rental payments, mortgage payments, lease payments, land contract payments, hotel/motel stays, etc.)
- Home maintenance that is of general utility or cosmetic value and is considered to be a standard housing obligation of the beneficiary.

Replacement or repair of appliances should follow the general rules under assistive technology. Repairs to the home must be in compliance with all local codes and be performed by the appropriate contractor (refer to the general rules of the Environmental Modifications subsection of this chapter). Replacement or repair of appliances, and repairs to the home or apartment do not need a prescription or order from a physician.

17.3.G. Peer-Delivered or -Operated Support Services

NOTE: This service is a State Plan EPSDT service when delivered to children birth-21 years.

Peer-delivered or peer-operated support services are programs and services that provide individuals with opportunities to learn and share coping skills and strategies, move into more active assistance and away from passive roles, and to build and/or enhance self-esteem and self-confidence.

17.3.G.1. Drop-In Centers [Re-numbered 4/1/18]

Peer-Run Drop-In Centers provide an informal, supportive environment to assist beneficiaries with mental illness in the recovery process. If a beneficiary chooses to participate in Peer-Run Drop-In Center services, such services may be included in an IPOS if medically necessary for the beneficiary. Peer-Run Drop-In Centers provide opportunities to learn and share coping skills and strategies, to move into more active

assistance and away from passive beneficiary roles and identities, and to build and/or enhance self-esteem and self-confidence. Under no circumstances may Peer-Run Drop-In Centers be used as respite for caregivers (paid or non-paid) or residential providers of individuals.

PIHPs must seek approval from MDHHS prior to establishing new drop-in programs. Proposed drop-in centers will be reviewed against the following criteria:

- Staff and board of directors of the center are 100% primary consumers;
- PIHP actively supports consumers' autonomy and independence in making day-to-day decisions about the program;
- PIHP facilitates consumers' ability to handle the finances of the program;
- The drop-in center is at a non-CMH site;
- The drop-in center has applied for 501(c)(3) non-profit status;
- There is a contract between the drop-in center and the PIHP, or its subcontractor, identifying the roles and responsibilities of each party; and
- There is a liaison appointed by the PIHP to work with the program.

Some beneficiaries use drop-in centers anonymously and do not have a drop-in center listed as a service in their IPOS. For those beneficiaries who do have drop-in specified in their IPOS, it must be documented to be medically necessary and identify:

- Goals and how the program supports those goals; and
- The amount, scope and duration of the services to be delivered.

The individual clinical record provides evidence that the services were delivered consistent with the plan.

17.3.G.2. Peer Specialist Services [Re-numbered 4/1/18]

Peer specialist services provide individuals with opportunities to support, mentor and assist beneficiaries to achieve community inclusion, participation, independence, recovery, resiliency and/or productivity. Peers are individuals who have a unique background and skill level from their experience in utilizing services and supports to achieve their personal goals of community membership, independence and productivity. Peers have a special ability to gain trust and respect of other beneficiaries based on shared experience and perspectives with disabilities, and with planning and negotiating human services systems.

- Vocational assistance provides support for beneficiaries seeking education and/or training opportunities, finding a job, achieving successful employment activities, and developing self-employment opportunities (reported as skill-building or supported employment).
- Housing assistance provides support locating and acquiring appropriate housing for achieving independent living; finding and choosing roommates; utilizing short-term, interim, or one-time-only financial assistance in order to transition from restrictive settings into independent integrated living arrangements; making applications for

Section 8 Housing vouchers; managing costs or room and board utilizing an individual budget; purchasing a home; etc. (reported as supports coordination).

- Services and supports planning and utilization assistance provides assistance and partnership in:
  - The person-centered planning process (reported as either treatment planning or supports coordination);
  - Developing and applying arrangements that support self-determination;
  - Directly selecting, employing or directing support staff;
  - Sharing stories of recovery and/or advocacy involvement and initiative for the purpose of assisting recovery and self-advocacy;
  - Accessing entitlements;
  - Developing health and wellness plans;
  - Developing advance directives;
  - Learning about and pursuing alternatives to guardianship;
  - Providing supportive services during crises;
  - Developing, implementing and providing ongoing guidance for advocacy and support groups;
  - Integration of physical and mental health care;
  - Developing, implementing and providing health and wellness classes to address preventable risk factors for medical conditions.

Activities provided by peers are completed in partnership with beneficiaries for the specific purpose of achieving increased beneficiary community inclusion and participation, independence and productivity.

Individuals providing Peer Support Services must be able to demonstrate their experience in relationship to the types of guidance, support and mentoring activities they will provide. Individuals providing these services should be those generally recognized and accepted to be peers. Beneficiaries utilizing Peer Support Services must freely choose the individual who is providing Peer Support Services. Individuals who are functioning as Peer Support Specialists serving beneficiaries with mental illness must:

- have a serious mental illness;
- have received public mental health services currently or in the past;
- provide at least 10 hours per week of services described above with supported documentation written in the IPOS; and
- meet the MDHHS application approval process for specialized training and certification requirements.

17.3.G.3. Peer Recovery Coach Services [Subsection Added 4/1/18]

Peer Recovery Coach Services	Peer Recovery Coach services are provided by a person in a journey of recovery from addictions or co-occurring disorders who identifies with a beneficiary based on a shared background and life experience. The Peer Recovery Coach serves as a personal guide and mentor for beneficiaries seeking, or already in, recovery from substance use disorders. Peer Recovery Coaches support a beneficiary's journey toward recovery and wellness by creating and sustaining networks of formal and informal services and supports while role modeling the many pathways to recovery as each individual determines his or her own way. The Peer Recovery Coach helps to remove barriers and obstacles, and links the beneficiary to resources in the recovery community. Services provided by a Peer Recovery Coach support beneficiaries to become and stay engaged in the recovery process and reduce the likelihood of relapse. Activities are targeted to beneficiaries at all places along the path to recovery, including outreach for persons who are still active in their addiction, up to and including individuals who have been in recovery for several years. Peer Recovery Coaches embody a powerful message of hope, helping beneficiaries achieve a full and meaningful life in the community. The Peer Recovery Coach can assist with tasks such as setting recovery goals, developing recovery action plans, and solving problems directly related to recovery. The Peer Recovery Coach supports each beneficiary to fully participate in communities of their choosing in the environment most supportive of their recovery and that promotes housing of their choice to build recovery connections and supports. Utilizing a strength-based perspective and emphasizing assessment of recovery capital, services are designed to include prevention strategies and the integration of physical and behavioral health services to attain and maintain recovery and prevent relapse. Beneficiaries utilizing Peer Recovery Coach services must freely choose the individual who is providing Peer Recovery Coach services. The Peer Recovery Coach shall receive regular supervision by a case manager, treatment practitioner, prevention staff or an experienced Certified Peer Recovery Coach who has over two continuous years in recovery and over two years in the direct provision of recovery coach services and supports.
Requirements	Individuals who work as a Peer Recovery Coach serving beneficiaries with substance use or co-occurring disorders must: ▪ Be at least 18 years of age; ▪ Have two continuous years in recovery from addition(s), with experience in navigating treatment services and/or prevention; ▪ Share their recovery story as a tool in helping others; ▪ Have experience receiving publicly-funded treatment and recovery services for addiction(s); ▪ Be employed at least 10 hours per week by a licensed Substance Use Disorder Treatment Organization, a PIHP, a Community Mental Health Services Program, or another organization under contract to one or more of the forgoing organizations that provide substance abuse treatment and/or recovery support services; and ▪ Attend and successfully complete the MDHHS Peer Recovery Coach training and certification. **(text added 4/1/18)**

17.3.G.4. Youth Peer Support Services [Re-numbered 4/1/18]

Youth Peer Support is designed to support youth with a serious emotional disturbance through shared activities and interventions. The goals of Youth Peer Support include supporting youth empowerment, assisting youth in developing skills to improve their overall functioning and quality of life, and working collaboratively with others involved in delivering the youth's care. Youth Peer Support services can be in the form of direct support, information sharing and skill building.

Youth Peer Support Services are provided by trained youth peer support specialists, one-on-one or in a group, for youth with serious emotional disturbance who are resolving conflicts, enhancing skills to improve their overall functioning, integrating with community, school and family and/or transitioning into adulthood. Services provide support and assistance for youth in accordance with the goals in their plan of service to assist the youth with community integration, improving family relationships and resolving conflicts, and making a transition to adulthood, including achieving successful independent living options, obtaining employment, and navigating the public human services system.

Youth Peer Support Specialists must have lived experience navigating behavioral health systems and must participate in and complete the approved MDHHS training curriculum. Youth Peer Support activities are identified as part of the assessment and the person-centered/family-driven, youth-guided planning process. The goals of Youth Peer Support services shall be included in the individualized plan of service where interventions are provided in the home and community. These goals will be mutually identified in active collaboration with the youth receiving services and must be delivered by a Youth Peer Support Specialist with lived experience. Youth Peer Support is intended to be provided to children and youth who are middle school to 21 years of age. It is not intended to substitute for other services such as respite or community living support services. The Youth Peer Support Specialist shall receive regular supervision by a child mental health professional and shall participate as an active member of the treatment team.

Qualifications for the Youth Peer Support Specialist include:

- Young adult, ages 18 through 26, with lived experience who received mental health services as a youth.
- Willing and able to self-identify as a person who has or is receiving behavioral health services and is prepared to use that experience in helping others.
- Experience receiving services as a youth in complex, child serving systems preferred (behavioral health, child welfare, juvenile justice, special education, etc.).
- Employed by PIHP/CMHSP or its contract providers.
- Trained in the MDHHS approved curriculum and ongoing training model.

17.3.G.5. Peer Mentoring Services [Re-numbered 4/1/18]

Peer Mentoring services provide adults with intellectual and developmental disabilities with opportunities to support, mentor and assist beneficiaries to achieve community inclusion and participation, independence, and productivity. Peer Mentors are individuals with intellectual and developmental disabilities who have a unique skill level from their experience in utilizing services and supports to achieve their goals. Peer Mentors offer the benefit of their personal experiences, passing along encouragement and support to help others construct their own advocacy. Beneficiaries utilizing Peer Mentoring services must freely choose the individual who is providing Peer Mentoring services from available trained Peer Mentors.

Activities provided by Peer Mentors are completed in partnership with beneficiaries for the specific purpose of achieving increased beneficiary community inclusion and participation, independence, and productivity by:

- sharing personal stories of advocacy for the purpose of supporting self-advocacy and independence, person-centered planning goals, and arrangements that support self-direction;
- navigating transportation systems;
- building bridges to people and resources within the community;
- identifying recreation opportunities;
- providing information on entitlements;
- assisting beneficiaries to move towards independence;
- providing housing information by helping to identify affordable and accessible housing for achieving independent living; finding and choosing roommates; making applications for Section 8 Housing vouchers; managing budgets;
- providing vocational information to beneficiaries who are seeking post-secondary education and/or training opportunities, finding a job, and achieving successful employment.

Requirements

Individuals who are functioning as Peer Mentors serving beneficiaries with intellectual and developmental disabilities must:

- be 18 years of age.
- have an intellectual/developmental disability.
- attend the Michigan Developmental Disabilities Council's Peer Mentor 101 training by referral from their local CMHSP.
- complete a supervised 90-120 hour internship at their local CMHSP. (The CMHSP is expected to hire the individual after certification.)
- share their personal experiences to guide and support beneficiaries.

- participate in annual continuing education trainings to maintain skills and expand knowledge base.

The use of the Peer Mentor code for billing purposes is permissible only after the individual is certified by the Michigan Developmental Disabilities Council.

17.3.H. Prevention-Direct Service Models [Change Made 7/1/18]

Prevention-direct service models are programs using individual, family and group interventions designed to reduce the incidence of behavioral, emotional or cognitive dysfunction, thus reducing the need for individuals to seek treatment through the public mental health system. One or more of the following direct prevention models must be made available by the PIHP or its provider network:

- Child Care Expulsion Prevention
- School Success Programs
- Children of Adults with Mental Illness/Integrated Services (NOTE: This service is a State Plan EPSDT service when delivered to children birth-21 years.)
- Infant Mental Health when not enrolled as a Home-Based program
- Parent Education (NOTE: This service is a State Plan EPSDT service when delivered to children birth-21 years.)

Coverage includes:

Child Care Expulsion Prevention (CCEP)	CCEP, an infant and early childhood mental health consultation model, **(text added 7/1/18)** provides consultation to child care providers and parents who care for children under the age of six who are experiencing behavioral and emotional challenges in their child care settings. Sometimes these challenges may put children at risk of expulsion from the child care setting. CCEP aims to reduce expulsion and increase the number of families and child care providers who successfully nurture the social and emotional development of children 0-5 in child care settings. **(revised 7/1/18)** CCEP programs provide short-term child/family-centered mental health consultation for children with challenging behaviors which includes: ▪ Observation and functional assessment at home and at child care ▪ Individualized plan of service developed by a team comprised of the family, child care provider, other identified support person(s) that the family identifies. ▪ Intervention (e.g., coaching and support for parents and providers to build their reflective capacity, learning new ways to interact with the child to build their social-emotional skills and resilience, providing educational resources for parents and providers, modifying the physical environment, connecting family to community resources, providing counseling for families in crisis, and referral for ongoing mental health services, if needed). **(revised 7/1/18)**

	Provider qualifications: ▪ Master's prepared early childhood mental health professional plus specific training in the evaluated model as approved by MDHHS. Effective October 1, 2009, training requirement must, at a minimum, include Endorsement, at Level 2, by the Michigan Association of Infant Mental Health; Level 3 preferred. **(revised 7/1/18)**
School Success Program	Works with parents so that they can be more involved in their child's life, monitor and supervise their child's behaviors; works with youth to develop pro-social behaviors, coping mechanisms, and problem solving skills; and consults with teachers in order to assist them in developing relationships with these students. Mental Health staff also act as a liaison between home and school. Provider qualifications: ▪ Child Mental Health Professional
Children of Adults with Mental Illness/Integrated Services	Designed to prevent emotional and behavioral disorders among children whose parents are receiving services from the public mental health system and to improve outcomes for adult beneficiaries who are parents. The Integrated Services approach includes assessment and service planning for the adult beneficiaries related to their parenting role and their children's needs. Treatment objectives, services, and supports are incorporated into the service plan through a person-centered planning process for the adult beneficiary who is a parent. Linking the adult beneficiary and child to available community services, respite care and providing for crisis planning are essential components. Provider qualifications: ▪ Mental Health Professional
Infant Mental Health	Provides home-based parent-infant support and intervention services to families where the parent's condition and life circumstances, or the characteristics of the infant, threaten the parent-infant attachment and the consequent social, emotional, behavioral and cognitive development of the infant. Services reduce the incidence and prevalence of abuse, neglect, developmental delay, behavioral and emotional disorder. PIHPs or their provider networks may provide infant mental health services as a specific service when it is not part of a Department certified home-based program. Provider qualifications: ▪ Masters-prepared early childhood mental health professional plus specific training. Effective October 1, 2009, training requirement must minimally have Endorsement Level 2 by the Michigan Association of Infant Mental Health; Level 3 preferred.
Parent Education	Provided to parents using evaluated models that promote nurturing parenting attitudes and skills, teach developmental stages of childhood (including social-emotional developmental stages), teach positive approaches to child behavior/discipline and interventions the parent may utilize to support healthy social and emotional development, and to remediate problem behaviors. Provider qualifications: ▪ Child Mental Health Professional who is trained in the model

17.3.I. Respite Care Services

Respite care services are intended to assist in maintaining a goal of living in a natural community home and are provided on a short-term, intermittent basis to relieve the

beneficiary's family or other primary caregiver(s) from daily stress and care demands during times when they are providing unpaid care. Respite is not intended to be provided on a continuous, long-term basis where it is a part of daily services that would enable an unpaid caregiver to work elsewhere full time. In those cases, community living supports, or other services of paid support or training staff, should be used. Decisions about the methods and amounts of respite should be decided during person-centered planning. PIHPs may not require active clinical treatment as a prerequisite for receiving respite care. These services do not supplant or substitute for community living support or other services of paid support/training staff.

- "Short-term" means the respite service is provided during a limited period of time (e.g., a few hours, a few days, weekends, or for vacations).
- "Intermittent" means the respite service does not occur regularly or continuously. The service stops and starts repeatedly or with a time period in between.
- "Primary" caregivers are typically the same people who provide at least some unpaid supports daily.
- "Unpaid" means that respite may only be provided during those portions of the day when no one is being paid to provide the care, i.e., not a time when the beneficiary is receiving a paid State Plan (e.g., home help) or waiver service (e.g., community living supports) or service through other programs (e.g., school).
- Children who are living in a family foster care home may receive respite services. The only exclusion of receiving respite services in a family foster care home is when the child is receiving Therapeutic Foster Care as a Medicaid SED waiver service because that is considered in the bundled rate. (Refer to the Child Therapeutic Foster Care subsection in the Children's Serious Emotional Disturbance Home and Community-Based Services Waiver Appendix for additional information.)

Since adult beneficiaries living at home typically receive home help services and hire their family members, respite is not available when the family member is being paid to provide the home help service, but may be available at other times throughout the day when the caregiver is not paid.

Respite care may be provided in the following settings:

- Beneficiary's home or place of residence
- Licensed family foster care home
- Facility approved by the State that is not a private residence (e.g., group home or licensed respite care facility)
- Home of a friend or relative chosen by the beneficiary and members of the planning team
- Licensed camp
- In community (social/recreational) settings with a respite worker trained, if needed, by the family
- Licensed family child care home

Respite care may not be provided in:

- day program settings
- ICF/IIDs, nursing homes, or hospitals

Respite care may not be provided by:

- parent of a minor beneficiary receiving the service
- spouse of the beneficiary served
- beneficiary's guardian
- unpaid primary care giver

Cost of room and board must not be included as part of the respite care unless provided as part of the respite care in a facility that is not a private residence.

17.3.J. Skill-Building Assistance

NOTE: This service is a State Plan EPSDT service when delivered to children birth-21 years.

Skill-building assistance consists of activities identified in the individual plan of services and designed by a professional within his/her scope of practice that assist a beneficiary to increase his economic self-sufficiency and/or to engage in meaningful activities such as school, work, and/or volunteering. The services provide knowledge and specialized skill development and/or support. Skill-building assistance may be provided in the beneficiary's residence or in community settings.

Documentation must be maintained by the PIHP that the beneficiary is not currently eligible for supported employment services provided by Michigan Rehabilitation Services (MRS) or the Bureau of Services for Blind Persons (BSBP). Information must be updated when the beneficiary's MRS or BSBP eligibility conditions change.

Coverage includes:

- Out-of-home adaptive skills training: Assistance with acquisition, retention, or improvement in self-help, socialization, and adaptive skills; and supports services incidental to the provision of that assistance, including:
  - Aides helping the beneficiary with his mobility, transferring, and personal hygiene functions at the various sites where adaptive skills training is provided in the community.
  - When necessary, helping the person to engage in the adaptive skills training activities (e.g., interpreting).

  Services must be furnished on a regularly scheduled basis (several hours a day, one or more days a week) as determined in the individual plan of services and should be coordinated with any physical, occupational, or speech therapies listed in the plan of

supports and services. Services may serve to reinforce skills or lessons taught in school, therapy, or other settings.

- Work preparatory services are aimed at preparing a beneficiary for paid or unpaid employment, but are not job task-oriented. They include teaching such concepts as attendance, task completion, problem solving, and safety. Work preparatory services are provided to people not able to join the general workforce, or are unable to participate in a transitional sheltered workshop within one year (excluding supported employment programs).

  Activities included in these services are directed primarily at reaching habilitative goals (e.g., improving attention span and motor skills), not at teaching specific job skills. These services must be reflected in the beneficiary's person-centered plan and directed to habilitative or rehabilitative objectives rather than employment objectives.
- Transportation from the beneficiary's place of residence to the skill building assistance training, between skills training sites if applicable, and back to the beneficiary's place of residence.

Coverage excludes:

- Services that would otherwise be available to the beneficiary.

17.3.K. Support and Service Coordination [Change Made 4/1/18]

NOTE: This service is a State Plan EPSDT service when delivered to children birth-21 years.

Functions performed by a supports coordinator, supports coordinator assistant, services and supports broker, or otherwise designated representative of the PIHP that include assessing the need for support and service coordination, and assurance of the following:

- Planning and/or facilitating planning using person-centered principles
- Developing an individual plan of service using the person-centered planning process
- Linking to, coordinating with, follow-up of, advocacy with, and/or monitoring of Specialty Services and Supports and other community services/supports.
- Brokering of providers of services/supports
- Assistance with access to entitlements and/or legal representation
- Coordination with the Medicaid Health Plan, Medicaid fee-for-service, or other health care providers

The role of the supports coordinator assistant is to perform the functions listed above, as they are needed, in lieu of a supports coordinator or case manager. A beneficiary would have only one of the three possible options: targeted case manager, supports coordinator, or supports coordinator assistant. When a supports coordinator assistant is used, a qualified supports coordinator or targeted case manager must supervise the assistant. The role and qualifications of the targeted case manager are described in the Targeted Case Management section of this chapter.

A services and supports broker is used to explore the availability of community services and supports, housing, and employment and then to make the necessary arrangement to link the beneficiary with those supports. The role of the supports coordinator or supports coordinator assistant when a services and supports broker is used is to perform the remainder of the functions listed above as they are needed, and to assure that brokering of providers of services and supports is performed.

Whenever services and supports brokers provide any of the supports coordination functions, it is expected that the beneficiary will also have a supports coordinator or case manager, or their assistant, employed by the PIHP or its provider network who assures that the other functions above are in place.

If a beneficiary has both a supports coordinator or supports coordinator assistant AND a services and supports broker, the individual plan of service must clearly identify the staff who is responsible for each function. The PIHP must assure that it is not paying for the supports coordinator (or supports coordinator assistant) and the services and supports broker to perform service brokering. Likewise, when a supports coordinator (or supports coordinator assistant) facilitates a person-centered planning meeting, it is expected that the PIHP would not "double count" the time of any services and supports broker who also attends. During its annual on-site visits, the MDHHS will review individual plans of service to verify that there is no duplication of service provision when both a supports coordinator assistant and a services and supports broker are assigned supports coordination responsibilities in a beneficiary's plan of service.

Supports strategies will incorporate the principles of empowerment, community inclusion, health and safety assurances, and the use of natural supports. Supports coordinators will work closely with the beneficiary to assure his ongoing satisfaction with the process and outcomes of the supports, services, and available resources.

Supports Coordination is reported only when there is face-to-face contact with the beneficiary. Related activities, such as telephone calls to schedule appointments or arrange supports, are functions that are performed by a supports coordinator but not reported separately. Supports coordination functions must assure:

- The desires and needs of the beneficiary are determined
- The supports and services desired and needed by the beneficiary are identified and implemented
- Housing and employment issues are addressed
- Social networks are developed
- Appointments and meetings are scheduled
- Person-centered planning is provided, and independent facilitation of person-centered planning is made available
- Natural and community supports are used
- The quality of the supports and services, as well as the health and safety of the beneficiary, are monitored

- Income/benefits are maximized
- Activities are documented
- Plans of supports/services are reviewed at such intervals as are indicated during planning

While supports coordination as part of the overall plan implementation and/or facilitation may include initiation of other coverage and/or short-term provision of supports, it shall not include direct delivery of ongoing day-to-day supports and/or training, or provision of other Medicaid services. Supports coordinators are prohibited from exercising the agency's authority to authorize or deny the provision of services. Supports coordination may not duplicate services that are the responsibility of another program.

The supports coordination functions to be performed and the frequency of face-to-face and other contacts are specified in the beneficiary's plan. The beneficiary's record must contain sufficient information to document the provision of supports coordination, including the nature of the service, the date, and the location of contacts, including whether the contacts were face-to-face. The frequency and scope of supports coordination contacts must take into consideration the health and safety needs of the individual.

Qualifications of Supports Coordinators	A minimum of a Bachelor's degree in a human services field and one year of experience working with people with developmental disabilities if supporting that population; or a Bachelor's degree in a human services field and one year of experience with people with mental illness if supporting that population.
Qualifications of Supports Coordinator Assistants (text deleted 4/1/18) and Independent Services and Supports Brokers	Minimum of a high school diploma and equivalent experience (i.e., possesses knowledge, skills and abilities similar to supports coordinator qualifications) and functions under the supervision of a qualified supports coordinator. Independent services and supports brokers must meet these qualifications and function under the guidance and oversight of a qualified supports coordinator or case manager.

17.3.L. SUPPORTED/ INTEGRATED EMPLOYMENT SERVICES

NOTE: This service is a State Plan EPSDT service when delivered to children birth-21 years.

Provide job development, initial and ongoing support services, and activities as identified in the individual plan of services that assist beneficiaries to obtain and maintain paid employment that would otherwise be unachievable without such supports. Support services are provided continuously, intermittently, or on a diminishing basis as needed throughout the period of employment. Capacity to intervene to provide assistance to the individual and/or employer in episodic occurrences of need is included in this service. Supported/ integrated employment must be provided in integrated work settings where the beneficiary works alongside people who do not have disabilities.

Coverage includes:

- Job development, job placement, job coaching, and long-term follow-along services required to maintain employment.
- Consumer-run businesses (e.g., vocational components of Fairweather Lodges, supported self-employment)
- Transportation provided from the beneficiary's place of residence to the site of the supported employment service, among the supported employment sites if applicable, and back to the beneficiary's place of residence.

Coverage excludes:

- Employment preparation.
- Services otherwise available to the beneficiary under the Individuals with Disabilities Education Act (IDEA).

17.3.M. 1915(c) Children's Serious Emotional Disturbance Home and Community-Based Services Waiver (SEDW)

All SEDW Wraparound enrolled providers must meet all the requirements in the enrollment standards as listed in the Qualified Staff subsection. In addition, due to the intense needs and level of risk of children/youth and their families served in the SEDW community-based waiver, all SEDW Wraparound providers must meet the following additional requirements:

- Wraparound facilitators must possess a bachelor's degree and be a CMHP or be supervised by a CMHP.
- Wraparound facilitators and those who provide supervision to facilitators will attend additional training (16 hours) related to provision of support to children/youth and their families served in the waiver annually as required by MDHHS. This training is in addition to requirements identified in the Qualified Staff subsection and is for all supervisors and Wraparound facilitators.
- Caseloads shall be 8-10 per facilitator based on needs and risks of the child/youth and family. Caseloads may increase to a maximum of 12 when two child/youth and family teams are transitioning from Wraparound.
- SEDW site reviews will assess fidelity to the model through case file review, quality assurance of all SEDW-provided services/supports, and interviews with children/youth and family members.
- All SEDW enrolled providers must participate in the statewide evaluation project that consists of gathering data on the Family Status Report at intake, quarterly, and at graduation.
- Completion of the Michigan Wraparound Fidelity Index at six months and upon graduation.
- Participation in any additional model fidelity or quality assurance evaluation tools as requested by MDHHS.

17.3.N. Fiscal Intermediary Services

Fiscal Intermediary Services is defined as services that assist the adult beneficiary, or a representative identified in the beneficiary's individual plan of services, to meet the beneficiary's goals of community participation and integration, independence or productivity while controlling his individual budget and choosing staff who will provide the services and supports identified in the IPOS and authorized by the PIHP. The fiscal intermediary helps the beneficiary manage and distribute funds contained in the individual budget. Fiscal intermediary services include, but are not limited to:

- Facilitation of the employment of service workers by the beneficiary, including federal, state and local tax withholding/payments, unemployment compensation fees, wage settlements, and fiscal accounting;
- Tracking and monitoring participant-directed budget expenditures and identifying potential over- and under-expenditures;
- Assuring adherence to federal and state laws and regulations; and
- Ensuring compliance with documentation requirements related to management of public funds.

The fiscal intermediary may also perform other supportive functions that enable the beneficiary to self-direct needed services and supports. These functions may include selecting, contracting with or employing and directing providers of services, verification of provider qualifications (including reference and background checks), and assisting the beneficiary to understand billing and documentation requirements.

Fiscal intermediary services may not be authorized for use by a beneficiary's representative where that representative is not conducting tasks in ways that fit the beneficiary's preferences, and/or do not promote achievement of the goals contained in the beneficiary's plan of service so as to promote independence and inclusive community living for the beneficiary, or when they are acting in a manner that is in conflict with the interests of the beneficiary.

Fiscal intermediary services must be performed by entities with demonstrated competence in managing budgets and performing other functions and responsibilities of a fiscal intermediary. Neither providers of other covered services to the beneficiary, family members, or guardians of the beneficiary may provide fiscal intermediary services to the beneficiary.

SECTION 18 – BEHAVIORAL HEALTH TREATMENT SERVICES/APPLIED BEHAVIOR ANALYSIS

The purpose of this policy is to provide for the coverage of Behavioral Health Treatment (BHT) services, including Applied Behavior Analysis (ABA), for children under 21 years of age with Autism Spectrum Disorders (ASD). All children, including children with ASD, must receive EPSDT services that are designed to assure that children receive early detection and preventive care, in addition to medically necessary treatment services to correct or ameliorate any physical or behavioral conditions, so that health problems are averted or diagnosed and treated as early as possible.

According to the U.S. Department of Health & Human Services, autism is characterized by impaired social interactions, problems with verbal and nonverbal communication, repetitive behaviors, and/or severely limited activities and interests. Early detection and treatment can have a significant impact on the child's development. Autism can be viewed as a continuum or spectrum, known as ASD, and includes Autistic Disorder, Asperger's Disorder, and Pervasive Developmental Disorder-Not Otherwise Specified (PDD-NOS). The disorders on the spectrum vary in severity and presentation, but have certain common core symptoms. The goals of treatment for ASD focus on improving core deficits in communication, social interactions, and restricted behaviors. Changing these fundamental deficits may benefit children by developing greater functional skills and independence.

BHT services prevent the progression of ASD, prolong life, and promote the physical and mental health and efficiency of the child. Medical necessity and recommendation for BHT services is determined by a physician, or other licensed practitioner working within their scope of practice under state law. Direct patient care services that treat or address ASD under the state plan are available to children under 21 years of age as required by the EPSDT benefit.

18.1 SCREENING

The American Academy of Pediatrics (AAP) endorses early identification of developmental disorders as being essential to the well-being of children and their families. Early identification of developmental disorders through screening by health care professionals should lead to further evaluation, diagnosis, and treatment. Early identification of a developmental disorder's underlying etiology may affect the medical treatment of the child and the parent's/guardian's intervention planning. Screening for ASD typically occurs during an EPSDT well child visit with the child's primary care provider (PCP). EPSDT well child visits may include a review of the child's overall medical and physical health, hearing, speech, vision, behavioral and developmental status, and screening for ASD with a validated and standardized screening tool. The EPSDT well child evaluation is also designed to rule out medical or behavioral conditions other than ASD, and include those conditions that may have behavioral implications and/or may co-occur with ASD. A full medical and physical examination must be performed before the child is referred for further evaluation.

18.2 REFERRAL

The PCP who screened the child for ASD and determined a referral for further evaluation was necessary will contact the Pre-paid Inpatient Health Plan (PIHP) directly to arrange for a follow-up evaluation. The PCP must refer the child to the PIHP in the geographic service area for Medicaid beneficiaries. The PIHP will contact the child's parent(s)/guardian(s) to arrange a follow-up appointment for a comprehensive diagnostic evaluation and behavioral assessment. Each PIHP will identify a specific point of access for children who have been screened and are being referred for a diagnostic evaluation and behavioral

assessment of ASD. If the PCP determines the child who screened positive for ASD is in need of occupational, physical, or speech therapy, the PCP will refer the child directly for the service(s) needed.

After a beneficiary is screened and the PCP determines a referral is necessary for a follow-up visit, the PIHP is responsible for the comprehensive diagnostic evaluation, behavioral assessment, BHT services (including ABA) for eligible Medicaid beneficiaries, and for the related EPSDT medically necessary Mental Health Specialty Services. Occupational therapy, physical therapy, and speech therapy for children with ASD who do not meet the eligibility requirements for developmental disabilities by the PIHP are covered by the Medicaid Health Plan or by Medicaid Fee-for-Service.

18.3 Comprehensive Diagnostic Evaluations

Accurate and early diagnosis of ASD is critical in ensuring appropriate intervention and positive outcomes. The comprehensive diagnostic evaluation must be performed before the child receives BHT services. The comprehensive diagnostic evaluation is a neurodevelopmental review of cognitive, behavioral, emotional, adaptive, and social functioning, and should include validated evaluation tools. Based on the evaluation, the practitioner determines the child's diagnosis, recommends general ASD treatment interventions, and refers the child for a behavior assessment which is provided or supervised by a BCBA to recommend more specific ASD treatment interventions. The diagnostic evaluations are performed by a qualified licensed practitioner working within their scope of practice and who is qualified and experienced in diagnosing ASD. A qualified licensed practitioner includes:

- a physician with a specialty in psychiatry or neurology;
- a physician with a subspecialty in developmental pediatrics, developmental-behavioral pediatrics or a related discipline;
- a physician with a specialty in pediatrics or other appropriate specialty with training, experience or expertise in ASD and/or behavioral health;
- a psychologist;
- an advanced practice registered nurse with training, experience, or expertise in ASD and/or behavioral health;
- a physician assistant with training, experience, or expertise in ASD and/or behavioral health; or
- a clinical social worker, working within their scope of practice, and is qualified and experienced in diagnosing ASD.

The determination of a diagnosis by a qualified licensed practitioner is accomplished by direct observation and utilizing the Autism Diagnostic Observation Schedule-Second Edition (ADOS-2), and by administering a comprehensive clinical interview including a developmental symptom history (medical, behavioral, and social history) such as the Autism Diagnostic Interview-Revised (ADI-R) or clinical equivalent. In addition, a qualified licensed practitioner will rate symptom severity with the Developmental Disabilities Children's Global Assessment Scale (DD-CGAS). Other tools should be used if the clinician feels it is necessary to determine a diagnosis and medical necessity service recommendations. Other tools may include:

- cognitive/developmental tests, such as the Mullen Scales of Early Learning, Wechsler Preschool and Primary Scale of Intelligence-IV (WPPSI-IV), Wechsler Intelligence Scale for Children-IV

(WISC-IV), Wechsler Intelligence Scale for Children-V (WISC-V), or Differential Ability Scales-II (DAS-II);

- adaptive behavior tests, such as Vineland Adaptive Behavior Scale-II (VABS-II), Adaptive Behavior Assessment System-III (ABAS-III), or Diagnostic Adaptive Behavior Scale (DABS); and/or
- symptom monitoring, such as Social Responsiveness Scale-II (SRS-II), Aberrant Behavior Checklist, or Social Communication Questionnaire (SCQ).

18.4 MEDICAL NECESSITY CRITERIA

Medical necessity and recommendation for BHT services is determined by a physician or other licensed practitioner working within their scope of practice under state law. The child must demonstrate substantial functional impairment in social communication, patterns of behavior, and social interaction as evidenced by meeting criteria A and B (listed below); and require BHT services to address the following areas:

A. The child currently demonstrates substantial functional impairment in social communication and social interaction across multiple contexts, and is manifested by all of the following:

   1. Deficits in social-emotional reciprocity ranging, for example, from abnormal social approach and failure of normal back-and-forth conversation, to reduced sharing of interests, emotions, or affect, to failure to initiate or respond to social interactions.

   2. Deficits in nonverbal communicative behaviors used for social interaction ranging, for example, from poorly integrated verbal and nonverbal communication, to abnormalities in eye contact and body language or deficits in understanding and use of gestures, to a total lack of facial expressions and nonverbal communication.

   3. Deficits in developing, maintaining, and understanding relationships ranging, for example, from difficulties adjusting behavior to suit various social contexts, to difficulties in sharing imaginative play or in making friends, to absence of interest in peers.

B. The child currently demonstrates substantial restricted, repetitive and stereotyped patterns of behavior, interests, and activities, as manifested by at least two of the following:

   1. Stereotyped or repetitive motor movements, use of objects, or speech (e.g., simple motor stereotypes, lining up toys or flipping objects, echolalia, and/or idiosyncratic phrases).

   2. Insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behavior (e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, and/or need to take same route or eat the same food every day).

   3. Highly restricted, fixated interests that are abnormal in intensity or focus (e.g., strong attachment to or preoccupation with unusual objects and/or excessively circumscribed or perseverative interest).

4. Hyper- or hypo-reactivity to sensory input or unusual interest in sensory aspects of the environment (e.g., apparent indifference to pain/temperature, adverse response to specific sounds or textures, excessive smelling or touching of objects, and/or visual fascination with lights or movement).

18.5 Determination of Eligibility for BHT [Change Made 7/1/18]

The following is the process for determining eligibility for BHT services for a child with a confirmed diagnosis of ASD. Eligibility determination and recommendation for BHT must be performed by a qualified licensed practitioner through direct observation utilizing the ADOS-2 and symptom rating using the DD-CGAS. BHT services are available for children under 21 years of age with a diagnosis of ASD from the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), and who have the developmental capacity to clinically participate in the available interventions covered by BHT services. A well-established DSM-IV diagnosis of Autistic Disorder, Asperger's Disorder or PDD-NOS should be given the diagnosis of ASD. Children who have marked deficits in social communication but whose symptoms do not otherwise meet criteria for ASD should be evaluated for social (pragmatic) communication disorder.

The following requirements must be met:

- Child is under 21 years of age.
- Child received a diagnosis of ASD from a qualified licensed practitioner utilizing valid evaluation tools.
- Child is medically able to benefit from the BHT treatment.
- Treatment outcomes are expected to result in a generalization of adaptive behaviors across different settings to maintain the BHT interventions and that they can be demonstrated beyond the treatment sessions. Measurable variables may include increased social-communication, increased interactive play/age-appropriate leisure skills, increased reciprocal communication, etc.
- Coordination with the school and/or early intervention program is critical. Collaboration between school and community providers is needed to coordinate treatment and to prevent duplication of services. This collaboration may take the form of phone calls, written communication logs, participation in team meetings (i.e., Individualized Education Plan/Individualized **(revised 7/1/18)** Family Service Plan [IEP/IFSP], Individual Plan of Service [IPOS], etc.).
- Services are able to be provided in the child's home and community, including centers and clinics.
- Symptoms are present in the early developmental period (symptoms may not fully manifest until social demands exceed limited capacities, or may be masked by learned strategies later in life).
- Symptoms cause clinically significant impairment in social, occupational, and/or other important areas of current functioning that are fundamental to maintain health, social inclusion, and increased independence.
- A qualified licensed practitioner recommends BHT services and the services are medically necessary for the child.
- Services must be based on the individual child and the parent's/guardian's needs and must consider the child's age, school attendance requirements, and other daily activities as documented in the IPOS. Families of minor children are expected to provide a minimum of eight hours of care per day on average throughout the month.

18.6 Prior Authorization

BHT services are authorized for a time period not to exceed 365 days. The 365-day authorization period for services may be re-authorized annually based on recommendation of medical necessity by a qualified licensed practitioner working within their scope of practice under state law.

18.7 Re-evaluation

An annual re-evaluation by a qualified licensed practitioner to assess eligibility criteria must be conducted through direct observation utilizing the ADOS-2 and symptoms rated using the DD-CGAS. Additional tools should be used if the clinician feels it is necessary to determine medical necessity and recommended services. Other tools may include cognitive/developmental tests, adaptive behavior tests, and/or symptom monitoring.

18.8 Discharge Criteria

Discharge from BHT services is determined by a qualified BHT professional for children who meet any of the following criteria:

- The child has achieved treatment goals and less intensive modes of services are medically necessary and appropriate.
- The child is either no longer eligible for Medicaid or is no longer a State of Michigan resident.
- The child has not demonstrated measureable improvement and progress toward goals, and the predicted outcomes as evidenced by a lack of generalization of adaptive behaviors across different settings where the benefits of the BHT interventions are not able to be maintained or they are not replicable beyond the BHT treatment sessions through a period of six months.
- Targeted behaviors and symptoms are becoming persistently worse with BHT treatment over time or with successive authorizations.
- The child no longer meets the eligibility criteria as evidenced by use of valid evaluation tools administered by a qualified licensed practitioner.
- The child and/or parent/guardian is not able to meaningfully participate in the BHT services, and does not follow through with treatment recommendations to a degree that compromises the potential effectiveness and outcome of the BHT service.

18.9 BHT Services

18.9.A. Behavioral Assessment

Behavioral assessments must use a validated instrument and can include direct observational assessment, observation, record review, data collection, and analysis by a qualified provider. Examples of behavior assessments include function analysis and functional behavior assessments. The behavioral assessment must include the current level of functioning of the child using a validated data collection method. Behavioral assessments and ongoing measurements of improvement must include behavioral outcome tools. Examples of behavioral outcome tools include Verbal Behavior-Milestones Assessment and Placement Program (VB-MAPP), Assessment of Basic

Language and Learning Skills -Revised (ABLLS-R), and Assessment of Functional Living Skills (AFLS).

18.9.B. Behavioral Intervention

BHT services include a variety of behavioral interventions which have been identified as evidence-based by nationally recognized research reviews and/or other nationally recognized scientific and clinical evidence. BHT services are designed to be delivered primarily in the home and in other community settings. Behavioral intervention services include, but are not limited to, the following categories of evidence-based interventions:

- Collecting information systematically regarding behaviors, environments, and task demands (e.g., shaping, demand fading, task analysis);
- Adapting environments to promote positive behaviors and learning while discouraging negative behaviors (e.g., naturalistic intervention, antecedent based intervention, visual supports, stimulus fading);
- Applying reinforcement to change behaviors and promote learning (e.g., reinforcement, differential reinforcement of alternative behaviors, extinction);
- Teaching techniques to promote positive behaviors, build motivation, and develop social, communication, and adaptive skills (e.g., discrete trial teaching, modeling, social skills instruction, picture exchange communication systems, pivotal response training, social narratives, self-management, prompting, chaining, imitation);
- Teaching parents/guardians to provide individualized interventions for their child for the benefit of the child (e.g., parent/guardian implemented/mediated intervention);
- Using typically developing peers (e.g., individuals who do not have ASD) to teach and interact with children with ASD (e.g., peer mediated instruction, structured play groups, peer social interaction training); and
- Applying technological tools to change behaviors and teach skills (e.g., video modeling, tablet-based learning software).

In addition to the above listed categories of interventions, covered BHT treatment services may also include any other intervention supported by credible scientific and/or clinical evidence, as appropriate for each individual. Based on the behavioral plan of care which is adjusted over time based on data collected by the qualified provider to maximize the effectiveness of BHT treatment services, the provider selects and adapts one or more of these services, as appropriate for each individual.

18.9.C. Behavioral Observation and Direction

Behavioral observation and direction is the clinical direction and oversight provided by a qualified provider to a lower level provider based on the required provider standards and qualifications regarding the provision of services to a child. The qualified provider delivers face–to-face observation and direction to a lower level provider regarding developmental and behavioral techniques, progress measurement, data collection, function of behaviors, and generalization of acquired skills for each child. This service is for the direct benefit of the child and provides a real time response to the intervention to

maximize the benefit for the child. It also informs of any modifications needed to the methods to be implemented to support the accomplishment of outcomes in the behavioral plan of care.

18.9.D. TELEPRACTICE FOR BHT SERVICES [CHANGE MADE 7/1/18]

All telepractice services must be prior authorized (i.e., IPOS indicates telepractice as an identified treatment modality for the beneficiary) by the Michigan Department of Health and Human Services (MDHHS). Telepractice is the use of telecommunications and information technologies for the exchange of encrypted patient data for the provision of services (e.g., access or travel to needed medical services may be prohibitive). Telepractice must be obtained through real-time interaction between the child's physical location (patient site) and the provider's physical location (provider site). Telepractice services are provided to patients through hardwire or internet connection. It is the expectation that providers, facilitators, and staff involved in telepractice are trained in the use of equipment and software prior to servicing patients, and services provided via telepractice are provided as part of an array of comprehensive services that include in-person visits and assessments with the primary supervising BHT provider. Qualified providers of behavioral health services are able to arrange telepractice services for the purposes of teaching the parents/guardians to provide individualized interventions to their child and to engage in behavioral health clinical observation and direction (i.e. increase oversight of the provision of services to the beneficiary to support the outcomes of the behavioral plan of care developed by the primary supervising BHT provider). **(revised 7/1/18)** Qualified providers of behavioral health services include Board Certified Behavior Analysts (BCBA), Board Certified Assistant Behavior Analysts (BCaBA), Licensed Psychologists (LP), Limited Licensed Psychologists (LLP), and Qualified Behavioral Health Professionals (QBHP). The provider of the telepractice service is only able to monitor one child/family at a time. The administration of telepractice services are subject to the same provision of services that are provided to a patient in person. Providers of telepractice services must be currently certified by the Behavior Analyst Certification Board (BACB), be a QBHP enrolled in a BACB degree program, be licensed in the State of Michigan as a fully licensed psychologist, or be a practitioner who holds a limited license and is under the direction of a fully licensed psychologist. Providers must ensure the privacy of the child and secure any information shared via telemedicine.

The technology used must meet the requirements of audio and visual compliance in accordance with current regulations and industry standards. Refer to the General Information for Providers Chapter of this manual for the complete Health Insurance Portability and Accountability Act (HIPAA) compliance requirements.

The patient site may be located within a center, clinic, at the patient's home, or any other established site deemed appropriate by the provider. The room must be free from distractions that would interfere with the telepractice session. A facilitator must be trained in the use of the telepractice technology and be physically present at the patient site during the entire telepractice session to assist the patient at the direction of the qualified provider of behavioral health. Occupational, physical, and speech therapy are not covered under telepractice services. Refer to the Telemedicine Services database on the MDHHS website for appropriate or allowed telemedicine services that may be

covered by the Medicaid Health Plan or by Medicaid Fee-for-Service. (Refer to the Directory Appendix for website information.)

18.10 BHT Service Level

BHT services are available for Medicaid beneficiaries diagnosed with ASD and are provided for all levels of severity of ASD. The behavioral intervention should be provided at an appropriate level of intensity in an appropriate setting(s) within their community for an appropriate period of time, depending on the needs of the child and their parents/guardians. Clinical determinations of service intensity, setting(s), and duration are designed to facilitate the child's goal attainment. These supports may serve to reinforce skills or lessons taught in school, therapy, or other settings, but are not intended to supplant services provided in school or other settings, or to be provided when the child would typically be in school but for the parent's/guardian's choice to home-school their child. Each child's IPOS must document that these services do not include special education and related services defined in the Individuals with Disabilities Education Act (IDEA) that are available to the child through a local education agency. The recommended service level, setting(s), and duration will be included in the child's IPOS, with the planning team and the parent(s)/guardian(s) reviewing the IPOS at regular intervals (minimally every three months) and, if indicated, adjusting the service level and setting(s) to meet the child's changing needs. The service level includes the number of hours of intervention provided to the child. The service level determination will be based on research-based interventions integrated into the behavioral plan of care with input from the planning team. Service intensity will vary with each child and should reflect the goals of treatment, specific needs of the child, and response to treatment. The PIHP's Utilization Management will authorize the level of services prior to the delivery of services.

- **Focused Behavioral Intervention:** Focused behavioral intervention is provided an average of 5-15 hours per week (actual hours needed are determined by the behavioral plan of care and interventions required).
- **Comprehensive Behavioral Intervention:** Comprehensive behavioral intervention is provided an average of 16-25 hours per week (actual hours needed are determined by the behavioral plan of care and interventions required).

18.11 BHT Service Evaluation

As part of the IPOS, there is a comprehensive, individualized behavioral plan of care that includes specific targeted behaviors, along with measurable, achievable, and realistic goals for improvement. BCBA and other qualified providers develop, monitor, and implement the behavioral plan of care. These providers are responsible for effectively evaluating the child's response to treatment and skill acquisition. Ongoing determination of the level of service (minimally every six months) requires evidence of measurable and ongoing improvement in targeted behaviors that are demonstrated with the use of reliable and valid assessment instruments (i.e., VB-MAPP, ABLLS-R, AFLS) and other appropriate documentation of analysis (i.e., graphs, assessment reports, records of service, progress reports, etc.).

18.12 BHT Service Provider Qualifications

BHT services are highly specialized services that require specific qualified providers who are available within PIHP/CMHSP provider networks and have extensive experience providing specialty mental health and behavioral health services. BHT services must be provided under the direction of a BCBA, another appropriately qualified LP or LLP, or a Master's prepared QBHP. These services must be provided directly to, or on behalf of, the child by training their parents/guardians, behavior technicians, and BCaBAs to

deliver the behavioral interventions. The BCBA and other qualified providers are also responsible for communicating progress on goals to parents/guardians minimally every three to six months; clinical skill development and supervision of BCaBA, QBHP, and behavior technicians; and collaborating with support coordinators/case managers and the parents/guardians on goals and objectives with participation in development of the IPOS that includes the behavioral plan of care.

18.12.A. BHT SUPERVISORS [CHANGES MADE 7/1/18]

Board Certified Behavior Analyst-Doctoral (BCBA-D) or Board Certified Behavior Analyst (BCBA)	• Services Provided: Behavioral assessment, behavioral intervention, and behavioral observation and direction. • License/Certification: Current certification as a BCBA through the BACB. The BACB is the national entity accredited by the National Commission for Certifying Agencies (NCCA). • Education and Training: Minimum of a master's degree from an accredited institution conferred in a degree program in which the candidate completed a BACB approved course sequence.
Licensed Psychologist (LP)	• Must be certified as a BCBA by September 30, 2020. • Services Provided: Behavioral assessment, behavioral intervention, and behavioral observation and direction. • License/Certification: LP means a doctoral level psychologist licensed by the State of Michigan. Must complete all coursework and experience requirements. • Education and Training: Minimum doctorate degree from an accredited institution. Works within their scope of practice and has extensive knowledge and training in behavior analysis. Extensive knowledge is defined as having received documented coursework at the graduate level from an accredited university in at least three of the six following areas: ➢ Ethical considerations. ➢ Definitions and characteristics; and principles, processes and concepts of behavior. ➢ Behavioral assessment and selecting interventions outcomes and strategies. ➢ Experimental evaluation of interventions. ➢ Measurement of behavior, and developing and interpreting behavioral data. ➢ Behavioral change procedures and systems supports. • A minimum of one year experience in treating children with ASD based on the principles of behavior analysis. Works in consultation with the BCBA to discuss the caseload, progress, and treatment of the child with ASD.

Limited License Psychologist (LLP)	• Must be certified as a BCBA by September 30, 2020. • Services Provided: Behavioral assessment, behavioral intervention, and behavioral observation and direction. • License/Certification: LLP means a doctoral or master level psychologist licensed by the State of Michigan. Master's Limited Psychologist **(revised 7/1/18)** license is good for one two (2)-year period. Must complete all coursework and experience requirements. • Education and Training: Minimum of a master's or doctorate degree from an accredited institution. Works within their scope of practice and has extensive knowledge and training in behavior analysis. Extensive knowledge is defined as having received documented coursework at the graduate level from an accredited university in at least three of the six following areas: ➢ Ethical considerations. ➢ Definitions and characteristics and principles, processes and concepts of behavior. ➢ Behavioral assessment and selecting interventions outcomes and strategies. ➢ Experimental evaluation of interventions. ➢ Measurement of behavior, and developing and interpreting behavioral data. ➢ Behavioral change procedures and systems supports. • A minimum of one year experience in treating children with ASD based on the principles of behavior analysis. Works in consultation with the BCBA to discuss the progress and treatment of the child with ASD.
Board Certified Assistant Behavior Analyst (BCaBA)	• Services Provided: Behavioral assessment, behavioral intervention, and behavioral observation and direction. • License/Certification: Current certification as a BCaBA through the BACB. The BACB is the national entity accredited by the NCCA. • Education and Training: Minimum of a bachelor's degree from an accredited institution conferred in a degree program in which the candidate completed a BACB approved course sequence. • Other Standard: Works under the supervision of the BCBA.
Qualified Behavioral Health Professional (QBHP)	• Must be certified as a BCBA by September 30, 2020. • Services Provided: Behavioral assessment, behavioral intervention, and behavioral observation and direction. • License/Certification: A license or certification is not required, but is optional. • Education and Training: QBHP must meet one of the following state requirements: ➢ Must be a physician or licensed practitioner with specialized training and one year of experience in the examination, evaluation, and treatment of children with ASD.

	➢ Minimum of a master's degree in a mental health-related field or BACB approved degree category from an accredited institution with specialized training and one year of experience in the examination, evaluation, and treatment of children with ASD. Works within their scope of practice, works under the supervision of the BCBA, and has extensive knowledge and training in behavior analysis. Extensive knowledge is defined as having received documented coursework at the graduate level (i.e. completion of three BACB evaluated graduate courses or BACB verified course sequences meeting specific standards toward certification) **(text added 7/1/18)** from an accredited university in at least three of the six following areas: ♦ Ethical considerations. ♦ Definitions and characteristics; and principles, processes and concepts of behavior. ♦ Behavioral assessment, and selecting interventions outcomes and strategies. ♦ Experimental evaluation of interventions. ♦ Measurement of behavior, and developing and interpreting behavioral data. ♦ Behavioral change procedures and systems supports.
Behavior Technician	• Services Provided: Behavioral intervention. • License/Certification: A license or certification is not required. • Education and Training: Will receive BACB Registered Behavior Technician (RBT) training conducted by a professional experienced in BHT services (BCBA, BCaBA, LP, LLP, and/or QBHP), but is not required to register with the BACB upon completion in order to furnish services. • Works under the supervision of the BCBA or other professional (BCaBA, LP, LLP or QBHP) overseeing the behavioral plan of care, with minimally one hour of clinical observation and direction for every 10 hours of direct treatment. • Must be at least 18 years of age; able to practice universal precautions to protect against the transmission of communicable disease; able to communicate expressively and receptively in order to follow individual plan requirements and beneficiary-specific emergency procedures and to report on activities performed; and be in good standing with the law (i.e., not a fugitive from justice, a convicted felon who is either under jurisdiction or whose felony relates to the kind of duty to be performed, or an illegal alien). Must be able to perform and be certified in basic first aid procedures and is trained in the IPOS/behavioral plan of care utilizing the person-centered planning process.

CHILDREN'S WAIVER COMMUNITY LIVING SUPPORT SERVICES APPENDIX

SECTION 1 - CHILDREN WITH CHALLENGING BEHAVIORS

1.1 PURPOSE

This Section is to help the CMHSP determine whether the challenging behavioral needs of the child support hourly care and other support services, and to determine the appropriate range of hourly care that can be authorized under the Community Living Support (CLS) waiver service. The following categories do not, in and of themselves, establish eligibility for publicly funded hourly care.

The amount of CLS services (i.e., the number of hours) that can be authorized for a child is based on several factors, including the child's care needs which establish waiver eligibility, child's and family's circumstances, and other resources for daily care (e.g., private health insurance, trusts bequests, private pay). In addition to identifying the family situation and the specific behaviors as described in the category definitions, the following elements contribute to the overall assessment of need:

- Type of behaviors identified;
- Frequency, intensity, and duration of identified behaviors;
- How recently serious behaviors occurred;
- Actual specific effects of the behavior on persons in family and property;
- Level of family intervention required to prevent behavioral episodes;
- Extent to which family must alter normal routine to address behavioral needs of the child;
- Prognosis for change in the child's behavior;
- Whether or not child functions more effectively in any current setting than in other settings; and
- Age, size, and mobility of child.

1.2 CATEGORIES OF CARE

1.2.A. CATEGORY IV

Qualifications	Demonstrates mild level behaviors that may interfere with the daily routine of the family.
Definitions	**Mild Behavior:** Infrequent or intermittent behaviors including pinching, hitting, slapping, kicking, head banging, and/or elopement without careful supervision when there is evidence of lack of judgment regarding danger, or an extremely high activity level requiring extensive supervision and redirection.

1.2.B. CATEGORY III

Qualifications	Demonstrates a daily pattern of medium level behaviors including self-injurious, physically aggressive or assaultive behaviors that have not resulted in hospitalization or emergency room treatment for injuries in the past year, or has engaged in occasional, significant property destruction that is not life-threatening.
Definitions	**Pattern of Behavior:** In addition to a single serious episode in the last year, significant daily behaviors are documented. **Medium Behavior:** Includes behaviors defined in the Category II definition of "moderate behavior" when emergency room treatment or hospitalization have not been required for treatment of injuries resulting from the behavior. Examples include head banging resulting in bleeding and bruising without concussion or detached retina, hair pulling without removing hair from the scalp, smearing feces without PICA, and biting without drawing blood. **Occasional Property Destruction:** Property destruction that occurs with a frequency not greater than one time per week.

1.2.C. CATEGORY II

Qualifications	Demonstrates a daily pattern of moderate self-injurious, physically aggressive or assaultive behavior when medical intervention or emergency room treatment has been required for treatment of injuries in the past year without resulting hospitalization, or if the child has engaged in frequent, significant property destruction that is not life-threatening.
Definitions	**Moderate Behavior:** Includes behaviors that pose a significant risk of injury to self or others in the immediate environment. Examples include physical assault or self-abuse resulting in injuries requiring hospital emergency room treatment without hospital admission in the past year, biting that breaks the skin, hair pulling resulting in removal of clumps of hair from the scalp, multiple daily episodes of smearing feces with associated PICA, and head banging resulting in documented concussion or detached retina.

1.2.D. CATEGORY I

Qualifications	Demonstrates a pattern of severe self-injurious, physically aggressive or assaultive behavior, or life-threatening property destruction that has occurred one or more times in the past year. Documented evidence of additional behavioral problems on a frequent basis each day supports a need for one-to-one intensive behavioral treatment.
Definitions	**Severe Behavior:** Poses a very significant risk of serious injury or death to self, a family member, or others in the immediate environment. Examples include fire setting, physical assault or self-abuse resulting in injuries to self or others requiring inpatient hospital admission for treatment in the past year.

SECTION 2 – MEDICALLY AND PHYSICALLY COMPLEX CHILDREN

2.1 PURPOSE

The purpose of this Section is to help the CMHSP determine whether CLS services are medically necessary. The following categories do not, in and of themselves, establish eligibility for publicly funded hourly care.

2.1.A. CATEGORY IV

Qualifications	A medical condition and requires significant levels of daily assistance or guidance with activities of daily living (ADLs). In addition, medical condition is stable and observations and interventions are required infrequently. Interventions require minimal training and are associated with minimal or no risk to health status.
Examples	Includes levels of support that would exceed those expected for a person of the child's age in the areas of: ▪ Assistance and/or guidance in ADLs including eating, toileting, bathing, grooming, dressing, and mobility (ambulation and transferring); ▪ Assistance and/or guidance with physical transfer (e.g. bed to chair); ▪ Assistance and/or guidance with therapeutic positioning and physical therapy; or ▪ The child weighs 80 pounds or more and is not ambulatory and/or not mobile and unable to assist the primary caregiver.

2.1.B. CATEGORY III

Qualifications	A medical condition that routinely requires daily hourly care or support in order to maintain and/or improve health status. Clinical observations and interventions may be intermittent. Medical interventions are typically associated with minimal risk to health status, and delayed interventions are not associated with imminent risk to health status.
Examples	Includes a combination of interventions such as: ▪ G-tube feedings with no oral suctioning needs; ▪ PRN oxygen administration less often than daily over the past 30 days with or without pulse oximeter; ▪ Daily oxygen administration at less than two liters without pulse oximeter and without the need for on-going judgments and observations for oxygen needs (e.g. routine nightly administration without other skilled nursing interventions); ▪ Catheterization fewer than five times per day; ▪ Routine chest physiotherapy four or more times per day; ▪ Ostomy care; ▪ Total feeding or formal feeding program requiring more than 45 minutes per meal with need for special trunk-head positioning;

	▪ Concurrent diagnosis of severe hypertonicity, severe contractures, or severe scoliosis that requires therapeutic positioning every two hours; or ▪ Documented evidence that positioning causes apnea and cyanosis, and that positioning is limited to positions with the body in less than a 45 degree angle to horizontal plane.

2.1.C. CATEGORY II AND CATEGORY I

Services for Category II and Category I children are covered under the Medicaid State Plan private duty nursing (PDN) benefit. Refer to the Private Duty Nursing Chapter of this manual for PDN coverage criteria.

SECTION 3 – COVERAGE DECISIONS

3.1 DECISION RESPONSIBILITY

The MDHHS Children's Waiver Review Team will continue to review all plans of service and current assessments, and prior authorize waiver services, for those children who:

- Qualify for Category of Care I; or
- Have been approved to receive additional CLS hours under the exception process.

The responsible CMHSP, following the Children's Waiver Decision Guide in the following subsection, will review and prior authorize waiver services for those Children's Waiver beneficiaries who are determined to qualify for Categories II, III, or IV.

3.2 DECISION GUIDE

The determination of the amount of hourly care should result from a person-centered planning/family-centered practice process that considers both the child's and family's needs. The Children's Waiver Decision Guide Table below assists in identifying the range of hours provided for children based on their category of care and the family's resources to provide that care. It is expected that hourly care services will be provided within the range for which the child qualifies. Within the four Categories of Care are five sections that apply to the child's family status. In determining the total number of hours, it is acceptable to use the highest range within the appropriate section of the eligible category. If the child is receiving Home Help services, those hours must be considered as part of the total hours allowable. For example, a child determined to have Category III level of care needs is eligible for a maximum of six hours a day while in school. If that child receives two hours per day of Home Help, CWP could then provide a maximum of four hours of CLS staffing per day. The range of hours identified in the guide is an average daily amount that is provided seven days a week, based on a monthly total authorization.

If the child is attending school an average of 25 hours per week, the Section VI maximum would apply unless the maximum exceeds the range qualified for in Sections I-V. In that case, the maximum range in Sections I-V would apply. The Section VI maximum would not be required during school breaks, such as Christmas, Easter, and summer vacations, or if the child is out of school due to illness for 5 or more consecutive days.

CHILDREN'S WAIVER DECISION GUIDE TABLE				
ADDITIONAL FAMILY RESOURCES	**DOCUMENTED CATEGORY OF NEED FOR HOURLY CARE AUTHORIZATION**			
	CATEGORY IV	**CATEGORY III**	**CATEGORY II**	**CATEGORY I**
Section I – Number of Caregivers				
1. Two or more caregivers live in home; both work F/T	4 - 8	6 - 10	8 - 12	12 - 16
2. Two adult caregivers; one works F/T	2 - 8	2 - 8	4 - 10	10 - 16
3. Two adult caregivers; neither is employed	2 - 4	2 - 6	4 - 8	8 - 12
4. One adult caregiver lives in home and works F/T	4 - 8	4 - 10	8 - 12	12 - 16
5. One adult caregiver; does not work F/T	2 - 6	2 - 8	8 - 10	10 - 14
Section II – Health Status of Caregivers				
1. Significant health issues	6 - 8	6 - 10	10 - 14	12 - 16
2. Some health issues	4 - 6	4 - 8	8 - 12	10 - 12
Section III – Additional Dependent Children				
1. Applicant has one or more siblings age 5 or older	2 - 4	2 - 6	4 - 8	8 - 12
2. Applicant has one or more siblings under age 5	4 - 6	4 - 8	6 - 8	8 - 12
Section IV – Additional Children with Special Needs				
1. Applicant has one or more siblings with nursing needs	4 - 8	6 - 8	4 - 8	8 - 12
2. Applicant has one or more siblings with non-nursing special needs	2 - 4	2 - 6	N/A	N/A
Section V – Night Interventions				
1. Requires 2 or fewer interventions at night or total time less than one hour	2 - 4	2 - 6	4 - 8	8 - 12
2. Requires 3 or more interventions requiring one hour or more to complete	4 - 8	6 - 8	6 - 10	8 - 12
Section VI – School				
1. Child attends school an average of 25 hours per week	6 max	6 max	8 max	12 max

3.3 Decision Guide Table Definitions

The definitions used in each section of the Decision Guide Table are as follows:

SECTION	DEFINITIONS
I – Number of Caregivers	Caregiver is defined as a legally responsible adult(s) living in the home or adult(s) who is not legally responsible but chooses to participate in providing care for the child. Full-Time (F/T) is defined as a person who works 30 or more hours per week for wages, or a person who attends school 30 or more hours per week.
II – Health Status of Caregivers	Significant health concerns of a caregiver is defined as one or more of the primary caregivers have a significant health or emotional condition which prevents that caregiver from providing care for the child. Example: A parent that recently had back surgery with full body cast or similar condition. Some health concerns of a caregiver is defined as one or more primary caregivers (as defined above) have a health or emotional condition that interferes with, but does not prevent, provision of care. Examples: Alcoholism, depression, lupus, back pain when lifting, lifting restrictions and similar health concerns; or primary caregiver is in therapy three or more times per month.

SECTION	DEFINITIONS
III - Additional Dependent Children	This section applies when the child has one or more siblings or related individuals under age 18 who reside in the home full-time and the caregiver is not paid for providing care.
IV - Additional Children With Special Needs	Additional special needs are identified when the child has one or more siblings or related individuals who reside in the home and do not currently receive hourly care supports. Siblings with nursing needs are children who meet the criteria for Intensity of Care-High or Intensity of Care-Medium (refer to the Additional Mental Health Services (B3s) Section of this chapter), whether or not those children are developmentally disabled. Siblings without skilled nursing needs are children with needs as identified in Category of Care I-IV definitions.
V – Night Interventions	If the child requires one or two interventions at night and the time required to complete the interventions is one hour or less, Section V-1 applies. If the child requires an average of three or more interventions per night, or the time required to complete the interventions is more than one hour, Section V-2 applies.
VI – School	Average hours of school should be used to determine the appropriate range of hours. Include transportation time if provided by the school. The number of hours of school attendance is based on the school year that applies to the child's educational classification. Variations in hours may be seen for children without a summer program. This factor limits the maximum number of hours that can be authorized for a child of any age in a center-based school program for more than 25 hours per week, or a child who has reached the age of 6 and for whom there is no medical justification for a home-bound school program. The school maximum is also waived for that time period when a child is out of school for at least 5 consecutive days due to illness, surgery, or scheduled school breaks.

3.4 Exception Process

The exception process ensures the safety and quality of care of children served by the waiver through consideration of the unique needs of each child and family, and special circumstances that may arise. When occasional relief through respite services is not sufficient, an exception of hourly care may be authorized.

Contingent upon the availability of funds and upon receipt of a Prior Review and Approval Request (PRAR), limited authority to exceed the published hourly care amount defined in the Decision Guide subsection may be granted by MDHHS to a CMHSP to better serve identified children with exceptional care needs. The PRAR must be developed pursuant to family request, person-centered planning/family-centered practice team recommendation, and CMHSP administrative concurrence.

The PRAR must document and substantiate both a current clinical (either medical or psychological) necessity for the exception and a current lack of natural supports requisite for the provision of the needed level of care. The hourly care services must be essential to the successful implementation of a plan of active treatment as defined by CMS ICF/IID rules, and any enhancements must be essential to maintain the child within their home. Consideration for an exception will be limited to situations outside

the family's control that place the child in jeopardy of serious injury or significant deterioration of health status such as:

- A temporary deterioration of the child's clinical condition (e.g. need for nursing care following an acute hospitalization or surgical procedure, or an acute cyclic exacerbation of challenging behaviors);
- A temporary inability of the primary caregivers to provide the requisite level of care (e.g., an acute illness or injury);
- Health condition requires continuous implementation of high risk medically prescribed procedures requiring licensed nursing personnel that are not already addressed within the Decision Guide subsection. The procedures must be beyond the demonstrated capacity of the parents to provide;
- Behavior treatment needs significantly exceed the recommended ranges for the assigned category of care **and** this exception is essential to prevent an otherwise inevitable (i.e., previously documented) deterioration in behavior. The enhanced staffing must be continuously active in the implementation of the behavior treatment plan;
- Natural supports are unable to provide the requisite level of care (e.g., only available care providers have a physical, mental, or emotional disability or they cannot demonstrate competence with the procedures essential to the implementation of the treatment plan). The plan of service must also address plans to rectify the condition or circumstance.

Exceptions may be granted for a specified period not to exceed 180 days. Renewal requests must substantiate the continuing clinical necessity and lack of natural supports.

Exceptions approved by MDHHS can occur in one of the following ways:

- Temporary emergency basis only. Verbal approval can be given to the CMHSP, with written justification to be forwarded to MDHHS within 10 days; or
- In a non-emergency situation, the CMHSP provides MDHHS with written documentation of the specific rationale to support the exception (i.e., physician's prescription). This would include a revised Plan of Care, highlighting the care needs to be provided with the additional staffing hours, and all current assessments. A response from MDHHS will occur within 10 working days.

When approval of an exception is not granted through either of the two processes listed above, the family, case manager, or MDHHS may request a meeting in order to clarify and reconsider the basis for the exception.

MDHHS has the option to request a home visit to meet the child when it is necessary for an effective decision.

3.5 Appeal Process

The child and family have the right, under the Michigan Mental Health Code, to appeal a negative coverage decision to the director of the CMHSP. The child and family may also request a recipient's rights investigation through their CMHSP.

The CMS approval of the Children's Waiver requires the availability of a fair hearing for any Medicaid-eligible child enrolled in the Children's Waiver Program when that child is subject to a negative action. A negative action results when a Medicaid-covered service or benefit is taken away, reduced, or denied to a Medicaid beneficiary. The Medicaid beneficiary must be notified of the negative action in writing. The negative action notice must indicate:

- The beneficiary's right to appeal through the MDHHS administrative hearing process;
- The beneficiary has 90 days to submit an appeal; and
- Where to send the appeal.

The MDHHS appeal process may occur simultaneously with a recipient's rights or CMHSP administrative appeal process. Individuals and their families are encouraged to resolve disputes regarding waiver services at the local CMHSP level.

The CMHSP is financially responsible for any services that may be approved as a result of the judgment from the administration appeal process.

CHILDREN'S SERIOUS EMOTIONAL DISTURBANCE HOME AND COMMUNITY-BASED SERVICES WAIVER APPENDIX

SECTION 1 – GENERAL INFORMATION

The Children's Serious Emotional Disturbance Home and Community-Based Services Waiver (SEDW) Program provides services that are enhancements or additions to Medicaid state plan coverage for children up to age 21 with serious emotional disturbance (SED) who are enrolled in the SEDW. MDHHS operates the SEDW through contracts with the CMHSPs. The SEDW is a fee-for-service program administered by the CMHSP in partnership with other community agencies. The CMSHP will be held financially responsible for any costs authorized by the CMHSP and incurred on behalf of a SEDW beneficiary.

1.1 KEY PROVISIONS

The SEDW enables Medicaid to fund necessary home and community-based services for children up to age 21 with SED who meet the criteria for admission to a state inpatient psychiatric hospital and who are at risk of hospitalization without waiver services. The CMHSP is responsible for assessment of potential waiver candidates.

Application for the SEDW is made through the CMHSP. The CMHSP is responsible for the coordination of the SEDW services. The Wraparound Facilitator, the child and his family and friends, and other professional members of the planning team work cooperatively to identify the child's needs and to secure the necessary services. All services and supports must be included in an IPOS.

A SEDW beneficiary must receive at least one SED waiver service per month in order to retain eligibility.

1.2 ELIGIBILITY

To be eligible for this waiver, the child must meet all of the following criteria.

- Live in a participating county (refer to the Coverage Area subsection in this chapter); OR
- Live in foster care in a non-participating county pursuant to placement by MDHHS or the court of a participating county, with SEDW oversight by a participating county's CMHSP; AND
- Reside with the birth or adoptive family or have a plan to return to the birth or adoptive home; OR
- Reside with a legal guardian; OR
- Reside in a foster home with a permanency plan; OR
- Be age 18 or age 19 and live independently with supports; AND
- Meet current MDHHS criteria for the state psychiatric hospital for children; AND
- Medicaid eligibility criteria and become a Medicaid beneficiary; AND

- Demonstrate serious functional limitations that impair the ability to function in the community. As appropriate for age, functional limitation will be identified using the Child and Adolescent Functional Assessment Scale (CAFAS®) or the Preschool and Early Childhood Functional Assessment Scale (PECFAS®):
  - CAFAS® score of 90 or greater for children age 7 to 12; OR
  - CAFAS® score of 120 or greater for children age 13 to 18; OR
  - For children age 3 to 7, elevated PECFAS® subscale scores in at least one of these areas: self-harmful behaviors, mood/emotions, thinking/communicating or behavior towards others; AND
- Be under the age of 18 when approved for the waiver. If a child on the SEDW turns 18, continues to meet all non-age-related eligibility criteria, and continues to need waiver services, the child can remain on the waiver up to their 21st birthday.

1.3 COVERAGE AREA

Waiver services are limited to eligible children (up to the federally-approved maximums) living in the counties whose CMHSPs have:

- An approved SED Waiver plan with MDHHS;
- Demonstrated strong collaboration with essential community partners;
- The capacity to provide intensive community-based services; and
- The fiscal capacity to manage interagency funding appropriately, or have been approved to participate in the MDHHS SED Waiver Pilot program.

SECTION 2 – COVERED WAIVER SERVICES

Each child must have a comprehensive IPOS that specifies the services and supports that the child and his family will receive. The IPOS is to be developed through the Wraparound Planning Process. Each child must have a Wraparound Facilitator who is responsible to assist the child/family in identifying, planning and organizing the Child and Family Team, developing the IPOS, and coordinating services and supports. The Wraparound Facilitator is responsible for monitoring supports and service delivery, as well as the health and safety of the child, as part of their regular contact with the child and family, with oversight by the Community Team.

In addition to Medicaid state plan services, children enrolled in the SEDW may receive any of the following SED waiver services as identified in the IPOS.

2.1 COMMUNITY LIVING SUPPORTS

Community Living Supports (CLS) are used to increase or maintain personal self-sufficiency, thus facilitating a beneficiary's achievement of his goals of community inclusion and remaining in their home. The supports may be provided in the beneficiary's home or in community settings (including, but not limited to, libraries, city pools, camps, etc.).

CLS provides assistance to the family in the care of their child while facilitating the child's independence and integration into the community. The supports, as identified in the IPOS, are provided in the child's home and may be provided in community settings when integration into the community is an identified goal. Skills related to activities of daily living (such as personal hygiene, household chores, and socialization) may be included. CLS may also promote communication, relationship-building skills, and participation in leisure and community activities. These supports must be provided directly to, or on behalf of, the child enabling the child to attain or maintain their maximum potential. These supports may serve to reinforce skills or lessons taught in school, therapy, or other settings.

Community Living Supports includes:

- Assistance with skill development related to:
  - Activities of daily living (such as personal hygiene)
  - Household chores
  - Socialization
  - Improving communication and relationship-building skills
  - Participation in leisure and community activities
- Staff assistance, support and/or training with such activities as:
  - Improving the child's social interactions and internal controls by instilling positive behaviors and increasing resiliency factors that should reduce risk factors
  - Non-medical care (i.e., not requiring nurse or physician intervention)

- Transportation (excluding to and from medical appointments) from the beneficiary's home to community activities, among community activities, and from the community activities back to the beneficiary's residence
- Participation in regular community activities and recreation opportunities (attending classes, movies, concerts and events in a park; volunteering; etc.)
- Assisting the family in relating to and caring for their child
- Attendance at medical appointments
- Acquiring or procuring goods other than those listed as shopping and non-medical services

- Reminding, observing, rewarding and monitoring of pro-social behaviors.
- Medication administration.
- Staff assistance with preserving the health and safety of the beneficiary in order that he may reside or be supported in the most integrated, independent community setting.

2.2 Family Home Care Training

Family Home Care Training provides training and counseling services for the families of beneficiaries served by this waiver. For purposes of these services, "family" is defined as the person(s) who lives with or provides care to a beneficiary served by the waiver, and may include a parent and/or siblings or the foster parent(s) for a child in Therapeutic Child Foster Care. This service is provided by a Master's level social worker, psychologist, or QMHP, and includes instruction about treatment interventions and support intervention plans specified in the IPOS, and includes updates as necessary to safely maintain the child at home.

Family Home Care Training is also a counseling service directed to the family and designed to improve and develop the family's skills in dealing with the life circumstances of parenting a child with special needs and to help the child remain at home. All family training must be included in the child's IPOS and must be provided on a face-to-face basis (i.e., in person and with the family present).

2.3 Family Support and Training

This service is provided by a peer-parent who has completed MDHHS endorsed training. It is a family-focused service provided to families (birth or adoptive parents, siblings, relatives, foster family, and other unpaid caregivers) of children with serious emotional disturbance (SED) for the purpose of assisting the family in relating to and caring for a child with SED. The services target the family members who are caring for and/or living with a child receiving waiver services. The service is to be used in cases where the child is hindered or at risk of being hindered in their ability to achieve goals of: performing activities of daily living; improving functioning across life domain areas; perceiving, controlling or communicating with the environment in which they live; or improving their inclusion and participation in the community or productive activity, or opportunities for independent living.

Coverage includes education and training, including instructions about treatment regimens, to safely maintain the child at home (as specified in the individual plan of service (POS)) and peer support provided by a trained peer-parent (one-on-one or in a group) for assistance with identifying coping strategies for successfully caring for or living with a person with SED. Parent-to-parent support is designed to support parents/families of children with SED as part of the treatment process to be empowered, confident, and have skills that will enable them to assist their child to improve in functioning. The trained parent support partner has had or currently has a child with special mental health needs; provides education, training, and support; and augments the assessment and mental health treatment process. The peer-parent support partner provides these services to the enrolled child's parents and their family. These activities are provided in the home and in the community. NOTE: The unit of service when billing S5111 HM for children/youth on the SEDW is per session, 45 minutes or more.

The parent support partner must complete the MDHHS endorsed statewide training curriculum and be provided regular supervision and team consultation by the treating professionals. Completion of the initial three-day training curriculum is documented by a Certificate of Completion which must be maintained in the parent support partner's personnel file.

2.4 Therapeutic Activities

A therapeutic activity is an alternative service that can be used in lieu of, or in combination with, traditional professional services. The focus of therapeutic activities is to interact with the child to accomplish the goals identified in the POS. The POS ensures the child's health, safety and skill development and maintains the child in the community. Services must be directly related to an identified goal in the POS. Providers are identified through the wraparound planning process and participate in the development of a POS based on strengths, needs, and preferences of the child and family. Therapeutic activities may include the following: child and family training, coaching and supervision, monitoring of progress related to goals and objectives, and recommending changes to the POS. Services provided under Therapeutic Activities include music therapy, recreation therapy, and art therapy. NOTE: The unit of service when billing G0176 for children/youth on the SEDW is per session, 45 minutes or more.

The training, coaching, supervision and monitoring activities provided under this service are specific to music, art, and recreation therapy and must be provided by providers with the qualifications listed below.

Recreation Therapy	Must be provided by a Certified Therapeutic Recreation Specialist credentialed by the National Council for Therapeutic Recreation Certification (NCTRC).
Music Therapy	Must be provided by a Music Therapist - Board Certified (MT-BC) or by a music therapist listed on the National Music Therapy Registry (NMTR).
Art Therapy	Must be provided by a Registered Art Therapist - Board Certified (ATR-BC).

2.5 Respite Care

Respite care is services provided to beneficiaries unable to care for themselves that are furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care.

Federal Financial Participation (FFP) may not be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence. Respite care can be provided in the following locations:

- Beneficiary's home or place of residence
- Family friend's home in the community
- Licensed Therapeutic Foster Home
- Licensed Group Home

2.6 Child Therapeutic Foster Care

Child Therapeutic Foster Care (CTFC) is an evidence-based practice. It provides an intensive therapeutic living environment for a child with challenging behaviors. Important components of CTFC include:

- intensive parental supervision,
- positive adult-youth relationships,
- reduced contact with children with challenging behaviors, and
- family behavior treatment skills.

CTFC seeks to change the negative trajectory of a child's behavior by improving his social adjustment, family adjustment and peer group. CTFC attempts to decrease negative behavior, increase appropriate behavior, and build pro-social skills. Foster parents, teachers, therapists and other adults act as change agents for the child. The change agents contribute to the treatment of the child and the preparation of his family for the child's return to the home and community. Foster parents are specially recruited, trained and supervised. The total number of individuals (including beneficiaries served in the waiver) living in the home who are unrelated to the primary caregiver may not exceed one.

In addition to being licensed, all CTFC programs under this waiver are to be pre-enrolled by MDHHS to ensure they meet the requirements set forth in this policy. Separate payment will not be made for homemaker or chore services, for community living services provided by the foster parents, or for respite care furnished for the foster care parents to a child receiving CTFC services since these services are integral to, and inherent in, the provision of CTFC.

2.7 Therapeutic Overnight Camp

A group recreational and skill building service in a camp setting aimed at meeting the goal(s) detailed in the beneficiary's IPOS. A session can be one or more days and nights of camp. Room and Board costs are excluded from the SEDW payment for this service.

Additional criteria:

- Camps are licensed by MDHHS;
- The child's IPOS includes Therapeutic Overnight Camp; and
- Camp staff is trained in working with children with SED.

Coverage includes:

- Camp fees, including enrollment and other fees;
- Transportation to and from the camp; and
- Additional costs for staff with specialized training with this population.

Coverage excludes:

- Room and board for the camp.

2.8 Transitional Services

Transitional services is a one-time-only expense to assist beneficiaries returning to their family home and community while the family is in the process of securing other benefits (e.g., SSI) or resources (e.g., governmental rental assistance and/or home ownership programs) that may be available to assume these obligations and provide needed assistance.

Additional criteria for using Transitional Services:

- The beneficiary must have in his/her IPOS a goal to return to his/her home and community; and
- Documentation of the family's control (i.e., signed lease, rental agreement, deed) of their living arrangement in the family-centered plan of service; and
- Documentation of efforts (e.g., the family is on a waiting list) under way to secure other benefits (such as SSI) or public programs (e.g., governmental rental assistance, community housing initiatives and/or home ownership programs) so when these benefits become available, they will assume the obligation and provide the needed assistance.

Coverage includes:

- Assistance with utilities, insurance, and moving expenses where such expenses would pose a barrier to a successful transition to the beneficiary's family home;

- Interim assistance with utilities, insurance, or living expenses when the beneficiary's family, already living in an independent setting, experiences a temporary reduction or termination of their own or other community resources; and
- Home maintenance when, without a repair to the home or replacement of a necessary appliance, the beneficiary would be unable to move there or, if already living there, would be forced to leave for health and safety reasons.

All services provided must be in accordance with applicable state or local building codes. Standards of value purchasing must be followed. The home maintenance must be the most reasonable alternative, based on the results of a review of all options. The existing structure must have the capability to accept and support the proposed changes. The infrastructure of the home involved must be in compliance with any applicable local codes. The home maintenance involved shall exclude costs for improvements required exclusively to meet local building codes. The home maintenance must incorporate reasonable and necessary construction standards, excluding cosmetic improvements. The home maintenance or repair cannot result in valuation of the structure significantly above comparable neighborhood real estate values.

Coverage excludes those home maintenance or repairs to the home that are:

- Of general utility or are cosmetic;
- Considered to be standard housing obligations of the beneficiary's family;
- Not of direct medical or remedial benefit to the child;
- On-going housing costs; and
- Costs for room and board that are not directly associated with transition arrangements while securing other benefits.

Requests for transitional services must be prior authorized by the CMHSP following denial by all other applicable resources (e.g., private insurance, Medicaid). All services shall be provided in accordance with applicable state or local building codes.

2.9 Wraparound Services

Wraparound services for children and adolescents is a highly individualized planning process facilitated by specialized supports coordinators.

Wraparound utilizes a Child and Family Team, with team members determined by the family often representing multiple agencies and informal supports. The Child and Family Team creates a highly individualized Wraparound plan with the child/youth and family that consists of mental health specialty treatment, services and supports covered by the Medicaid mental health state plan, waiver, B3 services, and other community services and supports.

The Wraparound plan may also consist of other non-mental health services that are secured from, and funded by, other agencies in the community. The Wraparound plan is the result of a collaborative team planning process that focuses on the unique strengths, values and preferences of the child/youth and family, and is developed in partnership with other community agencies. This planning process tends to

work most effectively with children/youth and their families who, due to safety and other risk factors, require services from multiple systems and informal supports. The Community Team, which consists of parents/guardians/legal representatives, agency representatives, and other relevant community members, oversees Wraparound.

Coverage includes:

- Planning and/or facilitating planning using the Wraparound process, including at least one monthly face-to-face contact;
- Developing an IPOS utilizing the Wraparound process;
- Linking to, coordinating with, follow-up of, advocacy for, and/or monitoring of services with the Wraparound Community Team and other community services and supports;
- Brokering with providers of services with the assistance of the Wraparound Community Team;
- Assistance with access to other entitlements; and
- Coordination with the Medicaid Health Plan or other health care providers.

Coverage excludes:

- Case management that is the responsibility of the child welfare, juvenile justice, or foster care systems;
- Case management for legal or court-ordered non-medically necessary services;
- Direct service provision; and
- Services and supports that are the responsibility of other agencies on the Community Team.

All SEDW Wraparound enrolled providers must meet all of the requirements in the enrollment standards as listed in the Wraparound Services for Children and Adolescents subsection of the Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter. In addition, due to the intense needs and level of risk of children/youth and their families served in the SEDW community-based waiver, all SEDW Wraparound providers must meet the following additional requirements:

- Wraparound facilitators must possess a bachelor's degree and be a CMHP or be supervised by a CMHP.
- Wraparound facilitators and those who provide supervision to facilitators will attend additional training (16 hours) related to provision of support to children/youth and their families served in the waiver annually as required by MDHHS. This training is in addition to identified requirements for all supervisors and Wraparound facilitators.
- Caseloads shall be 8-10 per facilitator based on needs and risks of the child/youth and family. Caseloads may increase to a maximum of 12 when two child/youth and family teams are transitioning from Wraparound.

- SEDW site reviews will assess fidelity to the model through case file review, quality assurance of all SEDW-provided services/supports, and interviews with children/youth and family members.
- All SEDW Wraparound enrolled providers must participate in the statewide evaluation project that consists of gathering data on the Family Status Report at intake, quarterly and at graduation.
- Completion of the Michigan Wraparound Fidelity Index at six months and upon graduation.
- Participation in any additional model fidelity or quality assurance evaluation tools as requested by MDHHS.

2.10 Home Care Training, Non-Family

HCPCS Code S5116 – Non-Family Home Care Training/Session should be used to bill for this service. This service is reimbursable for up to four sessions per day but no more than 12 sessions per 90 days (i.e., three calendar months). A session can be of varying lengths of time but should meet the needs of the plan of service (POS); a billable session must be at least 45 minutes.

This service provides coaching, training, supervision and monitoring of Community Living Supports (CLS) staff by clinicians (i.e., licensed psychologist, Master's level social worker, occupational therapist, physical therapist, speech therapist, or Child Mental Health Professional). Professional staff work with CLS staff to implement the consumer's POS, with focus on services designed to improve the child's/youth's social interactions and self-control by instilling positive behaviors instead of behaviors that are socially disruptive, injurious to the consumer or others, or that cause property damage. The activities of the professional staff ensure the appropriateness of services delivered by CLS staff and continuity of care. This service can be provided by more than one clinician in any given month, as the service provider is selected on the basis of his/her competency in the aspect of the POS on which training is conducted.

Services must be provided by qualified providers who meet the requirements of, and in accordance with, 42 CFR §440.50 through §440.60(a) and other applicable state and federal laws or regulations.

SECTION 3 – MEDICAID STATE PLAN SERVICES

In addition to SEDW services, children served by the SEDW have access to Medicaid Mental Health State Plan services (e.g., psychotherapy, medication management, OT and PT evaluations, home based services) provided by their CMHSP on a fee-for-service basis. Services that can be billed to Medicaid are listed on the MDHHS CMHSP Serious Emotional Disturbance (SED) Waiver Database which is available on the MDHHS website. The database lists the CPT/HCPCS code, modifiers (when applicable), short description, Medicaid fee screen, and applicable quantity/timeframe parameters for each service. (Refer to the Directory Appendix for website information.)

Transportation is a Mental Health State Plan service covered under a number of HCPCS codes, only one of which can be billed fee-for-service for children on the SEDW. Parameters related to this service for SEDW enrollees are identified.

Prepaid Inpatient Health Plans (PIHPs) are responsible for transportation to and from the beneficiary's place of residence when provided so that a beneficiary may participate in a state plan, HSW, or additional/B3 service at an approved day program site or in a clubhouse psychosocial rehabilitation program. Medicaid Health Plans (MHPs) are responsible for assuring enrollee transportation to the primary health care services provided by the MHPs, and to non-mental health specialists and out-of-state medical providers. MDHHS is responsible for assuring transportation to medical appointments for Medicaid beneficiaries not enrolled in MHPs; and to dental, substance abuse, and mental health services (except those noted above and in the HSW program – described in the Habilitation Supports Waiver for Persons with Developmental Disabilities Section of this chapter) for all Medicaid beneficiaries.

For children enrolled in the SEDW, transportation may be reimbursed when separately specified in the individual plan of care and provided in order to enable a child served by the SEDW to gain access to waiver and other community services, activities, and resources. The transportation benefit is limited to mileage reimbursement, and can be paid to hourly staff (e.g., respite and CLS) and clinical/professional staff providers. Family, neighbors, friends, or community agencies that can provide this service without charge must be utilized before seeking funding through the SEDW. The SEDW-enrolled child, legally responsible caregivers, and foster care providers cannot be reimbursed for mileage.

SECTION 4 – PROVIDER QUALIFICATIONS

4.1 RESPITE AND CLS

Individuals who provide respite and CLS must, in addition to the specific training, supervision and standards for each support/service, be:

- A responsible adult at least 18 years of age;
- Free from communicable disease;
- Able to read and follow written plans of service/supports as well as beneficiary-specific emergency procedures;
- Able to write legible progress and/or status notes;
- In "good standing" with the law (i.e., not a fugitive from justice, a convicted felon or illegal alien); and
- Able to perform basic first aid and emergency procedures.

The individual must also have successfully completed Recipient Rights Training.

4.2 WRAPAROUND FACILITATOR

Wraparound facilitators must:

- Complete MDHHS wraparound training;
- Possess a bachelor's degree in human services or a related field, or other approved work/personal experience in providing direct services or linking of services for children with SED;
- Have a criminal history screen, including state and local child protection agency registries; and
- Be supervised by an individual who meets criteria as a qualified mental health professional who has completed MDHHS required training.

4.3 CHILD THERAPEUTIC FOSTER CARE

Child Therapeutic Foster Care providers must be:

- Licensed as a Foster Care Provider (MCL 722.122);
- Certified by MDHHS;
- Enrolled by MDHHS as a CTFC provider; and
- Trained in the child's IPOS.

4.4 THERAPEUTIC OVERNIGHT CAMP

Therapeutic Overnight Camps must be licensed and certified by MDHHS. Staff must be trained in the child's IPOS.