

Bulletin Number: MSA 11-19

Distribution: Prepaid Inpatient Health Plans (PIHP) and Community Mental Health Service Providers (CMHSP)

Issued: June 1, 2011

Subject: Revisions to Mental Health/Substance Abuse Chapter, Section 7 - Home-Based Services

Effective: July 1, 2011

Programs Affected: Children's Mental Health Home-Based Services

This bulletin revises Section 7 – Home Based Services of the Mental Health/Substance Abuse Chapter of the Medicaid Provider Manual. These changes were developed after extensive research and input from the Michigan Department of Community Health staff, CMHSPs, providers and families.

Please see the attached document for the revised language as it would appear in the Medicaid Provider Manual.

Manual Maintenance

Retain this bulletin until applicable information has been incorporated into the Michigan Medicaid Provider Manual.

Questions

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Community Health, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mail at ProviderSupport@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, and phone number so you may be contacted if necessary. Providers may phone toll-free 1-800-292-2550.

Approved



Stephen Fitton, Director
Medical Services Administration

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.

7.1 PROGRAM REQUIREMENTS AND APPROVAL

Medicaid providers seeking to become providers of home-based services must request approval from MDCH through an enrollment process. Once enrolled, a program must re-enroll every three years. (Refer to the Directory Appendix for contact information.) MDCH 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 MDCH must include basic program information submitted in a format prescribed by MDCH. 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 MDCH or provisional approval will be withdrawn.

Organizational Structure	<p>The organizational structure through which the mental health home-based services program shall be delivered must be specified. The following requirements must be met:</p> <ul style="list-style-type: none"> ▪ Enrolled home-based services providers are available and sufficient to ensure that home-based services 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.
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	<ul style="list-style-type: none"> ▪ 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.
<p>Qualified Staff</p>	<p>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 Mental Retardation Professional (QMRP).</p> <p>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 4 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.</p>
<p>Plan of Service</p>	<p>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. See the Family-Driven and Youth-Guided Policy and Practice Guideline for more explicit information on this topic.</p> <p>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.</p>

<p>Amount and Scope of Service</p>	<p>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.</p> <p>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.</p> <p>A minimum of 4 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.</p> <p>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 3 months.</p> <p>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.</p>
<p>Location of Service</p>	<p>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 and community.</p>

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 3 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 a mental, 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 mental retardation or other developmental disability, drug abuse/alcoholism or those with a V-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: <ul style="list-style-type: none"> ▪ 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.

	<ul style="list-style-type: none"> ▪ 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. <p>An assessment tool specifically targeting socio-emotional functioning which can assist in determining functional impairment is the Devereux Early Childhood Assessment, Infant/Toddler or Preschool Version.</p> <p>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).</p> <p>Other assessment tools may be utilized by the practitioner based on the needs of the infant/toddler or parent(s).</p>
Duration/History	<p>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:</p> <ul style="list-style-type: none"> ▪ 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	<p>A child has a mental, behavioral or emotional disorder sufficient to meet diagnostic criteria specified within the current version of the DSM or ICD not solely the result of mental retardation or other developmental disability, drug abuse/alcoholism or those with a V-code diagnosis, and the beneficiary meets the criteria listed below for degree of disability/functional impairment and duration/service history.</p>
Functional Impairment	<p>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:</p> <ul style="list-style-type: none"> ▪ Impaired physical development, sensory, sensory motor or organizational processing difficulty, failure to control bodily functions (e.g., bed wetting).

	<ul style="list-style-type: none"> ▪ 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. <p>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).</p> <p>Additional assessment tools may be utilized based on the needs of the child and/or parent(s).</p>
Duration/History	<p>The following specify length of time criteria for determining when the child's functional disabilities justify his referral for enhanced support services:</p> <ul style="list-style-type: none"> ▪ 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

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 to 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	<p>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 (V Codes).</p>
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<p>Functional Impairment</p>	<p>For purposes of qualification for home-based services, children/adolescents may be considered markedly or severely functionally impaired if the minor has:</p> <ul style="list-style-type: none"> ▪ 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.
<p>Duration/History</p>	<p>The following specify the length of time the youth's functional disability has interfered with his/her daily living and led to his/her referral for home-based services:</p> <ul style="list-style-type: none"> ▪ Evidence of six continuous months of illness, symptomatology, or dysfunction; ▪ Six cumulative months of symptomatology/dysfunction in a twelve-month period; or ▪ On the basis of a specific diagnosis (e.g., schizophrenia), disability is likely to continue for more than one year.