

Distribution: Mental Health/Substance Abuse 04-03
(Prepaid Inpatient Health Plans)

Issued: September 1, 2004

Subject: Changes to Program Requirements;
Additional Mental Health Services;
Additional Substance Abuse Services

Effective: October 1, 2004

Programs Affected: Medicaid

This bulletin transmits additions to the Mental Health/Substance Abuse Chapter of the Medicaid Provider Manual that reflect changes required by the December 22, 2003 approval of the 1915(b) Medicaid Waiver for Specialty Services and Supports by the Centers for Medicare and Medicaid Services. The changes integrate additional services that are covered by Medicaid for beneficiaries with mental illness, developmental disabilities, and/or substance use disorders; and medical necessity criteria for all specialty services and supports covered by this chapter, except the Children's Waiver.

Additions to Section 2 – Program Requirements

2.5 MEDICAL NECESSITY

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

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; and
- Responsive to particular needs of multi-cultural populations and furnished in a culturally relevant manner; and
- Responsive to the particular needs of beneficiaries with sensory or mobility impairments and provided with the necessary accommodations; and
- 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;
 - 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.

Other Additions

Two new sections, Section 17 – Additional Mental Health Services (B3s) and Section 18 – Additional Substance Abuse Services (B3s), are attached.

Manual Maintenance

The changes transmitted in this bulletin will be incorporated into the Mental Health/Substance Abuse Chapter of the October 1, 2004 on-line version of the Medicaid Provider Manual. If using that version of the manual, this bulletin may be discarded. Retain this bulletin for future reference if utilizing the January 2004 CD version of the Manual. The Manual is available on-line at www.michigan.gov/mdch, click on Providers, Information for Medicaid Providers, Medicaid Provider Manual.

Questions

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

Approved



Paul Reinhart, Director
Medical Services Administration

attachment

SECTION 17 – ADDITIONAL MENTAL HEALTH SERVICES (B3s)

Certain Medicaid-funded mental health supports and services may be provided, 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.

17.1 DEFINITIONS OF GOALS THAT MEET THE INTENT 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.

<p>Community Inclusion and Participation</p>	<p>The individual uses community services and participates in community activities in the same manner as the typical community citizen.</p> <p>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 mental retardation).</p>
<p>Independence</p>	<p>"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.</p> <p>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 enter adulthood and live independently.</p>

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. 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.
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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 and the MDCH/PIHP Contract, Section 1.2; and
- The service(s) having been identified during person-centered planning; and
- The service(s) being medically necessary as defined in MDCH/PIHP Contract, Attachment P.3.2.1, Medical Necessity Criteria, as amended; and
- 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.

Provider qualifications and service locations that are not otherwise identified in this section must meet the requirements identified in the General Information and Program Requirements 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 or Certificate of Medical Necessity 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

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, reminding, 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 state plan services, e.g., Personal Care (assistance with ADLs in a certified specialized residential setting) and Home Help or Enhanced 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 is needed, the beneficiary, with the help of the PIHP case manager or supports coordinator, **must** request Home Help and, if necessary, Enhanced Home Help from the Family Independence Agency (FIA) **before** CLS assistance with meal preparation, laundry, routine household care and maintenance, activities of daily living and/or shopping may be authorized by a PIHP. Reminding, observing, guiding and/or training of these activities are CLS coverages that do not supplant Home Help or Enhanced Home Help. The PIHP case manager or supports coordinator must also assist, if necessary, the beneficiary in filling out and sending a request for Fair Hearing when Home Help, Enhanced Home Help, or the requested amount, scope and duration are denied by the FIA.

- 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 Personal Care services. Transportation to medical appointments is covered by Medicaid through FIA or the Medicaid Health Plan. Payment for CLS services may not be made, directly or indirectly, to responsible relatives (i.e., spouses, parents of minor children).

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 Enhanced Home Help services when the individual's needs for this assistance have been officially determined by FIA or the Administrative Tribunal to exceed the FIA's allowable parameters. CLS may be used for these activities while the beneficiary awaits determination by FIA of the amount, scope and duration of Home Help or Enhanced Home Help. CLS may also be used for these activities while the beneficiary awaits the decision from a Fair Hearing of the appeal of an FIA decision.

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

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 electric 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, or the Americans with Disabilities Act; or are the responsibilities of Michigan Rehabilitation Services.

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. EXTENDED OBSERVATION BEDS (23 HOURS)

This program, that must be pre-approved by MDCH (refer to the Programs Requiring Special Approval subsection of this chapter), is a hospital-based service, less than 24 hours in duration, involving rapid diagnosis, treatment and stabilization of an individual with a psychiatric or substance abuse emergency, and that results in sufficient amelioration of the situation to allow the person to be discharged and transferred to an outpatient care service.

17.3.F. FAMILY SUPPORT AND TRAINING

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 one-on-one or in group for assistance with identifying coping strategies for successfully caring for or living with a person with disabilities.

17.3.G. HOUSING ASSISTANCE

Housing assistance is assistance with short-term, interim, or one-time-only expenses for beneficiaries transitioning from restrictive settings 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 service 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
- 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
- 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
- Costs for room and board that are not directly associated with transition arrangements while securing other benefits
- 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.H. PEER-DELIVERED OR -OPERATED SUPPORT SERVICES

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

Coverage includes:

- drop-in centers
- vocational and housing programs
- peer counseling
- peer case management, supports coordination or supports specialist services
- crisis alternatives to hospitalization
- advocacy training
- peer support groups
- peer education

<p>Program Approval</p>	<p>PIHPs must seek approval from MDCH prior to establishing new drop-in programs. Proposed drop-in centers will be reviewed against the following criteria:</p> <ul style="list-style-type: none"> • Staff and board of directors of the center are 100% primary consumers • PIHP allows consumers the autonomy and independence to make day-to-day decisions about the program • PIHP allows consumers the 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 identifying the roles and responsibilities of each party
<p>Documentation</p>	<p>Individual plan of service identifies goals and how the program supports those goals; and the amount, scope and duration of the services to be delivered. Individual clinical record provides evidence that the services were delivered consistent with the plan.</p>
<p>Qualifications</p>	<p>Peer case managers, supports coordinators or supports specialists must be trained and supervised by a PIHP or CMHSP case manager or supports coordinator who meets the qualifications of case manager or supports coordinator. Peer counselors must be trained and supervised by a qualified mental health therapist.</p>

17.3.I. PREVENTION-DIRECT SERVICE MODELS

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,
- Infant Mental Health when not enrolled as a Home-Based program, and
- Parent Education.

Coverage includes:

Child Care Expulsion Prevention (CCEP)	<p>CCEP 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 licensed child care programs.</p> <p>CCEP programs provide short-term child/family-centered mental health consultation for children with challenging behaviors which includes:</p> <p>Observation and functional assessment at home and at child care:</p> <ul style="list-style-type: none"> • Individualized plan of service developed by team • Intervention (e.g., coaching and support for parents and providers to learn new ways to interact with child, providing educational resources for parents and providers, modifying the physical environment, connecting family to community resources, providing counseling for families in crisis) <p>Provider qualifications:</p> <ul style="list-style-type: none"> • Early childhood mental health professional (MA, MSW, PhD)
School Success Program	<p>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.</p> <p>Provider qualifications:</p> <ul style="list-style-type: none"> • Mental health therapist (BSW, MSW, or MA)

<p>Children of Adults with Mental Illness/Integrated Services</p>	<p>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 clients 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. These services are provided by the adult beneficiary's mental health services coordinator and/or therapist employed by or under contract to the PIHP or its provider network.</p>
<p>Infant Mental Health</p>	<p>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.</p> <p>Provider qualifications:</p> <ul style="list-style-type: none"> • Masters-prepared mental health therapist who is trained in Infant Mental Health interventions.
<p>Parent Education</p>	<p>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.</p> <p>Provider qualifications:</p> <ul style="list-style-type: none"> • Parent education is provided by a mental health professional who is trained in the model.

17.3.J. RESPITE CARE SERVICES

Services that are provided to assist in maintaining a goal of living in a natural community home by temporarily relieving the **unpaid** primary care giver. 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.

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

Respite care may not be provided in:

- day program settings
- ICF/MRs, 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.K. SKILL-BUILDING ASSISTANCE

Skill-building assistance consists of activities 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 sheltered work services provided by Michigan Rehabilitation Services (MRS). Information must be updated when the beneficiary's MRS 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, 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 service 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 through the Rehabilitation Act of 1973, or Individuals with Disabilities Education Act (P.L. 94-142).

17.3.L. SUPPORT AND SERVICE COORDINATION

Functions performed by a supports coordinator, coordinator assistant, case manager assistant, supports and services 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** and the case manager **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 four possible options: targeted case management, supports coordinator, case management assistant, or supports coordinator assistant. When a supports coordinator assistant is used, a qualified supports coordinator must supervise the assistant. When a case manager assistant is used, a qualified 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, supports coordinator assistant, or case manager 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.

Independent supports and services brokers may be used for the brokering of providers of services/supports. However, it is expected that the beneficiary will also have a supports coordinator, case manager, or their assistant employed by the PIHP or its provider network who assures that the other functions listed above are in place.

If a beneficiary has both a supports coordinator, assistant case manager, or 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 or case manager assistant) and the services and supports broker to perform service brokering. Likewise, when a supports coordinator (or supports coordinator assistant or case manager 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 MDCH 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 as a face-to-face contact with the beneficiary; however, the function includes not only the face-to-face contact but also related activities that 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 may not include direct delivery of ongoing day-to-day supports and/or training, or provision of other Medicaid services.

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 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, Case Manager Assistants, and Supports and Services 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 supports and services brokers must meet these qualifications and function under the guidance and oversight of a qualified supports coordinator or case manager.

17.3.M. SUPPORTED/INTEGRATED EMPLOYMENT SERVICES

Provide job development, initial and ongoing support services to assist beneficiaries to obtain and maintain paid employment that would otherwise be unachievable without such supports. Supports services are provided continuously 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 through the Rehabilitation Act of 1973, as amended, or under the Individuals with Disabilities Education Act (IDEA); or through Michigan Rehabilitation Services.

SECTION 18 - ADDITIONAL SUBSTANCE ABUSE SERVICES (B3s)

Certain Medicaid-funded substance abuse services may be provided in addition to the Medicaid State Plan Specialty Supports and Services through the authority of 1915(b)(3) of the Social Security Act (hereafter referred to as B3s). These B3 substance abuse services are to be provided to eligible beneficiaries who both reside in the PIHP's region and request the services. The B3 services may be purchased with the Medicaid capitation or with Medicaid savings as described in the MDCH/PIHP contract. Medicaid funds may not be used to pay for room and board for B3 services.

The PIHP may provide these services only when the service:

- Meets medical necessity criteria for the beneficiary (Refer to MDCH/PIHP Contract, Attachment P.3.2.1, Medical Necessity Criteria); and
- Is based on individualized determination of need; and
- Is cost effective; and
- Does not preclude the provision of a necessary state plan service; and
- Meets access standards contained in the Substance Abuse Services, Covered Services subsection of this chapter, including a level of care (LOC) determination based on an evaluation of the six assessment dimensions of the current ASAM Patient Placement Criteria

18.1 SUB-ACUTE DETOXIFICATION

Sub-acute detoxification is defined as medically 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. Sub-acute detoxification must be staffed 24-hours-per-day, seven-days-per-week by a licensed physician or by the designated representative of a licensed physician.

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 client 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
 - AAR service requirements found in the Substance Abuse Services, Covered Services subsection of this chapter
 - LOC determination based on an evaluation of the six assessment dimensions of the current ASAM Patient Placement 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.

18.2 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.

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
 - AAR service requirements found in the Substance Abuse Services, Covered Services subsection of this chapter
 - LOC determination based on an evaluation of the six assessment dimensions of the current ASAM Patient Placement Criteria
- The PIHP may authorize up to 22 days of treatment.
- 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.