MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Distribution: Community Mental Health Services Programs 03-06

Issued: September 1, 2003

Subject: Revised Chapter III – Coverages and Limitations for Prepaid Inpatient Health Plans, Mental Health, Substance Abuse and Children's Waiver

Effective: October 1, 2003

Programs Affected: Medicaid

Attached is a revised Chapter III for the Prepaid Inpatient Health Plans, Mental Health and Substance Abuse policy manual. The revised chapter contains comprehensive revisions that reflect changes in the management of mental health and substance abuse services that are effective October 1, 2003. The revisions include removal of references to alternative and allowable services per order of the Policy Hearing Authority Decision of May 31, 2002, elimination of redundancies, and language updates.

Manual Maintenance

The following manual maintenance should be completed on October 1, 2003:

- Replace the current CMHSP Chapter III (distributed as CMHSP 98-09 & 99-01) with the attached Chapter III.
- The following bulletins are obsolete and should be discarded: CMHSP 03-01; CMHSP 02-03; CMHSP 02-01; CMHSP 00-01; CMHSP 98-10; CMHSP 98-08; CMHSP 98-07; CMHSP 98-06; CMHSP 98-04; CMSHP 98-03; CMHSP 98-01.
- This bulletin may be discarded after manual maintenance is completed.

Questions

Any questions regarding this bulletin should be directed to: Provider Support, 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 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

CHAPTER III – COVERAGES AND LIMITATIONS

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SECTION 1 – GENERAL INFORMATION

Information contained in this chapter is to be used in conjunction with other chapters of the Medicaid manual including the Billing and Reimbursement for Professionals Chapter, the Billing and Reimbursement for Institutional Providers Chapter, the Practitioner Chapter and the Billing and Reimbursement for Dental Providers Chapter, as well as the related procedure code databases located on the Michigan Department of Community Health (MDCH) website. (See Directory Appendix for contact information.)

1.1 MDCH APPROVAL

Pursuant to Michigan's Medicaid state plan and federally approved 1915(b) waiver and 1915(c) Habilitation Supports Waivers (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 MDCH 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 MDCH 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 those specialty services/supports included in this manual.

Section A.1.a. of the Social Security Act permits alternative services to be provided at the discretion of the PIHP from its Medicaid capitation payment. The alternative services are described in the MDCH/PIHP contract. Services selected during the person-centered planning process may be a mix of state plan, HSW, and alternative services, or state plan or HSW or alternative 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 MDCH through a fee-for-service (FFS) payment system. The Children's Waiver program is described in the Children's Home and Community-Based 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.

1.3 PROVIDER REGISTRY

The PIHPs must register with MDCH any Medicaid state plan, HSW, alternative or allowable service they provide directly or through one of their contracted providers, or an affiliate as applicable, as specified in the MDCH/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 Mental Health Services for MDCH approval of special programs. (See 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 MDCH.

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

1.4 PROGRAMS REQUIRING SPECIAL APPROVAL

Certain programs and sites require the PIHP to request specific approval by MDCH prior to service delivery. Programs must be approved by MDCH prior to service provision in order to be reported as a Medicaid cost. (See Directory Appendix for contact information.) Programs previously approved by MDCH 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
- Home-Based Services
- Intensive Crisis Stabilization

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

Children's Waiver services remain the responsibility of CMHSPs. CMHSPs must submit requests for approvals and changes to MDCH, Division of Mental Health Services to Children and Families.

1.5 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 {MHP} 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 beneficiary has been treated by the MHP for mild/moderate symptomatology and temporary or limited functional impairments and has exhausted the 20-visit maximum for the calendar year. (Exhausting the 20-visit maximum is not necessary prior to referring complex cases to PIHP/CMHSP.) The MHP's mental health consultant and the PIHP/CMHSP medical director concur that additional treatment through the PIHP/CMHSP is medically necessary and can reasonably be expected to achieve the intended purpose (i.e., improvement in the beneficiary's condition) of the additional treatment.

The "mental health conditions" listed in the table above are description 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 receive all mental health services from the PIHP.

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 (for mental illness) or services selection guidelines (for developmental disabilities) attached to the MDCH/PIHP contract, 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 MDCH/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.

1.6 DEFINITION OF TERMS

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

Allowable Services	Those substance abuse services that may be provided with Medicaid savings from the current year, as well as carried forward PIHP capitation payments, as specified in the MDCH/PIHP contract. Allowable services are described in the MDCH/PIHP contract.
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.
Alternatives	In Michigan, services that are permissible to provide in lieu of state plan services, and that may be paid for from the PIHP's Medicaid capitation payment. The list and description of alternative services are located in the MDCH/PIHP contract.
Certificate of Medical Necessity (CMN)	A document written 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 and address; ▪ Practitioner's signature, date of signature, and telephone number; ▪ The supplier's name and address; ▪ The expected start date of the order (if different from the date of signature); ▪ A complete description of the item or service; ▪ The amount and length of time the item or service is needed; ▪ Beneficiary's diagnosis; and ▪ The medical necessity of the item or service. (If required by Medicare or other insurer, a CMN may replace a prescription as an order for an item or service. If a CMN is completed, a separate prescription is not required.)

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, certified social worker or social worker, 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 Service or Medicaid Covered Services	For the purposes of this manual, Medicaid State Plan Services.
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 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.
Mental Health Professional	A physician, psychologist, certified or registered social worker, social work technician under the supervision of a professional, professional counselor, psychiatric nurse, or registered nurse under the supervision of a professional. (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.
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, social worker, physical therapist, occupational therapist, speech pathologist or audiologist, registered nurse, therapeutic recreation specialist, or rehabilitation counselor. (Refer to Staff Provider Qualifications in the Program Requirements Section of this chapter for specific requirements of the professionals.)
Qualified Mental Retardation Professional (QMRP)	An individual who meets the qualifications under 42 CFR.438.430. A QMRP is a person who has specialized training or one year of experience in treating or working with a person who has mental retardation; and is a psychologist, physician, educator with a degree in education from an accredited program, social worker, physical therapist, occupational therapist, speech pathologist or audiologist, registered nurse, therapeutic recreation specialist, or rehabilitation counselor. (Refer to Staff Provider Qualifications in the Program Requirements Section of this chapter for specific requirements of the professionals.)
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).

SECTION 2 – PROGRAM REQUIREMENTS

2.1 MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES SERVICES

Mental health and developmental disabilities services (state plan, HSW, and alternatives) 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], MIChoice waiver providers, school-based services providers, and the county Family Independence Agency [FIA] 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.

2.2 SUBSTANCE ABUSE SERVICES

Substance abuse services must be furnished by service providers licensed by the Michigan Department of Consumer and Industry Services (DCIS) 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:

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

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 apply.

2.3 LOCATION OF SERVICE

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 other 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 DCIS-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 Facilities Chapter of this manual for PASAAR information as well as mental health services provided by Nursing Facilities.

Medicaid does not cover services provided to beneficiaries involuntarily residing in non-medical public facilities (such as jails or prisons). Medically necessary specialty services may be provided in situations when a child is temporarily placed in a non-medical public facility because placement in another facility (e.g., foster care) is not immediately available.

2.3.A. DAY PROGRAM SITES

The PIHP may organize a set of state plan, HSW or alternative services at a day program site, but the site and the set of services must be approved by MDCH. 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 is 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 supervision of professional staff who are licensed, certified, or registered to provide health-related services.

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 the MDCH. (See Directory Appendix for contact information) MDCH 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 alternative 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 profession 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 MDCH by the PIHP, and upon a site visit by MDCH.

2.4 STAFF PROVIDER QUALIFICATIONS

Providers of specialty services and supports (including state plan, HSW, and alternatives) 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 MDCH/PIHP contract must be followed.

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 MDCH/PIHP contract (i.e., not a fugitive from justice, a convicted felon, or an illegal alien).

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.
Dietitian	An individual who is a Registered Dietitian or an individual who meets the qualification of Registered Dietitian established by the American Dietetic Association.
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.
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 registered by the State of Michigan to practice as an occupational therapist.
Occupational Therapist Assistant (OTA)	An individual who is registered by the State of Michigan to practice as an occupational therapy assistant and who is supervised by a qualified occupational therapist.
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 Agency (DEA) registration.
Physician's Assistant	An individual licensed by the State of Michigan as a physician's assistant. Practice as a physician's assistant means the practice of medicine or osteopathic medicine and surgery performed under the supervision of a physician(s) license.
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 Secretary of the Department of Education or the Council on Postsecondary Accreditation. The individual must be supervised by the physical therapist licensed by the State of Michigan and must comply with the policy on Education and Utilization of Physical Therapy Assistant published by the American Physical Therapy Association.
Professional Counselor	An individual who is 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 DCIS) 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 DCIS) 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.
Social Worker	An individual who possesses a Michigan Certificate of Registration as a certified social worker; or a Michigan Certificate of Registration as a social worker; or a bachelor's degree with a major in social work and a Michigan Certificate of Registration as a social work technician.

Speech Pathologist or Audiologist	An individual who has a Certificate of Clinical Competence (CCC) from the American Speech and Language Association; the equivalent educational requirements and work experience necessary for the certificate; or has completed the academic program and is acquiring supervised work experience to qualify for the certificate.

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 alternative services described in the MDCH/PIHP contract. The PIHP is not responsible for providing state plan covered services that MDCH 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 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.)

3.1 ASSERTIVE COMMUNITY TREATMENT (ACT)

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

3.2 ASSESSMENTS

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, 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 health care professional for the purposes of determining eligibility for specialty services and supports, and the treatment needs of the beneficiary.

3.3 Behavioral Management Review

A behavior management or treatment plan, where needed, is developed through the person-centered planning process that involves the beneficiary. Any behavior management or 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 with the formal training or experience in applied behavior analysis; and one of whom shall be a licensed physician/psychiatrist. 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. 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.

3.4 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.

3.5 Clubhouse Psychosocial Rehabilitation Programs

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

3.6 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.

3.7 Crisis Residential Services

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

3.8 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.

3.9 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, 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.

3.10 Home-Based Services

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

3.11 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. Individual/group therapy is performed by a mental health professional.

3.12 Intensive Crisis Stabilization Services

See the Intensive/Crisis Stabilization Services Section of this chapter for specific program requirements.

3.13 Intermediate Care Facility For Individuals With Mental Retardation (ICF/MR)

Health and rehabilitative services provided in specially licensed facilities of 16 beds or less to beneficiaries with mental retardation or related conditions who need active treatment.

3.14 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, psychiatric nurse, physician assistant, nurse practitioner, registered nurse, or licensed practical nurse assisting the physician may perform medication administration.

3.15 MEDICATION REVIEW

Medication Review is evaluating and monitoring medications, their effects, and the need for continuing or changing the medication regimen. A physician, psychiatric nurse, physician assistant, nurse practitioner, registered nurse, or 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.

3.16 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. A physician, psychiatric nurse, physician assistant, nurse practitioner, certified social worker, social work technician supervised by a professional, professional counselor, QMRP, QMHP, or registered nurse supervised by a professional, may provide nursing facility mental health monitoring.

3.17 OCCUPATIONAL THERAPY

Evaluation	Therapy
Activities provided by an occupational therapist currently registered 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. Therapy must be skilled (requiring the skills, knowledge, and education of a registered 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.

Evaluation	Therapy
	Services must be prescribed by a physician and may be provided on an individual or group basis by an occupational therapist or occupational therapy assistant, currently registered 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.

3.18 Personal Care in Licensed Specialized Residential Settings

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

3.19 Physical Therapy

Evaluation	Therapy
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. 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, registered occupational therapist, family member or caregiver) would not be considered as a Medicaid cost under this coverage. Services may be provided by a physical therapist currently licensed by the State of Michigan, or an assistant (the physical therapist must supervise and monitor the assistant's performance with continuous assessment of the beneficiary's progress), or an aide who is under the supervision of a physical therapist currently licensed by the State of Michigan.

3.20 SPEECH, HEARING, AND LANGUAGE

Evaluation	Therapy
Activities provided by a speech-language pathologist or audiologist possessing a current Certificate of Clinical Competence (CCC) 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 certified 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, registered occupational therapist, family member, or caregiver) would not be considered as a Medicaid cost under this coverage. Services may be provided by a speech-language pathologist or audiologist possessing a current CCC 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 CCC). All documentation by the candidate must be reviewed and signed by the appropriately credentialed supervising speech-language pathologist or audiologist.

3.21 SUBSTANCE ABUSE

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

3.22 TARGETED CASE MANAGEMENT

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

3.23 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 alternative service at an approved day program site or in a 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. The FIA 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 FIA or MHP for additional information and the Ambulance Chapter 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., FIA, MHP, volunteer, family member), and for the least expensive available means suitable to the beneficiary's need.

3.24 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.

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.

SECTION 4 – ASSERTIVE COMMUNITY TREATMENT PROGRAM (ACT)

Assertive Community Treatment (ACT) is a set of intensive clinical, medical and psychosocial services provided by a mobile multi-disciplinary treatment team. The team also 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, and medical care and supports to allow beneficiaries to function in social, educational, and vocational settings. ACT services are based on the principles of recovery and person-centered practice and are individually tailored to meet the needs of the beneficiary. Services are provided in the beneficiary's residence or other community locations by all members of the ACT team. All team staff must have a basic knowledge of ACT programs and principles acquired through work experience and/or ACT specific training.

4.1 PROGRAM APPROVAL

Medicaid providers wishing to become providers of ACT services must obtain approval from MDCH and meet the program components outlined below. Provider programs with more than one ACT team must be approved and registered separately.

4.2 TARGET POPULATION

ACT services are targeted to beneficiaries with serious mental illness who require intensive services and supports and who, without ACT, would require more restrictive services and/or settings.

- Beneficiaries with serious mental illness with difficulty managing medications without ongoing support, or with psychotic/affective symptoms despite medication compliance.
- Beneficiaries with serious mental illness with a co-occurring substance disorder.
- Beneficiaries with serious mental illness who exhibit socially disruptive behavior that puts them at high risk for arrest and inappropriate incarceration or those exiting a county jail or prison.
- Beneficiaries with serious mental illness who are frequent users of inpatient psychiatric hospital services, crisis services, crisis residential, or homeless shelters.
- Older beneficiaries with serious mental illness with complex medical/medication conditions.

4.3 ESSENTIAL ELEMENTS

Team-Based Service Delivery	ACT is a team-based service that includes shared service delivery responsibility. Case management services are interwoven with treatment and rehabilitative services, and are provided by all members of the team. Substance abuse treatment provided within the context of the ACT team must meet the criteria located in the Substance Abuse Services Section of this chapter. Team meetings occur Monday through Friday and are attended by all members on duty. The status of all beneficiaries is briefly reviewed and documentation of daily team meetings includes all individuals discussed and all staff members present. The daily schedule is organized and contacts scheduled.

Team Composition	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. The minimum essential ACT staffing requirements are: ▪ A physician who provides psychiatric coverage for all beneficiaries served by the team. The physician is considered part of the team and meets with the team on a frequent basis. The physician (MD or DO) must possess a valid license to practice medicine in Michigan, a Michigan Controlled Substance License, and a DEA registration. ▪ A registered nurse (RN) is required (in addition to the physician). The nurse oversees medication and provides direct services to the beneficiary in the community. ▪ A team coordinator with a minimum of a master's degree in a relevant discipline with appropriate licensure or certification to provide clinical supervision, plus a minimum of two years clinical experience with adults with serious mental illness. The team coordinator also provides direct services to beneficiaries in the community. The coordinator is assigned full-time to the ACT team. Additional positions should reflect the special conditions, services or supports required by the population or special populations to be served. ▪ Other professional staff licensed, certified, or registered by the State of Michigan or national organizations to provide health care services. ▪ Other staff not licensed, certified, or registered (i.e., paraprofessional staff, possessing at least a bachelor's degree in an unrelated field with one year experience working with adults with mental illness, or a high school diploma with two years experience working with the mentally ill population) are considered a part of staff-to-beneficiary ratio. Peer support staff, a valuable resource to both the recipients and members of the team, is not counted in the staff-to-beneficiary ratio. Under the supervision of the team leader, both may provide documentation in beneficiary records. This supervision is documented in the beneficiary record. Providers of substance abuse treatment must meet criteria in the Substance Abuse Services Section of this chapter.
Staff-to-Beneficiary Ratio	The staff-to-beneficiary ratio shall be no more than 1:10, i.e., a maximum of 10 beneficiaries to each member of the team. The ratio includes the team coordinator and all other team members who provide direct services, and excludes the physician, peers who do not meet paraprofessional or professional criteria, and clerical support staff.
Fixed Point of Responsibility	The ACT team is the fixed point of responsibility for the development of the individual plan of service 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 or obtained by the team including consultation with other disciplines and/or referrals to other supportive services as appropriate.

Availability of Services	Availability of services must include: ▪ Twenty-four-hour/seven-day crisis response coverage (including psychiatric availability) that is handled directly by members of the team. ▪ 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.
Individual Plan of Services	ACT services and interventions must be consistent and balanced through medical necessity and preferences of the beneficiary while embracing person-centered principles and recovery, with the goal of maximizing independence and progression into less intensive services. Beneficiaries with co-occurring substance use disorders must have both mental health and substance use disorders addressed in their individual plan of service. Treatment in the same program is preferred.

4.4 ELEMENTS OF ACT

"In Vivo" Settings	Services
According to the beneficiary's preference and clinical appropriateness, the majority of services are provided in the beneficiary's home or other community locations rather than the team office.	ACT teams provide a wide array of clinical, medical, or rehabilitative services during face-to-face interactions that are designed to help beneficiaries to live independently or facilitate the movement of beneficiaries from dependent settings to independent living. These services and supports are focused on maximizing independence and the beneficiary's quality of life, such as maintaining employment, social relationships and community inclusion. For beneficiaries with co-occurring substance use disorders, individualized treatment will be integrated by the team as part of the overall treatment approach. Services may include those defined elsewhere in this section, as well as others that are consistent with preferences, professionally accepted standards of care, and are medically necessary. ACT services may be used as an alternative to hospitalization. The following criteria shall be used to determine the appropriateness of these services as an alternative to hospitalization.

4.5 ELIGIBILITY CRITERIA

Utilization of ACT services in high acuity conditions/situations allows beneficiaries to remain in their community 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 persistent mental illness who may be at risk for inpatient hospitalization, 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 program is an individually tailored combination of services and supports that may vary in intensity over time based on the beneficiary's needs and condition. Services include multiple daily contacts and 24-hour, seven-days-per-week crisis availability provided by a multi-disciplinary team which includes psychiatric and skilled medical staff.

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

Diagnosis	The beneficiary must have a mental illness, as reflected in a primary, validated, current version of DSM or ICD diagnosis (not including V Codes), including personality disorders.
Severity of Illness	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 role performance expectations. ▪ Drug/Medication Conditions - Drug/medication compliance and/or coexisting 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 person 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 vivo, to improve the beneficiary's condition and/or allow the person to function without more restrictive care, and the person 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 person'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 or a 24-hour protective environment. ▪ The person 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 compliance 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.

SECTION 5 – CLUBHOUSE PSYCHOSOCIAL REHABILITATION PROGRAMS

A clubhouse program is a community-based psychosocial rehabilitation program in which the beneficiary (also called clubhouse "members"), with staff assistance, is engaged in operating all aspects of the clubhouse, including food service, clerical, reception, janitorial and other member supports and services such as employment, housing and education. In addition, members, with staff assistance, participate in the day-to-day decision-making and governance of the program and plan community projects and social activities to engage members in the community. Through the activities of the ordered day, clubhouse decision-making opportunities and social activities, individual members achieve or regain the confidence and skills necessary to lead vocationally productive and socially satisfying lives.

5.1 PROGRAM APPROVAL

PIHPs must seek approval for providers of psychosocial rehabilitation clubhouse services from MDCH. (See Directory Appendix for contact information) MDCH approval will be based on adherence to the requirements outlined below.

5.2 TARGET POPULATION

Clubhouse programs are appropriate for adults with a serious mental illness who wish to participate in a structured program with staff and peers and have identified psychosocial rehabilitative goals that can be achieved in a supportive and structured environment. The beneficiary must be able to participate in, and benefit from, the activities necessary to support the program and its members, and must not have behavioral/safety or health issues that cannot adequately be addressed in a program with a low staff-to-member ratio.

5.3 ESSENTIAL ELEMENTS

Member Choice/ Involvement	▪ 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 unit that they will regularly participate in during the 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 units and program structures so that members can influence and shape program operations.
Informal Setting	▪ 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. ▪ Members have access to the clubhouse during times other than the ordered day, including evenings, weekends, and all holidays.

Program Structure and Services	The program's structure and schedule identifies when the various program components occur, e.g., ordered-day, vocational/educational. Other activities, such as self-help groups and social activities shall be scheduled before and after the ordered day.
Ordered Day	The ordered day is a primary component of the program and provides an opportunity for members to regain self-worth, purpose, and confidence. It is made up of those tasks and activities necessary for the operation of the clubhouse and typically occurs during normal work hours. The ordered day is carried out in organizational units defined by the clubhouse that accomplish the work necessary to operate the clubhouse and meet the community living needs of the members, such as housing and transportation. Although participation in the 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 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.
Employment Services and Educational Supports	Services directly related to employment, including transitional employment, supported employment, on-the-job training, community volunteer opportunities, and supports for the completion or initiation of education or training and other vocational assistance must be available.
Member Supports	Opportunities for clubhouse members to provide and receive support in the community in areas of outreach, warm line, self-help groups, housing supports, entitlements, food, clothing and other basic necessities or assistance in locating community resources must be available.
Social Supports	Opportunities for members to develop a sense of a community through planning and organizing clubhouse social activities. This may also include opportunities to explore recreational resources and activities in the community. The interests and desires of the membership determine both spontaneous and planned activities.

5.4 Psychosocial Rehabilitation Components

Following are some of the broad domains of psychosocial rehabilitative goals and objectives. Based on the member's individual plan of service developed through the person-centered planning process, these are carried out during the member's participation in the ordered day and through interactions with other staff and members. Staff may also work informally with members on individual goals while working side-by-side in the clubhouse.

Symptom Identification and Care	▪ Identification and management of situations and prodromal symptoms to reduce the frequency, duration, and severity of psychological relapses. ▪ Gaining competence regarding how to respond to a psychiatric crisis. ▪ Gaining competence in understanding the role psychotropic medication plays in the stabilization of the members' well being. ▪ Working in partnership with members who express a desire to develop a crisis plan.

Competency Building	▪ Community living competencies (e.g., self-care, cooking, money management, personal grooming, maintenance of living environment). ▪ Social and interpersonal abilities (e.g., conversational competency, developing and/or maintaining a positive self-image, regaining the ability to evaluate the motivation and feelings of others to establish and maintain positive relationships). ▪ Personal adjustment abilities (e.g., developing and enhancing personal abilities in handling every day experiences and crisis, such as stress management, leisure time management, coping with symptoms of mental illness). The goal of this is to reduce dependency on professional caregivers and to enhance independence. ▪ Cognitive and adult role competency (e.g., task-oriented activities to develop and maintain cognitive abilities, to maximize adult role functioning such as increased attention, improved concentration, better memory, enhancing the ability to learn and establishing the ability to develop empathy).
Environmental Support	▪ Identification of existing natural supports for addressing personal needs (e.g., families, employers, and friends). ▪ Identification and development of organizational support, including such areas as sustaining personal entitlements, locating and using community resources or other supportive programs.

5.5 STAFF CAPACITY

The number of staff from the PIHP should be sufficient to effectively administer the program, but also allow the members sufficient leeway to participate meaningfully in the program. Clubhouse staff shall include:

- One full-time on-site clubhouse manager who is a qualified professional and has extensive experience with the target population and is licensed, certified, or registered by the State of Michigan or a national organization to provide health care services. The clubhouse manager is responsible for all aspects of clubhouse operations, staff supervision and the coordination of clubhouse services with case management and ACT.
- Other experienced professional staff licensed, certified, or registered by the State of Michigan or a national organization to provide health care services.

Other staff who are not licensed, certified, or registered by the State of Michigan to provide health care services may be part of the program, but shall operate under the supervision of a qualified professional. This supervision must be documented.

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 a 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.

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.

6.2.A. CHILD CRISIS RESIDENTIAL SERVICES

Nursing services must be available through regular consultation, and must be provided on an individual basis according to the level of need of the child. Child-caring institutions providing this service must have an attestation of adherence to federal standards on the use of seclusion and restraint.

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

Services must be provided under the auspices of an enrolled PIHP. The PIHP must identify the crisis residential program as part of their provider registration process with MDCH.

6.4 Qualified Staff

Treatment services must be provided under the supervision of a psychiatrist. A psychiatrist need not be present when services are delivered, but must be available by telephone at all times. The program must be under the immediate direction of a professional possessing at least a bachelor's degree in a human services field, and who has at least two years work experience providing services to beneficiaries with serious mental illness.

Treatment activities may be carried out by non-degreed 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/MDCH-approved training program for working with beneficiaries with mental illness.

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 DCIS and must be approved by MDCH to provide specialized crisis residential services. Services must not be provided in a hospital or other institutional setting.

Child caring institutions are permitted and may exceed 16 beds, according to the terms of their license.

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 course of 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 crisis period 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 service programs are designed to provide intensive services to children (birth through age 17) 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 promote normal development, promote healthy family functioning, support and preserve families, reunite families who have been separated, and reduce the usage of, or shorten the length of stay in, psychiatric hospitals and other substitute care settings. Treatment is based on the child's need with the focus on the family unit. The service style must support a strength-based approach, emphasizing assertive intervention, parent and professional teamwork, and community involvement with other service providers.

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 home-based services worker-to-family ratio must be established to accommodate the levels of intensity that may vary from two to twenty hours per week based on individual family needs. The worker-to-family ratio should not exceed 1:15 for a full-time equivalent position.

Medicaid providers seeking to become providers of home-based services must request approval from MDCH. (See Directory Appendix for contract information.) MDCH approval will be based on adherence to the requirements outlined below.

7.1 PROGRAM APPROVAL

Applications for approval must identify the target population to be served by the program. Providers must assure that staff providing services in this program meets the required qualifications.

Information submitted to MDCH must include the basic program information submitted in a format prescribed by MDCH. For approved providers, MDCH is available to assist the PIHP in securing any necessary training and technical assistance. If necessary during an initial period, the providers 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	The PIHP must specify the organizational structure through which the mental health home-based service program shall be delivered. The following requirements must be met: ▪ The structure must be centralized (i.e., the staff with responsibility for operating the home-based services program must be assigned to an identifiable service unit of an organization). ▪ Responsibility for directing, coordinating, and supervising the program must be assigned to a specific staff position. The supervisor of the program must meet the qualifications of a child mental health professional with three years of clinical experience. 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	Appropriately qualified staff must deliver the home-based services. Home-based professional staff must meet the qualifications of a child mental health professional. For home-based programs serving infants/toddlers (birth through age three) and their families, staff must be trained in infant mental health interventions. For home-based 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). 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 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.
Plan of Service	Home-based services must be provided in accordance with an individual plan of services 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 planning process.
Scope of Service	Home-based services programs combine individual therapy, family therapy, group therapy, crisis intervention, case management, and family collateral contacts. The family is defined as immediate or extended family or an individual 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.
Location of Service	Services are provided in the family home or community settings which all citizens use.

7.2 Eligibility Criteria

The criteria for home-based services are described below for children birth through age three years, children age four through age six, and children ages seven to seventeen years. 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 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 PIHP may maintain the child and family in Home-Based Services, even if they do not meet these criteria.

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 caregiving/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 provided through a PIHP. 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 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 two 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 parenting. Assessment tools specifically targeting socio-emotional functioning of assistance in determining functional impairment include: ▪ Infant-Toddler Mental Health Status Exam; ▪ Attachment-Interaction-Mastery-Support (AIMS); ▪ Temperament and Atypical Behavior Score (TABS); and ▪ DC: 0-3 Classification System. Assessment instruments specifically targeting child development include: ▪ Bayley Scales of Infant Care and Development. Tools assessing child development in social context include: ▪ Infant-Toddler Family Instrument (ITFI); ▪ Infant-Toddler Developmental Assessment (IDA); ▪ Objectives/Problems Checklist; and ▪ Hawaii Early Learning Profile (HELP). Appropriate Screening Instruments for initial triaging include: ▪ Ages and Stages Questionnaire (ASQ) ; ▪ Parent's Evaluation of Developmental Status (PEDS); and ▪ Denver Developmental Screening Test II.
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 parenting, 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 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.
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 three 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. ▪ Caregiving 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 caregiving environments, inappropriate parental expectations, abusive/neglectful or inconsistent parenting, occurrence of traumatic events, subjection to others' violent or otherwise harmful behavior.

	Assessment tools of assistance in determining functional impairment include, but are not limited to: ▪ Preschool and Early Childhood Functional Assessment Scale (PECFAS); and ▪ Child and Adolescent Level of Care Utilization System (CALOCUS).
Duration/History	The following specify length of time criteria for determining when the youth'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

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 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 (V Codes).
Functional Impairment	For purposes of qualification for home-based services, children and 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; ▪ 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 on CAFAS element involving Caregiver/Caregiving 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/her daily living and led to his/her referral for home-based services: ▪ 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.

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 MDCH 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, MDCH will only pay up to a Medicare-enrolled beneficiary's obligation to pay (i.e., co-insurance and deductibles). This limitation also applies if the beneficiary is eligible for, but not enrolled in, Medicare. (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 (Provider Types 68 and 73) or partial hospitalization services (Provider Types 41 and 75) 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 co-exist 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 table below:

Diagnosis	The beneficiary must be suffering from a mental illness, reflected in a primary, validated, current version of DSM Axis I, or ICD diagnosis (not including V 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). ➢ There has been significant destructive behavior toward property that endangers others. ▪ Drug/Medication Complications or Co-Existing General Medical Condition Requiring Care ➢ 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 co-existing 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 Axis I, or ICD diagnosis (not including V 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. ▪ Drug/Medication Complications or Co-Existing General Medical Condition Requiring Care ➢ 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 co-existing 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 patient'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 patient'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. Discharge criteria and aftercare planning are documented in the beneficiary's record.

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

Diagnosis	The beneficiary has a validated current version of DSM Axis I or ICD mental disorder (excluding V 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.

SECTION 9 – INTENSIVE CRISIS STABILIZATION SERVICES

Intensive/crisis stabilization services are structured treatment and support activities provided by a mental health crisis 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, 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 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 ENROLLMENT

Medicaid providers wishing to become providers of intensive/crisis services must enroll as an intensive/crisis services provider with the approval of MDCH and meet the program components outlined below.

9.2 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 abuse disorder or developmental disability.

9.3 SERVICES

Intensive/crisis services are intensive treatment interventions delivered by an intensive/crisis stabilization treatment team, under psychiatric supervision. Component services include:

- Intensive individual counseling/psychotherapy;
- Assessments (rendered by the treatment team);
- Family therapy;
- Psychiatric supervision; and
- Therapeutic support services by trained paraprofessionals.

9.4 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. Professionals providing intensive/crisis stabilization services must be health care professionals. Nursing services/consultation must be available.

The professional 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.

9.4 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.

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.

9.5 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.

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

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, in a licensed setting. 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 V 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, in a licensed setting. 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 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 V 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 patient'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 patient'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. Discharge criteria and aftercare planning are documented in the beneficiary's record.

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

Diagnosis	The beneficiary has a validated current version of DSM or ICD mental disorder (excluding V 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.

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 DCIS. These personal care services are distinctly different from the state plan Home Help program administered by FIA.

Personal care services are covered when authorized by a physician or the case manager or supports coordinator, 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.

11.2 PROVIDER QUALIFICATIONS

Personal care may be rendered to a Medicaid beneficiary in an Adult Foster Care setting licensed by DCIS and certified by DCIS 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 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

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

Access Assessment and Referral (AAR) Services	The AAR service is the system utilized to improve the accessibility to substance abuse treatment. This service must provide client informed choice of available treatment providers and an objective unbiased process to determine beneficiary need, level of care, referral and placement for substance abuse treatment. The substance abuse Assessment Process begins with the AAR service and continues as the beneficiary enters the substance abuse treatment program. The Assessment Process is the process for evaluating the condition of an individual relevant to treatment. The AAR service must include the following: ▪ The use of the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) to determine an initial diagnostic impression (also known as provisional diagnosis). The diagnostic impression must include all five axes. ▪ The use of the American Society of Addiction Medicine (ASAM) Patient Placement Criteria to determine substance abuse treatment placement/admission, continued stay and discharge/transfer. ▪ Any program/agency performing any or all portions of the AAR service must be licensed by DCIS to perform Screening, Assessment, Referral and Follow-up (SARF) services.
Outpatient Treatment	▪ Individual therapy is face-to-face counseling services with the beneficiary. ▪ Family therapy is face-to-face counseling with the beneficiary and his significant other and/or traditional or non-traditional family members. ▪ Group therapy is face-to-face counseling with three or more beneficiaries, and can include didactic lectures, therapeutic interventions/counseling, and other group-related activities. Outpatient treatment is an organized, non-residential treatment service or an office practice with clinicians educated/trained in providing professionally directed alcohol and other drug (AOD) treatment. The treatment occurs in regularly scheduled sessions, usually totaling fewer than nine contact hours per week. Examples include weekly or twice weekly individual therapy, group therapy, or a combination of the two. The treatment may be in association with participation in self-help groups. Treatment must be individualized based on a biopsychosocial 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) patient placement criteria. Beneficiary participation in referral and continuing care planning must occur prior to discharge.

Intensive Outpatient (IOP) Treatment	Intensive outpatient (IOP) treatment is a planned and organized non-residential treatment service in which AOD trained/educated clinicians provide several AOD treatment service components to beneficiaries. Treatment consists of regularly scheduled treatment, usually group therapy, within a structured program, at least three days per week for three consecutive hours each day. Examples include day or evening programs in which patients attend a full spectrum of treatment programming but live at home or in special residences. Treatment must be individualized based on a biopsychosocial 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 ASAM patient placement criteria. Beneficiary participation in referral and continuing planning must occur prior to discharge.
Office of Pharmacological and Alternative Therapies/Center for Substance Abuse Treatment (OPAT/CSAT) approved Pharmacological Supports	Covered services for Methadone and Levo-Alpha-Acetyl-Methadone (LAAM) pharmacological supports and laboratory services, as required by OPAT/CSAT regulations and the Administrative Rules for Substance Abuse Service Programs in Michigan, include: Methadone or LAAM medication Nursing services Physical examination Physician encounters (monthly) Laboratory tests TB skin test (as ordered by physician). Opiate-dependent patients may be provided chemotherapy using methadone or LAAM as an adjunct to therapy. Such services must be performed under the care of a physician licensed to practice medicine in the state of 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 DCIS and be certified by the OPAT/CSAT and licensed by the Drug Enforcement Administration (DEA). MDCH Enrollment Criteria for Methadone Maintenance and Detoxification Program attached to the MDCH PIHP contract must be followed.

12.2 ALLOWABLE SERVICES

The PIHPs may provide allowable services from Medicaid savings within their capitation payment (refer to the contract).

12.3 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
- Emergency medical care

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

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, 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.

13.4 STAFF QUALIFICATIONS

A primary case manager must be a qualified mental health or mental retardation professional (QMHP or QMRP); 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 QMRP who does possess the training or experience.

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. Children enrolled in the CWP who had reached age 18 years prior to October 1, 1996 may continue to receive waiver services until age 26.

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 MDCH must be submitted to the CWP Clinical Review Team at MDCH. The team is comprised of a physician, registered nurse, psychologist, and master's level 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 MDCH 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.

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

14.2 CLIENT 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/MR facility because of the intensity of the child's care and the lack of needed support, or the child currently resides in an ICF/MR 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/MR 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. 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. Under very limited circumstances, a parent or stepparent who possesses appropriate licensure/certification, special skills, documented training, and is considered a qualified provider, may function and be paid as a provider of this service. This would require documentation that the service being provided is not personal care; this service was not provided during time that the family is responsible to provide the care; and other qualified non-familial providers of these services are not currently available. Reimbursement for parents and step-parents may not exceed 248 hours during 30 consecutive days, and CLS provided by parents may not be used more than twice in a 12-month period. 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. 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 MDCH are not obligated for any restoration costs. If a family purchases or builds a home 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 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 MDCH 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 (previously called Didactic Services)	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 (previously called Psychological /Behavioral Treatment)	This service provides coaching, supervision and monitoring of CLS staff by professional staff (LLP, MSW, or QMRP). 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.
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. The maximum monthly respite allocation is 96 hours. In addition to monthly respite, vacation respite can be used up to 14 days per year and must be used in 24-hour increments.

	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/MR, nursing facility, or hospital) is not covered by the CWP. When a child requires skilled nursing interventions on a 24-hour exception basis, 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 may include devices, controls, or appliances specified in the individual plan of services which enable the child to increase his abilities to perform activities of daily living or to perceive, control or communicate with the environment in which he lives. This service 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 available under Medicaid or through other insurance (Refer to the Medical Supplies Chapter of this manual for information about Medicaid-covered equipment and supplies). The CMHSP, or its contract agency, may locally authorize medical equipment and supplies as defined in the most current version of the Instructional Manual for CWP. All other requests for specialized medical equipment and supplies must be prior authorized by the CWP Clinical Review Team following denial by all applicable insurance sources, e.g., private insurance, CSHCS, Medicaid. The item 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 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 beneficiary will be prevented. A prescription or CMN is required and is valid for one year from the date of signature. All items must be determined to be essential to the health, welfare, safety, 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. Repairs to specialized medical equipment that are not covered benefits through other insurances may be covered with prior approval by the CWP. There must be documentation in the 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 coverages must be sought and denied before requesting funding for repairs through the CWP. The CMHSP, or its contract agency, 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 CMHSP, or its contract agency, must provide evidence of training in the use of the equipment to prevent future incidents.

	Exclusions include ▪ Items that are not of direct medical or remedial benefit or that are considered to be experimental are not covered. "Experimental" means that the validity of use of the item has not been supported in one or more studies in a refereed professional journal. ▪ Furnishings and other non-custom items that may routinely be found in a home are excluded. ▪ Items that would normally be available to any child and would ordinarily be provided by families. ▪ Items that are considered family recreational choices are not covered. ▪ The purchase or lease of a vehicle and any repairs or routine maintenance to the vehicle is not covered. ▪ Educational supplies and equipment expected to be provided by the school. Vehicle modifications are limited to the installation of lifts, tie-down systems and raised roof or doors in a family-owned full-size van. The modification must be necessary to ensure the accessibility of the child with mobility impairments and the vehicle is the child's primary means of transportation. 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.
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 Provider Qualifications

14.4.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.

14.4.B. Individuals Performing Case Management Functions

Individuals Performing Case Management Functions must 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 (HSW)

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 alternative services. A HSW beneficiary must receive at least one HSW service per month in order to retain eligibility. Service selection guidelines for beneficiaries with developmental disabilities 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 MDCH 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/MR level of care services; and
- Chooses to participate in the HSW in lieu of ICF/MR 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 MDCH Bureau of Community Mental Health Services.

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.

15.1 WAIVER SUPPORTS AND SERVICES

Chore Services	Services to maintain the home in a clean, sanitary, and safe environment, include: ▪ Heavy household chores such as washing walls, floors and exterior windows; ▪ Tacking down loose rugs and tiles; ▪ Moving heavy furniture in order to provide safe mobility within the home; and ▪ Removing snow to provide safe access to, and egress from, the home.

	These services should be provided by persons not routinely providing other direct waiver supports and services, and only in cases where neither the beneficiary, nor anyone else in the household, is capable of performing or financially providing for them. In the case of rental property, the responsibility of the landlord, pursuant to the rental or lease agreement, must be examined prior to authorization of the service. This service may not be provided to beneficiaries who live in licensed settings because the activities are the responsibility of the home's licensee.
Community Living Supports (CLS)	Community Living Supports (CLS) facilitate an individual's independence and promote integration into the community. The supports can be provided in the beneficiary's residence (licensed facility, family home, own home or apartment) and in community settings. The supports are: ▪ Reminding, observing, guiding or training the beneficiary with: ➢ Meal preparation; ➢ Laundry; ➢ Routine household care and maintenance; ➢ Activities of daily living, such as bathing, eating, dressing, personal hygiene; and ➢ Shopping. ▪ Assistance, support and/or training the beneficiary with: ➢ Money management; ➢ Reminding, observing, and/or monitoring of medications; ➢ Non-medical care (not requiring nurse or physician intervention); ➢ Socialization and relationship building; ➢ Transportation*; ➢ Leisure choice and participation in regular community activities; and ➢ Attendance at medical appointments. The CLS do not include the costs associated with room and board. Payment for CLS does not include payments made, directly or indirectly, to responsible relatives (i.e., spouses or parents of minor children). The HSW services cannot supplant Medicaid services. The beneficiary must use the FIA Home Help or Enhanced Home Help services for assistance with meal preparation, laundry, routine household care and maintenance, activities of daily living (bathing, eating, dressing, personal hygiene), and shopping. * Transportation to medical appointments is covered by Medicaid through FIA or the Medicaid Health Plan.
Enhanced Dental	Accepted dental procedures that are not available to adults (over 21) under regular Medicaid dental coverage; provided to beneficiaries with dental problems sufficient to lead to more generalized disease due to infection or improper nutrition. Services are intended to reduce the risk of institutionalization and of having to provide higher cost procedures in the future. Common conditions that would qualify for these procedures include: ▪ Congenital deformities of the mid-face, palate, maxilla, and mandible;

	▪ Multiple recurrent cavities due to the person's inability to maintain optimal oral hygiene; ▪ Chronic periodontal disease secondary to medications and/or the person's inability to maintain oral hygiene; ▪ Chronic pain interfering with the ability to chew and swallow; ▪ Chronic abscess formation; and ▪ Other unique conditions that would lead to infection and/or nutritional deficiency if not otherwise corrected.
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 Supplies 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 or Certificate of Medical Necessity (CMN) 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; and ▪ Ancillary supplies and equipment necessary for proper functioning of such items. 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, are not covered. Educational equipment and supplies are expected to be provided by the school and 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.
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; ▪ 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); ▪ Special tweezers and nail clippers that accommodate the person's disability (e.g., reachers, or longer, wider handles); and ▪ Products or prostheses necessary to ameliorate negative visual impact of serious facial disfigurements (e.g., absence of ear, nose, or other feature or massive scarring) and/or skin conditions (including exposed area eczema, psoriasis, and/or acne) are included. Routine cosmetic products (e.g., make-up base, aftershave, mascara, and similar products) are not included. Refer to the Pharmacy Chapter in this manual for information about Medicaid-covered prescriptions.
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; and ▪ Installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies necessary for the welfare of the beneficiary.

	Adaptations or improvements to the home that are not of direct medical or remedial benefit to the beneficiary (e.g., carpeting, roof repair) are not included. "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. All items must be ordered on a prescription or CMN 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. 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. The environmental modification 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 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. 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, garages, raised garage doors, storage and organizers, landscaping and general home repairs. 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. 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. The HSW does not cover construction costs in a new home, or a home purchased after the beneficiary is enrolled in the waiver. 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. 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. 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 or the Americans with Disabilities Act (ADA). All services must be provided in accordance with applicable state or local building codes 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.
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, 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 care for the beneficiary.
Out-of-Home Non-Vocational 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 on a regularly scheduled basis (several hours a day, one or more days a week) as determined in the individual plan of services.

	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. 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	Services aimed at preparing a beneficiary for paid or unpaid employment, but that are not job task-oriented. They include teaching such concepts as compliance, attendance, task completion, problem solving, and safety. Prevocational services are provided to people not expected to be able to join the general workforce, or to participate in a transitional sheltered workshop within one year (excluding supported employment programs). 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. Activities included in these services are primarily directed at reaching habilitative goals, such as improving attention span and motor skills, not at teaching specific job skills. These services must be reflected in the person's individual plan of services and directed to habilitative objectives rather than employment objectives. When compensated, beneficiaries are paid at less than 50 percent of the minimum wage. This service must not otherwise be available to the beneficiary through the Rehabilitation Act of 1973, or Education of the Handicapped Act (P.L. 94-142). Documentation must be maintained by the PIHP that the beneficiary is not currently eligible for work activity or supported employment services provided by Michigan Rehabilitation Services (MRS). Information must be updated when MRS eligibility conditions change.
Private Duty Nursing (PDN)	Private Duty Nursing (PDN) services consist of nursing procedures to meet an individual's health needs that are directly related to his developmental disability. The PIHP must determine the extent to which the individual's health needs, as described in I. or II below, require nursing procedures as described in III. The PIHP must find that the beneficiary meets the criteria of either I and III listed below, or II and III listed below. PDN services are necessary to prevent institutionalization. **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 ventilation four or more hours per day or assisted respiration (Bi-PAP or CPAP); or ▪ Oral 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, in combination with a pulse oximeter and a documented need for observations and adjustments in the rate of oxygen administration.

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 progressively debilitating physical disorder.

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.

	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; monitoring fluid and electrolyte balance; suctioning of the airway; injections; indwelling central venous catheter care; managing mechanical ventilation; oxygen administration and evaluation; and tracheostomy care.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. *Private Duty Nursing is a Medicaid coverage for beneficiaries under age 21 who meet the medical criteria for eligibility and, therefore, private duty nursing services covered by this waiver are not available to that age group. Refer to the Private Duty Nursing Chapter of this manual for additional information.*
Respite Care	Respite is intended for beneficiaries whose primary caregivers typically are the same people day after day (e.g., family members and/or adult family foster care providers), and is provided during those portions of the day when the caregivers are not being paid to provide 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. Services must only be provided on an intermittent or short-term basis because of the absence or need for relief of those persons normally providing the care of a waiver beneficiary during times when they are not being paid to provide care.

	Respite care 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) chosen by the beneficiary and members of the planning team (including staff providing supports coordination). 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/MR, nursing facility, or hospital) or MDCH 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 involves working with the waiver beneficiary, and others that are identified by the beneficiary such as family member(s), in developing a written individual plan of services through the person-centered planning process. Using person-centered processes (including planning), support coordination assists in identifying and implementing support strategies. Supports strategies will incorporate the principles of empowerment, community inclusion, health and safety assurances, and the use of natural supports. Support 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 means face-to-face and related contacts, (e.g., making telephone calls to schedule appointments or arrange supports), including 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. ▪ Natural and community supports are used. ▪ The quality of the supports and services, as well as the health and safety of the beneficiary, is monitored. ▪ Income/benefits are maximized, including providing direct assistance with obtaining other insurance or state plan benefits as requested by the beneficiary.

	▪ Activities are documented. ▪ Plans of supports/services are reviewed at such intervals as are indicated during planning. Additionally, the supports coordinator coordinates with the qualified mental retardation professional (QMRP) on the process of initial waiver eligibility certification and annual re-certification. Supports coordination does not include any activities defined as Out-of-Home Non-Vocational Habilitation, Prevocational Services, Supported Employment, or CLS. 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 may not include direct delivery of ongoing day-to-day supports and/or training, or provision of other Medicaid services. The frequency and scope (face-to-face and telephone) of supports coordination contacts must reflect the intensity of the beneficiary's health and welfare needs identified in the individual plan of services.
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: ▪ Paid work consisting of 10 or more hours a week, paid at 50 percent of minimum wage or higher. ▪ 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 supports such as job coach, employment specialist, or personal assistant. ▪ For beneficiaries who require these supports for less than 50 percent of their employment hours. For example, a beneficiary employed 20 hours per week could receive less than 10 hours of supports. 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. This service must not otherwise be available to the beneficiary through the Rehabilitation Act of 1973, as amended, or under the Individuals with Disabilities Education Act (IDEA).

15.2 SUPPORTS AND SERVICE 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

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

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.

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, a convicted felon, or an illegal alien).
- Able to perform basic first aid procedures.

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 [SBS] Chapter of this manual for additional information.)