MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

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Distribution: Prepaid Inpatient Health Plans

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Subject: Mental Health and Substance Abuse Policy Changes

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Programs Affected: Medicaid

This bulletin describes policy changes to the Mental Health and Substance Abuse Medicaid service array approved by the federal Centers for Medicare and Medicaid Services (CMS).

Throughout the document, references to the portion of the Mental Health/Substance Abuse Chapter of the Medicaid Provider Manual affected by the change are noted.

CHANGES TO HABILITATION SUPPORTS WAIVER (HSW) FOR PERSONS WITH DEVELOPMENTAL DISABILITIES

THE FOLLOWING CHANGES AFFECT POLICY CURRENTLY CONTAINED IN SECTION 15.1 WAIVER SUPPORTS AND SERVICES.

Enhanced Dental Services

Enhanced dental was deleted as a covered HSW service since dental service for adults was restored as a Medicaid State Plan coverage.

Out-of-Home Non-Vocational Habilitation

The definition and coverage parameters for out-of-home non-vocational habilitation services were modified to be consistent with federal Medicaid waiver requirements. The frequency of the provision now requires that services normally be furnished four or more hours per day on a regularly scheduled basis for one or more days per week unless provided as an adjunct to other day activities included in the beneficiary's plan of service.

Private Duty Nursing

PDN services are provided to HSW enrollees age 21 and older up to an average of 16 hours per day during a month, and consist of nursing procedures to meet an individual's health needs directly related to his developmental disability. Private duty nursing includes the provision of nursing treatments and observation provided by licensed nurses within the scope of the State's Nurse Practice Act consistent with physicians' orders. The individual receiving private duty nursing must also require at least one of the following habilitative services, whether being provided by natural supports or through the waiver:

- community living supports
- out-of-home non-vocational habilitation
- prevocational or supported employment

Prepaid Inpatient Health Plans (PIHPs) must find that the beneficiary meets Medical Criteria I or II described in the Mental Health/Substance Abuse Chapter of the Medicaid Provider Manual.

Medical Criteria II was changed to require a medical condition directly related to the developmental disability instead of simply a progressively debilitating physical disorder. It also requires the medical condition must have occurred during the developmental period prior to age 22, is likely to continue indefinitely, and results in a significant functional limitation in three or more areas of life activity. Illnesses or disability acquired after the developmental period, such as a stroke or heart condition, would not be considered directly related to the developmental disability.

Medical Criteria III was changed to make available an exception process to ensure the beneficiary's health, safety and welfare if the beneficiary's needs exceed the 16-hour-per-day maximum for a time-limited period not to exceed six months. Factors underlying the need for additional PDN must be identified in the beneficiary's plan, including strategies directed toward resolving the factors necessitating the exception, if applicable. Documentation must substantiate all of the following:

- Current medical necessity for the exception; and
- Additional PDN services are essential to the successful implementation of the beneficiary's written plan of care, and are essential to maintain the beneficiary within the least restrictive, safe, and humane environment suitable to his condition.

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

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

  The total number of additional PDN hours per day will be based on the physician's documentation of the extent and duration of the beneficiary's increased medical needs for a maximum of six months.

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

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

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

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

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

Respite

Respite policy was modified to clarify the intent of respite, and new restrictions were added regarding who may provide respite services.

Respite must only be provided on a 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. "Short-term" means the respite service is provided during a limited period of time, for example, a few hours, a few days, weekends, or for vacations. Respite is not intended to be provided on a continuous, long-term basis where it is a part of daily services that would enable an unpaid caregiver to work full-time. In those cases, community living supports, or other services of paid support or training staff, should be used. Decisions about the methods and amounts of respite are decided during the person-centered planning process. Respite care may not be provided by a parent of a minor beneficiary receiving the service, the spouse of the beneficiary, the beneficiary's legal guardian, or the primary unpaid caregiver.

Supports Coordination

The option of an independent supports broker was approved by CMS. Policy was modified as follows to implement this change.

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 (IPOS) through the person-centered planning process. Functions performed by a supports coordinator, coordinator assistant, or supports broker include an assurance of the following:

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

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

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

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

the supports coordinator, the supports coordinator assistant and the supports broker. The independent supports broker must work under the supervision of a qualified supports coordinator.

The PIHP must assure that it is not paying for the supports coordinator or supports coordinator assistant and the supports broker to perform the same function. Likewise, when a supports coordinator or supports coordinator assistant facilitates a person-centered planning meeting, it is expected that the PIHP would not "double count" the time of any supports broker who also attends. During its on-site visits, Michigan Department of Community Health (MDCH) will review the IPOS to verify that there is no duplication of service provision when both a supports coordinator or supports coordinator assistant and a supports broker are assigned supports coordination responsibilities in a beneficiary's plan of service.

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

Supports coordination is reported only as a face-to-face contact with the beneficiary; however, the function includes not only the face-to-face contact but also related activities (e.g., making telephone calls to schedule appointments or arrange supports) 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.
- Persons chosen by the beneficiary are involved in the planning process.
- Housing and employment issues* are addressed.
- Social networks are developed.
- Appointments and meetings are scheduled.
- Person-centered planning is provided and independent facilitation of person-centered planning is made available.
- Natural and community supports are used.
- The quality of the supports and services, as well as the health and safety of the beneficiary, is monitored.
- Income/benefits are maximized.
- Information is provided to assure that the beneficiary (and his/her representative(s), if applicable) is informed about self-determination.
- Monitoring of individual budgets (when applicable) for over- or under-utilization of funds is provided.
- 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 evaluation and re-evaluation of beneficiary level of care (i.e., supply status and update information, summarize input from supports providers, planning committee members, etc.).

While supports coordination as part of the overall plan implementation and/or facilitation may include initiation of other coverages and/or short-term provision of supports, it may not include direct delivery of ongoing day-to-day supports and/or training, or provision of other Medicaid services.

The supports coordination functions to be performed and the frequency of face-to-face and other contacts are specified in the beneficiary's plan. The frequency and scope of supports coordination contacts must take into consideration health and safety needs of the beneficiary.

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[*] Supports coordination does not include any activities defined as Out-of-Home Non-Vocational Habilitation, Prevocational Services, Supported Employment, or CLS.

THE FOLLOWING CHANGES AFFECT POLICY CURRENTLY CONTAINED IN SECTION 15.2 SUPPORTS AND SERVICE PROVIDER QUALIFICATIONS.

Supports and Service Provider Qualifications

Qualifications for the new coverage of Supports Broker were added as detailed below:

- Selected by the beneficiary.
- Demonstrates competence in areas of job responsibilities for supports broker.
- Functions under the supervision of a supports coordinator.

CHANGES TO ADDITIONAL MENTAL HEALTH SERVICES (B3s)

THE FOLLOWING CHANGES AFFECT POLICY CURRENTLY CONTAINED IN SECTION 17.3.H. PEER-DELIVERED OR –OPERATED SUPPORT SERVICES.

Peer-Delivered or -Operated Support Services

Peer-delivered or -operated support services were expanded beyond drop-in centers to include peer specialists. The following defines the services and coverage parameters.

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

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

- **Vocational assistance** provides support for beneficiaries seeking educational and/or training opportunities, finding a job, achieving successful employment activities, and developing self-employment opportunities (reported as skill-building or supported employment).
- **Housing assistance** provides support locating and acquiring appropriate housing for achieving independent living; finding and choosing roommates; utilizing short-term, interim, or one-time-only financial assistance in order to transition from restrictive settings into independent integrated living arrangements; making applications for Section 8 Housing vouchers; managing costs of room and board utilizing an individual budget; purchasing a home; etc. (reported as supports coordination∗).
- **Services and supports planning and utilization assistance** provides assistance and partnership in:
  - the person-centered planning process (reported as either treatment planning or supports coordination∗);
  - developing and applying arrangements that support self-determination;
  - directly selecting, employing or directing support staff;
  - sharing stories of recovery and/or advocacy involvement and initiative for the purpose of assisting recovery and self-advocacy;
  - accessing entitlements;

∗ Peer case managers, supports coordinators or supports specialists must be trained and supervised by a PIHP or CMHSP case manager or supports coordinator who meets the qualifications of case manager or supports coordinator. Peer counselors must be trained and supervised by a qualified mental health therapist.

- developing wellness plans;
- developing advance directives;
- learning about and pursuing alternatives to guardianship;
- providing supportive services during crises;
- developing, implementing and providing ongoing guidance for advocacy and support groups.

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

Qualifications

Individuals providing Peer Support Services must be able to demonstrate their experiences in relationship to the types of guidance, support and mentoring activities they will provide. Individuals providing these services should be those generally recognized and accepted to be peers. Beneficiaries utilizing Peer Support Services must freely choose the individual who is providing Peer Support Services. For individuals who are functioning as Peer Support Specialists serving beneficiaries with mental illness, MDCH may require specialized training and/or certification as it deems necessary.

Drop-in Centers

Peer-Run Drop-In Centers provide an informal, supportive environment to assist beneficiaries with mental illness in the recovery process. If a beneficiary chooses to participate in Peer-Run Drop-In Center services, such services may be included in an IPOS if medically necessary for the beneficiary. Peer-Run Drop-In Centers provide opportunities to learn and share coping skills and strategies, to move into more active assistance and away from passive patient roles and identities, and to build and/or enhance self-esteem and self-confidence. Under no circumstances may Peer-Run Drop-In Centers be used as respite for caregivers (paid or non-paid) or residential providers of individuals.

Program Approval

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

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

Documentation Requirements

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

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

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

THE FOLLOWING IMPLEMENTS NEW POLICY TO BE INCLUDED AT THE END OF SECTION 17.3 B3 SUPPORTS AND SERVICES

Fiscal Intermediary Services

CMS approved coverage of fiscal intermediary services for beneficiaries who prefer more control over their services and service budgets. The coverage definition and parameters of this new service are detailed below.

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

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

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

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

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

CHILDREN'S SERIOUS EMOTIONAL DISTURBANCE HOME AND COMMUNITY-BASED SERVICES WAIVER (SEDW)

THE FOLLOWING DESCRIBES NEW POLICY TO BE ADDED AS A NEW APPENDIX AT THE END OF THE MENTAL HEALTH/SUBSTANCE ABUSE CHAPTER.

CMS approved Children's SEDW fee-for-service coverage to be implemented by a limited number of community mental health services programs. Policy related to this new coverage is described below.

The Children's SEDW Program provides services that are enhancements or additions to Medicaid state plan coverage for children up to age 18 with serious emotional disturbance (SED) who are enrolled in the SEDW. MDCH operates the SEDW through contracts with the Community Mental Health Services Programs (CMHSPs). The SEDW is a fee-for-service program administered by the CMHSP in partnership with other community agencies. The CMHSP will be held financially responsible for any costs authorized by the CMHSP and incurred on behalf of a SEDW beneficiary.

Key Provisions

The SEDW enables Medicaid to fund necessary home and community-based services for children up to age 18 with SED who meet the criteria for admission to a state inpatient psychiatric hospital and who are at risk of hospitalization without waiver services. The CMHSP is responsible for assessment of potential waiver candidates.

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

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

Eligibility

To be eligible for this waiver, the child must meet medical and financial eligibility criteria below.

Medical criteria:

- current MDCH contract criteria for the state psychiatric hospital, and
- demonstrate serious functional limitations that impair their ability to function in the community (functional criteria will be identified using the Child and Adolescent Functional Assessment Scale [CAFAS])
  - CAFAS score of 90 or greater for children age 12 or younger; or
  - CAFAS score of 120 or greater for children ages 13 to 18.

  These scores identify the top 25th percentile of children served by CMHSPs.

Financial criteria:

- Low-income families with children as described in Section 1931 of the Social Security Act; or
- SSI recipients; or
- Optional categorically needy, aged, or disabled individuals who have income at 100% of the Federal poverty level (FPL); or
- Special home and community-based waiver individuals who:
  - Would be eligible for Medicaid if they were in an institution; and
  - Have been determined to need home and community-based services in order to remain in the community; and
  - Are covered under the terms of this waiver; and
  - Have a special income level equal to 300% of the SSI Federal Benefits Rate (FBR).

Coverage Area

Waiver services are limited to 43 children in the counties whose CMHSPs have:

- an approved SED Waiver plan with the MDCH;
- demonstrated strong collaboration with essential community partners;
- the capacity to provide intensive community-based services; and
- the fiscal capacity to manage interagency funding appropriately.

Currently, the approved CMHSPs are:

- Central Michigan
- Clinton-Eaton-Ingham
- Livingston
- Macomb
- Van Buren

Covered Waiver Services

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

In addition to Medicaid State Plan services, children enrolled in the SEDW may receive the following SED waiver services as identified in the IPOS:

- **Community Living Supports**

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

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

  Community Living Supports includes:

  - Assistance with skill development related to:
    - Activities of daily living (such as personal hygiene);
    - Household chores;
    - Socialization;
    - Improving communication and relationship-building skills; and
    - Participation in leisure and community activities.
  - Staff assistance, support and/or training with such activities as:
    - Improving the child's social interactions and internal controls by instilling positive behaviors and increasing resiliency factors that should reduce risk factors;
    - Non-medical care (i.e., not requiring nurse or physician intervention);
    - Transportation (excluding to and from medical appointments) from the beneficiary's home to community activities, among community activities, and from the community activities back to the beneficiary's residence;
    - Participation in regular community activities and recreation opportunities (attending classes, movies, concerts and events in a park; volunteering; etc.);
    - Assisting the family in relating to and caring for their child;

  - Attendance at medical appointments; and
  - Acquiring or procuring goods other than those listed as shopping and non-medical services.
- Reminding, observing, rewarding and monitoring of pro-social behaviors.
- Medication administration.
- Staff assistance with preserving the health and safety of the beneficiary in order that he/she may reside or be supported in the most integrated, independent community setting.

- **Family Training/Support**

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

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

- **Respite Care**

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

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

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

- **Child Therapeutic Foster Care**

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

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

CTFC seeks to change the negative trajectory of a child’s behavior by improving his/her social adjustment, family adjustment and peer group. CTFC attempts to decrease negative behavior, increase appropriate behavior, and build pro-social skills. Foster parents, teachers, therapists and other adults act as change agents for the child. The change agents contribute to the treatment of the child and the preparation of his/her family for the child’s return to the home and community. Foster parents are specially recruited, trained and supervised. The total number of individuals (including beneficiaries served in the waiver) living in the home who are unrelated to the primary caregiver may not exceed one. In addition to being licensed, all CTFC programs under this waiver are to be pre-enrolled by MDCH to ensure they meet the requirements set forth in this policy. Separate payment will not be made for homemaker or chore services, for community living services provided by the foster parents, or for respite care furnished for the foster care parents to a child receiving CTFC services since these services are integral to, and inherent in, the provision of CTFC.

- **Therapeutic Overnight Camp**

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

  Additional criteria:

  - Camps are licensed by the Department of Human Services (DHS);
  - The child's IPOS includes Therapeutic Overnight Camp; and
  - Camp staff is trained in working with children with SED.

  Coverage includes:

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

  Coverage excludes:

  - Room and board for the camp.

- **Transitional Services**

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

  Additional criteria for using Transitional Services:

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

  Coverage includes:

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

  All services provided must be in accordance with applicable state or local building codes. Standards of value purchasing must be followed. The home maintenance must be the most reasonable alternative, based on the results of a review of all options. The existing structure must have the capability to accept and support the proposed changes. The infrastructure of the home involved must be in compliance with any applicable local codes. The home maintenance involved shall exclude costs for improvements required exclusively to meet local building codes. The home maintenance must incorporate reasonable and necessary construction

standards, excluding cosmetic improvements. The home maintenance or repair cannot result in valuation of the structure significantly above comparable neighborhood real estate values.

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

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

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

- **Wraparound Services**

Wraparound Service Facilitation and Coordination for Children and Adolescents is a highly individualized planning process performed by specialized wraparound facilitators employed by the CMHSP, other approved community-based mental health and developmental disability services providers, or its provider network who, using the Wraparound model, coordinate the planning for, and delivery of, services and supports that are medically necessary for the child.

The planning process identifies the child's strengths and needs, as well as strategies and outcomes. Wraparound utilizes a Child and Family Team with team members determined by the family, often representing multiple agencies and informal supports. The Child and Family Team creates a highly individualized family-centered plan of service for the child that consists of mental health specialty treatment, services and supports covered by the Medicaid Mental Health State Plan or the SED waiver. The plan may also consist of other non-mental health services that are secured from and funded by other agencies in the community. The Wraparound plan is the result of a collaborative team planning process that focuses on the unique strengths, values, and preferences of the child and family and is developed in partnership with other community agencies. The Community Team, which consists of parents, agency representatives, and other relevant community members, oversees wraparound services.

Coverage includes:

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

Coverage excludes:

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

Provider Qualifications

- **Individuals who provide Respite and CLS**

  Individuals who provide respite and CLS must, in addition to the specific training, supervision and standards for each support/service, be:
  - A responsible adult at least 18 years of age;
  - Free from communicable disease;
  - Able to read and follow written plans of service/supports as well as beneficiary-specific emergency procedures;
  - Able to write legible progress and/or status notes;
  - In "good standing" with the law (i.e., not a fugitive from justice, a convicted felon or illegal alien); and
  - Able to perform basic first aid and emergency procedures.
  - The individual must also have successfully completed Recipient Rights Training.

- **Wraparound Facilitators**

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

- **Child Therapeutic Foster Care Providers**

  Child Therapeutic Foster Care must be:
  - Licensed as a Foster Care Provider (MCL 722.122);
  - Certified by DHS;
  - Enrolled by MDCH as a CTFC provider; and
  - Trained in the child's IPOS.

- **Therapeutic Overnight Camps**

  Therapeutic Overnight Camps must be:
  - Licensed and certified by DHS;
  - Trained in the child's IPOS.

Manual Maintenance

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

Questions

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

Approved

Paul Reinhart, Director
Medical Services Administration