MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Bulletin Number: MSA 14-63

Distribution: Prepaid Inpatient Health Plans (PIHP), Community Mental Health Services Programs (CMHSP)

Issued: December 29, 2014

Subject: Healthy Michigan Plan Behavioral Health Benefit

Effective: February 1, 2015

Programs Affected: Healthy Michigan Plan

The purpose of this bulletin is to provide information and policy regarding the Behavioral Health Benefit for the Healthy Michigan Plan. Information and policy will be incorporated into the Healthy Michigan Plan Chapter of the Medicaid Provider Manual.

GENERAL INFORMATION

This section applies to Behavioral Health supports and services providers. Behavioral Health, as referenced in this section, is inclusive of mental health disorders, substance use disorders and intellectual/developmental disabilities. Information contained in this section is to be used in conjunction with other chapters of the Medicaid Provider Manual (e.g., the Billing & Reimbursement Chapters, the Practitioner Chapter and the Mental Health/Substance Abuse Chapter) as well as the related procedure code databases located on the Michigan Department of Community Health (MDCH) website at www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Provider Specific Information.

Pursuant to Michigan's Medicaid State Plan and federally approved Section 1115 waiver, community-based behavioral health services and supports are covered by the Healthy Michigan Plan when delivered under the auspices of an approved Prepaid Inpatient Health Plan (PIHP).

The requirements and information found in the General Information Section of the Mental Health/Substance Abuse Chapter also apply to the provision of the Healthy Michigan Plan behavioral health supports and services.

In addition to the definition of terms found in the General Information Section of the Mental Health/Substance Abuse Chapter, the following definitions are applicable to the Healthy Michigan Plan.

DEFINITION OF TERMS

American Society of Addiction Medicine (ASAM) Criteria: The clinical guide designed by ASAM to improve assessment and outcomes-driven treatment and recovery services. It is also used to match patients to appropriate types and levels of care. In general, the purpose of the ASAM Criteria is to enhance the use of multidimensional assessments to develop patient-centered service plans and to guide clinicians, counselors, and care managers in making objective decisions about patient admission, continuing care, and transfer/discharge for various levels of care for addictive, substance-related, and co-occurring conditions.

Behavioral Health: A categorical description that is inclusive of mental health disorders, substance use disorders and intellectual/developmental disabilities.

Behavioral Health Professional: For purposes of the Healthy Michigan Chapter, this is a categorical description used to refer to the individuals who provide mental health and/or substance use disorder services that are identified in the Provider Qualifications chart (www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Provider Specific Information).

Covered Services: For the purposes of the Healthy Michigan Plan chapter, Healthy Michigan Plan Specialty Behavioral Health Services.

PROGRAM REQUIREMENTS

Refer to the Program Requirements Section of the Mental Health/Substance Abuse Chapter. These requirements are consistent with the expectations for the Healthy Michigan Plan.

Additionally, as the Healthy Michigan Plan provides a behavioral health benefit, certain support services that are part of the Healthy Michigan Plan specialty behavioral health benefit do not require substance use disorder program licensure or accreditation to provide that service. Beneficiaries with a substance use disorder may receive these supports from a provider if the beneficiary meets the eligibility criteria outlined in each description. Those services are identified below:

- Assistive Technology;
- Community Living Supports;
- Enhanced Pharmacy;
- Environmental Modifications;
- Fiscal Intermediary;
- Housing Assistance;
- Occupational Therapy;
- Peer Specialist Services (recovery coach);
- Personal Care in Licensed Specialized Residential Care Settings;
- Physical Therapy;
- Respite Care;
- Skill Building Assistance;
- Support and Service Coordination;
- Speech, Hearing and Language Therapy; and
- Transportation.

COVERED SUPPORTS AND SERVICES

For those behavioral health support and service descriptions that had program changes as a result of becoming a behavioral health benefit under the Healthy Michigan Plan, the descriptions will be provided below. For those behavioral health supports and services that did not have program changes, the description will be provided in the Mental Health/Substance Abuse Chapter.

Assertive Community Treatment

Refer to the Assertive Community Treatment Program Section of the Mental Health/Substance Abuse Chapter.

Assessments

Refer to the Assessments subsection of the Mental Health/Substance Abuse Chapter.

Assistive Technology

Refer to the Assistive Technology subsection of the Mental Health/Substance Abuse Chapter.

Behavior Treatment Review

Refer to the Behavior Treatment Review subsection of the Mental Health/Substance Abuse Chapter.

Clubhouse Psychosocial Rehabilitation Programs

Refer to the Clubhouse Psychosocial Rehabilitation Programs subsection of the Mental Health/Substance Abuse Chapter.

Community Living Supports

Refer to the Community Living Supports subsection of the Mental Health/Substance Abuse Chapter.

Crisis Services

Crisis Interventions

Crisis Interventions are 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 means a situation in which an individual is experiencing the signs and symptoms of a serious behavioral health disorder, 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; or
- The individual's judgment is so impaired that he is unable to understand the need for treatment and, in the opinion of the behavioral health professional, his continued behavior as a result of the behavioral health disorder 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.

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 be used to avert an inpatient psychiatric admission or to shorten the length of an inpatient stay. Additionally, these services are designed for a subset of beneficiaries who meet the ASAM Criteria for Level 3.7 Medically Monitored Intensive Inpatient Services admission criteria or are at risk of admission, but who can be appropriately served in settings less intensive than a hospital. This service is also designed for beneficiaries who are intoxicated and at risk of admission to an acute setting or another level of care but can be appropriately served in this less intensive setting. The goal of crisis residential services is to facilitate reduction in the intensity of those factors that lead to crisis residential admission through a person-centered/individualized and recovery-oriented approach.

Population

Services are designed for a subset of beneficiaries who meet psychiatric inpatient/substance use disorder residential admission criteria or are at risk of admission to a high level of care setting, but who can be appropriately served in a less intensive setting.

Covered Services

Services must be designed to resolve the immediate crisis and improve the functioning level of the beneficiary to allow them to return to less intensive community living as soon as possible. Covered crisis residential services include:

- Psychiatric supervision (for programs providing mental health services and/or co-occurring disorders);
- Therapeutic support services;
- Medication management/stabilization and education;
- Behavioral services;
- Milieu therapy; and
- Nursing/medical services (on-site nursing services are required for those beneficiaries who are in the detoxification process, and who require medications to manage the current crisis).

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

The program must include on-site nursing services (Registered Nurse [RN] or Licensed Practical Nurse [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.

Provider Criteria

The PIHP must seek and maintain MDCH approval for the crisis residential program in order to use Healthy Michigan Plan funds for program services. Healthy Michigan Plan crisis residential programs may choose to provide a program for serious mental illness, intellectual/developmental disabilities, substance use disorders or a combined program. A program that will be offering services for substance use disorders must be licensed for residential substance use disorder treatment services per the Administrative Rules for Substance Use Disorder Programs and appropriately accredited through one of the organizations identified in the Substance Abuse Services subsection of the Mental Health/Substance Abuse Chapter. Established residential programs that purport to offer this service for individuals with substance use disorders will be required to seek re-approval of the program by MDCH when appropriate licensing and accreditation has been obtained. Programs currently approved to provide services for mental health and/or intellectual/developmental disabilities by MDCH through the delivery of Medicaid State Plan, Habilitation Supports Waiver (HSW) or additional/B3 services do not require re-approval.

Qualified Staff

Treatment services must be clinically supervised by a psychiatrist. A psychiatrist need not be present when services are delivered, but must be available by telephone at all times. The psychiatrist must provide psychiatric evaluation or assessments at the crisis residential home. Medication reviews performed at the crisis residential home must be performed by a physician, physician assistant or a nurse practitioner under the clinical supervision of the psychiatrist. The covered crisis residential services must be supervised on-site eight hours a day, Monday through Friday (and on call at all other times). Supervision must be by a behavioral health professional (Mental Health Professional [MHP] and/or a Substance Abuse Treatment Specialist [SATS] depending on the scope of services being provided) possessing at least a master's degree in human services and one year of experience providing behavioral health services to individuals with serious mental illness and/or substance use disorders; or a bachelor's degree in human services and at least two years of experience providing behavioral health services to individuals with serious mental illness and/or substance use disorders.

Treatment activities may be carried out by paraprofessional staff who have at least one year of satisfactory work experience providing behavioral health services to individuals with mental illness and/or substance use disorders, or who have successfully completed a PIHP/MDCH-approved training program for working with individuals with mental illness and/or substance use disorders.

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

Location of Services

Services must be provided to beneficiaries in licensed crisis residential foster care, group home settings not exceeding 16 beds in size, or in a licensed substance use disorder residential treatment program (when providing services for substance use disorders). Homes/settings must have appropriate licensure from the State and must be approved by MDCH to provide specialized crisis residential services. Services must not be provided in a hospital or other institutional setting.

Admission Criteria

Crisis residential services may be provided to beneficiaries who are assessed by, and admitted through, the authority of the local PIHP. Beneficiaries must meet psychiatric inpatient admission or residential substance use disorder level of care criteria but have symptoms and risk levels that permit them to be treated in such alternative settings. Services are designed for beneficiaries with mental health or substance use disorders, beneficiaries with a co-occurring mental health and substance use disorder, or beneficiaries with intellectual/developmental disabilities. For beneficiaries with a concomitant disorder with an intellectual/developmental disability, the primary reason for service must be mental illness or substance use disorder.

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. For substance use disorders, beneficiaries should be moved to another ASAM Level of Care within 14 days; however, services may be extended if justified by clinical need, medical necessity and as determined by the interdisciplinary team.

Individual Plan of Service/Treatment Plan

Services must be delivered according to an Individual Plan of Service (IPOS) or appropriate treatment plan process for substance use disorder beneficiaries (refer to the Treatment Planning subsection of the Mental Health/Substance abuse Chapter), based on an assessment of immediate need. The IPOS/treatment plan must be developed within 48 hours of admission and signed by the beneficiary (if possible), the guardian, the psychiatrist, and any other professionals involved in the treatment planning process, as determined by the needs of the beneficiary. If the beneficiary has an assigned case manager, the case manager must be involved in the treatment as soon as possible, and must also be involved in follow-up services.

The IPOS/treatment 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 goals and objectives; and
- Discharge plans, the need for aftercare/follow-up services, and the role of, and identification of, the case manager.

If the length of stay in the crisis residential program exceeds 14 days, an interdisciplinary team must develop a subsequent plan based on comprehensive assessments. The team is comprised of the beneficiary, the guardian, the psychiatrist, the case manager and other professionals whose disciplines are relevant to the needs of the beneficiary, including the individual Assertive Community Treatment (ACT) team, outpatient services provider, 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.)

Intensive Crisis Stabilization Services

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

Crisis situation means a situation in which an individual is experiencing the signs and symptoms of a serious behavioral health disorder, 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; or
- The individual's judgment is so impaired that he is unable to understand the need for treatment and, in the opinion of the behavioral health professional, his continued behavior as a result of the behavioral health disorder can reasonably be expected in the near future to result in physical harm to the individual or to another individual.

Approval

The PIHP must seek and maintain MDCH approval for the intensive crisis stabilization services in order to use Healthy Michigan Plan funds for program services. A program that will be offering services for substance use disorders must be licensed for outpatient substance use disorder treatment services per the Administrative Rules for Substance Use Disorder Programs and appropriately accredited through one of the organizations identified in the Substance Abuse Services subsection of the Mental Health/Substance Abuse Chapter. Established crisis stabilization service programs that purport to offer this service for individuals with substance use disorders will be required to seek re-approval of the program by MDCH when appropriate licensing and accreditation has been obtained. Programs currently approved to provide services for mental health and/or intellectual/developmental disabilities by MDCH through the delivery of Medicaid State Plan, Habilitation Supports Waiver (HSW) or additional/B3 services do not require re-approval.

Population

These services are for beneficiaries who have been assessed to meet criteria for psychiatric hospital admissions and/or substance use disorder residential/inpatient treatment 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 and/or substance use disorder residential/inpatient treatment if such services will result in a shortened stay. Beneficiaries must have a diagnosis of mental illness, substance use disorder or mental illness with a co-occurring substance use disorder, or intellectual/developmental disability.

Services

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

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

Qualified Staff

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

The treatment team may be assisted by trained paraprofessionals under appropriate supervision. Trained paraprofessionals must have at least one year of satisfactory work experience providing services to individuals with behavioral health disorders. Activities of trained paraprofessionals include assistance with therapeutic support services. In addition, the team may include one or more peer support specialists and/or recovery coaches.

Location of Services

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

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

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

Individual Plan of Service/Treatment Plan

Intensive/crisis stabilization services may be provided initially to alleviate an immediate behavioral health crisis. However, following resolution of the immediate situation (and within no more than 48 hours), an intensive/crisis stabilization services IPOS or appropriate treatment plan process for substance use disorder beneficiaries (refer to the Treatment Planning subsection of the Mental Health/Substance abuse Chapter), must be developed. The intensive/crisis stabilization IPOS/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 IPOS/treatment plan 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 the beneficiary's goals and objectives.
- Plans for follow-up services (including other behavioral health services where indicated) after the crisis has been resolved. The role of the case manager must be identified, where applicable.

Enhanced Pharmacy

Refer to the Enhanced Pharmacy subsection of the Mental Health/Substance Abuse Chapter.

Environmental Modifications

Refer to the Environmental Modifications subsection of the Mental Health/Substance Abuse Chapter.

Family Support and Training

Family-focused services are provided to the family (natural or adoptive parents, spouse, children, siblings, relatives, foster family, in-laws, and other unpaid caregivers) of beneficiaries with behavioral health disorders for the purpose of assisting the family in relating to and caring for a relative with a behavioral health disorder. The services target the family members who are caring for and/or living with the beneficiary who is receiving behavioral health services. The service is to be used in cases where the beneficiary is hindered or at risk of being hindered in his ability to achieve goals of:

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

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

Coverage includes:

- Education and training, including instructions about treatment regimens, and use of assistive technology and/or medical equipment needed to safely maintain the beneficiary at home as specified in the IPOS/treatment plan.
- Counseling and peer support provided by an appropriately trained counselor or appropriately trained peer. This can be in a one-on-one or group setting to provide assistance with identifying coping strategies for successfully caring for or living with a person who has a behavioral health disorder.
- Family Psycho-Education (SAMHSA model) for individuals with serious mental illness and their families. This evidence-based practice includes family educational groups, skills workshops, and joining.

Fiscal Intermediary Services

Refer to the Fiscal Intermediary Services subsection of the Mental Health/Substance Abuse Chapter.

Hospital-Based Psychiatric Services

Refer to the Inpatient Psychiatric Hospital Admissions Section and the Outpatient Partial Hospitalization Services Section of the Mental Health/Substance Abuse Chapter.

Housing Assistance

Refer to the Housing Assistance subsection of the Mental Health/Substance Abuse Chapter.

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

Refer to the Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) Services subsection of the Mental Health/Substance Abuse Chapter.

Medication Administration

Refer to the Medication Administration subsection of the Mental Health/Substance Abuse Chapter.

Medication Review

Refer to the Medication Review subsection of the Mental Health/Substance Abuse Chapter.

Occupational Therapy

Refer to the Occupational Therapy subsection of the Mental Health/Substance Abuse Chapter.

Outpatient Counseling and Therapy

Outpatient counseling and therapy is a non-residential treatment service that can take place in an office-based location with clinicians educated/trained in providing professionally directed behavioral health treatment or in a community-based location with appropriately educated/trained staff. The treatment occurs in regularly scheduled sessions, usually totaling fewer than nine contact hours per week but, when medically necessary and determined by individual need, can total over 20 hours in a week. Individual, family or group treatment services may be provided separately or in combination.

Treatment must be person-centered/individualized based on an appropriate assessment/evaluation and contain a 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 medical necessity and/or the ASAM Criteria. Beneficiary participation in referral and continuing care planning must occur prior to discharge and should be based on the needs of the beneficiary in order to support sustained recovery. Referral, continuing stay and recovery support needs must be identified through the person-centered/individualized treatment planning process.

Provider Qualifications

Substance use disorder outpatient service providers are required to be licensed as an organization. A program that will be offering services for substance use disorders must be licensed for outpatient substance use disorder treatment services per the Administrative Rules for Substance Use Disorder Programs and appropriately accredited through one of the organizations identified in the Substance Abuse Services subsection of the Mental Health/Substance Abuse Chapter. Substance use disorder outpatient providers offering the adjunct support services of case management, early intervention, integrated treatment for persons with mental health and substance use disorders and/or peer recovery and recovery support must have these areas added to their outpatient substance use disorder license as approved service categories.

All behavioral health organizations/providers of outpatient services must have appropriately licensed and credentialed staff and provide treatment that is within their established scope of practice. (Refer to the Provider Qualifications Chart that supports the Medicaid Provider Manual. The document is available on the MDCH website at www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Provider Specific Information >> Mental Health/Substance Abuse.)

Eligibility

Outpatient counseling and therapy may be provided only when:

- The service meets medical necessity criteria;
- It meets the person-centered service planning requirement;
- The current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) is used to determine an initial diagnostic impression (also known as provisional diagnosis);
- The service is based on individualized determination of need through the state established needs-based criteria;
- The service is cost effective;

- The ASAM Criteria are used in the determination of substance use disorder treatment placement/admission and/or continued stay needs; and
- The substance use disorder service is supported by a level of care determination using the six assessment dimensions of the current ASAM Criteria:

    - Withdrawal potential;
    - Medical conditions and complications;
    - Emotional, behavioral or cognitive conditions and complications;
    - Readiness to change;
    - Relapse, continued use or continued problem potential; and
    - Recovery/living environment.

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

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

Allowable Services

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

Individual Assessment: A face-to-face service for the purpose of identifying functional, treatment, and recovery needs of a behavioral health disorder and a basis for formulating the person-centered/individualized treatment planning process**.**

Individual Treatment Planning: Refer to the Treatment Planning subsection of the Mental Health/Substance Abuse Chapter.

Individual Therapy: Treatment activity designed to reduce maladaptive behaviors, maximize behavioral self-control, or restore normalized psychological functioning, reality orientation, re-motivation, and emotional adjustment, thus enabling improved functioning and more appropriate interpersonal and social relationships. Evidence-based practices such as Integrated Dual Disorder Treatment for Co-Occurring Disorders (IDDT/COD) and Dialectical Behavior Therapy (DBT) are included in this coverage. Individual therapy is provided by a Behavioral Health Professional practicing within their scope of practice and within the guidelines of the Provider Qualifications Chart.

Group Therapy: Face-to-face counseling with three or more beneficiaries, and can include didactic lectures, therapeutic interventions/counseling, and other group related activities. Treatment activity designed to reduce maladaptive behaviors, maximize behavioral self-control, or restore normalized psychological functioning, reality orientation, re-motivation, and emotional adjustment, thus enabling improved functioning and more appropriate interpersonal and social relationships. Evidence-based practices (such as IDDT/COD and DBT) are included in this coverage. Group therapy is provided by a Behavioral Health Professional practicing within their scope of practice and within the guidelines of the Provider Qualifications Chart.

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 Behavioral Health Professional practicing within their scope of practice and within the guidelines of the Provider Qualifications Chart.

The Provider Qualifications Chart is available on the MDCH website at www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Provider Specific Information >> Mental Health/Substance Abuse.

Crisis Intervention: Refer to the Crisis Interventions subsection of the Mental Health/Substance Abuse Chapter.

Referral/Linking/Coordinating/Management of Services: For the purpose of providing adjunct support for ensuring follow-through with identified providers, providing additional support in the community if primary services are to be provided in an office setting, addressing other needs identified as part of the assessment and/or establishing the beneficiary with another provider and/or level of care. This service may be provided individually or in conjunction with other services based on the needs of the beneficiary.

Peer Support Specialist/Recovery Coach and Recovery Support: For the purpose of providing adjunct support to outpatient services. Refer to the Peer Delivered or Peer Operated Support Services subsection of the Healthy Michigan Chapter for a description.

Compliance Monitoring: For the purpose of identifying abstinence or relapse when it is a part of the treatment plan or an identified part of the treatment program (excludes laboratory drug testing). Also includes tracking the appropriate use of prescribed medications.

Early Intervention: Includes stage-based interventions for beneficiaries with substance use disorders and beneficiaries who may not meet the threshold of abuse or dependence but are experiencing functional/social impairment as a result of use.

Detoxification/Withdrawal Monitoring: For the purpose of preventing/alleviating medical complications as they relate to no longer using a substance.

Division of Pharmacologic Therapies/Center for Substance Abuse Treatment (DPT/CSAT) Approved Pharmacological Supports: Refer to the Treatment (DPT/CSAT) Approved Pharmacological Supports subsection of the Mental Health/Substance Abuse Chapter.

Admission Criteria

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

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

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

Level of Care Criteria for Substance Use Disorders

Medically necessary outpatient services for beneficiaries with substance use disorders correspond to the frequency and duration of services established by the ASAM criteria and are referred to as follows:

- Level 0.5 – Early Intervention
- Level 1 – Outpatient
- Level 2.1 – Intensive Outpatient
- Level 2.5 – Partial Hospitalization Services

Outpatient services can include any variety of the covered services and are dependent on the individual needs of the beneficiary. The assessment, treatment plan and recovery support preparations are the only components that are consistent throughout the outpatient levels of care as each beneficiary must have these as part of the authorized treatment services. As a beneficiary's needs increase, more services and/or frequency/duration of

services may be utilized if these are medically necessary. The ASAM criteria correspond with established hours of services that take place during a week.

- **ASAM Level 0.5:** Services are not subdivided by the number of hours received during a week. The amount and type of services provided are based on individual needs based on the beneficiary's motivation to change and other risk factors that may be present.
- **ASAM Level 1:** Services from one hour to eight hours during a week.
- **ASAM Level 2.1:** Services from nine to 19 hours in a week. The services are offered at least three days a week to fulfill the minimum nine-hour commitment.
- **ASAM Level 2.5:** Services that are offered 20 or more hours in a week.

The medically necessary outpatient services for beneficiaries with a mental illness and/or a concomitant substance use disorder or intellectual/developmental disability correspond with the frequency and duration of the evidenced-based practice, promising practice or the specialty-focused service provided. The guidelines for these practices, along with the individual needs of the beneficiary, will establish the frequency, duration and type of treatment service.

Peer-Delivered or Peer-Operated Support Services

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

Peer specialist and recovery coach 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 behavioral health 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 experiences and perspectives with disabilities, and with planning and negotiating human services systems.

- Vocational assistance provides support for beneficiaries seeking education and/or training opportunities, finding a job, achieving successful employment activities, and developing self-employment opportunities (reported as skill-building or supported employment).
- Housing assistance provides support locating and acquiring appropriate housing for achieving independent living; finding and choosing roommates; utilizing short-term, interim, or one-time-only financial assistance in order to transition from restrictive settings into independent integrated living arrangements; making applications for Section 8 Housing vouchers; managing costs 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;
    - Developing health and wellness plans;
    - Developing advance directives;
    - Learning about and pursuing alternatives to guardianship;
    - Providing supportive services during crises;
    - Developing, implementing and providing ongoing guidance for advocacy and support groups;
    - Integration of physical and mental health care;
    - Developing, implementing and providing health and wellness classes to address preventable risk factors for medical conditions.

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

Peer Support Specialist and Recovery Coach Services

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

Individuals who are functioning as Peer Support Specialists serving beneficiaries with mental illness must:

- Have a serious mental illness;
- Have received public mental health services in the past or are currently receiving services;
- Provide at least 10 hours per week of services described above, with supported documentation written in the IPOS/treatment plan; and
- Meet the MDCH application approval process for specialized training and certification requirements.

Individuals who are functioning as a Recovery Coach serving beneficiaries with a substance use disorder must:

- Have a minimum of two years of recovery from a substance use disorder;
- Receive specialized training and certification approved by MDCH;
- Be employed through a substance use disorder treatment program or a Recovery Community Organization under contract with the PIHP; and
- Recognize that there are many pathways to recovery.

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

PIHPs must seek approval from MDCH prior to establishing new drop-in programs. Programs currently approved to provide services by MDCH through the delivery of Medicaid State Plan, HSW, or additional/B3 services do not require re-approval.

Proposed drop-in centers will be reviewed against the following criteria:

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

Some beneficiaries use drop-in centers anonymously and do not have a drop-in center listed as a service in their IPOS. For those beneficiaries who do have drop-in service 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.

Personal Care in Licensed Specialized Residential Settings

Refer to the Personal Care in Licensed Specialized Residential Settings subsection of the Mental Health/Substance Abuse Chapter.

Physical Therapy

Refer to the Physical Therapy subsection of the Mental Health/Substance Abuse Chapter.

Prevention-Direct Service Model

Children of Adults with Behavioral Health Disorders/Integrated Services: Designed to prevent emotional and behavioral disorders among children whose parents are receiving services from the specialty behavioral health service system and to improve outcomes for beneficiaries who are parents. The Integrated Services approach includes assessment and service planning for the beneficiary related to their parenting role and their children's needs. Treatment objectives, services, and supports are incorporated into the IPOS/**treatment plan** through a person-centered planning process for the beneficiary who is a parent. Linking the beneficiary and child to available community services, respite care and providing for crisis planning are essential components.

Provider qualifications:

- Mental Health Professional; and/or
- Substance Abuse Treatment Specialist.

Residential Substance Use Disorder Treatment

Refer to the Residential Treatment subsection of the Mental Health/Substance Abuse Chapter.

Respite Care Services

Refer to the Respite Care Services subsection of the Mental Health/Substance Abuse Chapter.

Skill-Building Assistance

Refer to the Skill-Building Assistance subsection of the Mental Health/Substance Abuse Chapter.

Speech, Hearing, and Language

Refer to the Speech, Hearing and Language subsection of the Mental Health/Substance Abuse Chapter.

Sub-Acute Detoxification

Refer to the Sub-Acute Detoxification subsection of the Mental Health/Substance Abuse Chapter.

Support and Service Coordination

Refer to the Support and Service Coordination subsection of the Mental Health/Substance Abuse Chapter.

Supported/Integrated Employment Services

Refer to the Supported/Integrated Employment Services subsection of the Mental Health/Substance Abuse Chapter.

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 Healthy Michigan Plan beneficiaries with a behavioral health disorder who have multiple service needs, have a high level of vulnerability, require access to a continuum of behavioral health services from the PIHP and/or are unable to independently access and sustain involvement with needed services.

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

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 IPOS developed through the person-centered planning process.

Additionally, providers serving beneficiaries with a substance use disorder must be licensed for outpatient substance use disorder treatment services per the Administrative Rules for Substance Abuse Services, with the case management service category and appropriately accredited through one of the organizations identified in the Substance Abuse Services subsection of the Mental Health/Substance Abuse Chapter. If a program is serving beneficiaries with a co-occurring mental health and substance used disorder, the outpatient license must also have the added service category of "integrated treatment for persons with mental health and substance use disorders. Established targeted case management programs that purport to offer this service for individuals with substance use disorders will be required to seek re-approval of the program by MDCH when appropriate licensing and accreditation has been obtained. Programs currently approved to provide services for mental health and/or intellectual/developmental disabilities by MDCH through the delivery of Medicaid State Plan, Habilitation Supports Waiver (HSW) or additional/B3 services do not require re-approval.

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 case record.

Core Requirements

Targeted case management services must:

- Assure that the person-centered planning process takes place and that it results in the development of the IPOS/treatment plan;
- Assure that the IPOS/treatment plan 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;
- Oversee implementation of the IPOS/treatment plan, including supporting the beneficiary's dreams, goals, and desires for optimizing independence; promoting recovery; and assisting in the development and maintenance of natural supports;
- Assure the participation of the beneficiary on an ongoing basis in discussions of his plans, goals, and status;

- Identify and address gaps in service provision;
- Coordinate the beneficiary's services and supports with all providers, making referrals, and advocate for the beneficiary;
- Assist the beneficiary to access programs that provide financial, medical, and other assistance such as Home Help and Transportation services;
- Assure coordination with the beneficiary's primary and other health care providers to assure continuity of care;
- Coordinate and assist the beneficiary in crisis intervention and discharge planning, including community supports after hospitalization;
- Facilitate the transition (e.g., from inpatient to community services, school to work, dependent to independent living) process, including arrangements for follow-up services;
- Assist the beneficiary with crisis planning; and
- Identify 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 IPOS/treatment plan 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/type 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 IPOS/treatment plan. The IPOS/treatment 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 IPOS/treatment 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 IPOS/treatment plan.

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

Staff Qualifications

A primary case manager for beneficiaries with a mental health or intellectual/developmental disability must be a Qualified Mental Health Professional (QMHP) or Qualified Intellectual Disabilities Professional (QIDP); or if the case manager has only a bachelor's degree but without the specialized training or experience, they must be supervised by a QMHP or QIDP who does possess the training or experience. A primary case manager for beneficiaries with a substance use disorder must be appropriately trained and supervised by a SATS. For beneficiaries with concomitant behavioral health disorders, the case manager must have the appropriate training or experience and/or be supervised by someone who does possess the training or experience for the concomitant disorders in question.

Transportation

Refer to the Transportation subsection of the Mental Health/Substance Abuse Chapter.

Treatment (DPT/CSAT) Approved Pharmacological Supports

Refer to the Treatment (DPT/CSAT) Approved Pharmacological Supports subsection of the Mental Health/Substance Abuse Chapter.

Treatment Planning

Refer to the Treatment Planning subsection of the Mental Health/Substance Abuse Chapter.

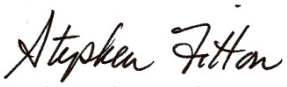
Manual Maintenance

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

Questions

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

Approved



Stephen Fitton, Director
Medical Services Administration