State of Michigan
CHAPTER III OF THE MEDICAID POLICY MANUAL, REVISION
New Section 17: ADDITIONAL MENTAL HEALTH SERVICES (B3s)

Certain Medicaid-funded mental health supports and services may be provided in addition to the Medicaid State Plan Specialty Supports and Services or Habilitation Waiver Services, through the authority of 1915(b)(3) of the Social Security Act (hereafter referred to as B3s). The intent of B3 supports and services is to fund medically necessary supports and services that promote community inclusion and participation, independence, and/or productivity when identified in the individual plan of service as one or more goals developed during person-centered planning.

<u>Definitions of goals that meet the intents and purpose of B3 supports and services:</u>

- **Community inclusion and participation means: the individual uses community services and participates in community activities in the same manner as the typical community citizen**.

  Examples are recreation (parks, movies, concerts, sporting events, arts classes, etc), shopping, socialization (visiting friends, attending club meetings, dining out) and civic (volunteering, voting, attending governmental meetings, etc.) activities. A beneficiary's use of and participation in community activities are expected to be integrated with that of the typical citizen's. So, for example, the beneficiary would attend an "integrated" yoga class at the community center, rather than a special yoga class for persons with mental retardation.

- **Independence means: "freedom from another's influence, control and determination." (Webster's New World College Dictionary, 1996) Independence in the B3 context means how the individual defines the extent of such freedom for him/herself during person-centered planning**.

  For example, to some beneficiaries, "freedom" could be living on their own, controlling their own budget, choosing an apartment as well as the persons who will live there with them, or getting around the community on their own. To others, "freedom" could be control over what and when to eat, what and when to watch television, when and how to bathe, or when to go to bed and arise.

- **Productivity means: engaged in activities that result in or lead to maintenance of or increased self-sufficiency. Those activities are typically going to school and work. The operational definition of productivity for an individual may be influenced by age-appropriateness**.

  For example, a person who is 76 may choose to volunteer or participate in other community or senior center activities, rather than have any productivity goals. Children under 18 would be expected to attend school, but may choose to work in addition. In order to use B3 supports and services, individuals would be expected to prepare for, or go to school or work in the same places that the typical citizen uses.

The goals (one or more of the above) and their operational definitions will vary according to the individual's needs and desires. However, goals that are inconsistent with least restrictive environment (i.e., most integrated home, work, community that meets the individual's needs and desires) and individual choice and control cannot be supported by B3 supports and services unless there is documentation that health and safety would otherwise be jeopardized; or that such least restrictive arrangements or choice and control opportunities have been demonstrated to be unsuccessful for that individual. Care should be taken to insure that these goals are those of the individual first, not those of a parent, guardian, provider, therapist, or case manager, no matter how well intentioned. The services in the plan, whether B3 supports and services alone, or in combination with state plan or Habilitation Supports Waiver services must reasonably be expected to achieve the goals and intended outcomes identified. The configuration of supports and services should assist the individual to attain outcomes that are typical in his/her community; and without such services and supports, would be impossible to attain.

Criteria for Authorizing B3 Support and Services:
The authorization of, and use of Medicaid funds for, any of the B3 supports and services, as well as their amount, scope and duration are dependent upon:

- The Medicaid beneficiary's eligibility for specialty services and supports as defined in this Chapter and the MDCH/PIHP Contract Section 1.2; and
- The service(s) having been identified during person-centered planning; and
- The service(s) being medically necessary as defined in MDCH/PIHP Contract Attachment P.3.2.1, Medical Necessity Criteria, as amended; and
- The service(s) being expected to achieve one or more of the above listed goals as identified in the beneficiary's plan of service; and
- Additional criteria indicated in certain B3 service definitions, as applicable.

Decisions regarding the authorization of a B3 service (including the amount, scope and duration) must take into account the PIHP's documented capacity to reasonably and equitably serve other Medicaid beneficiaries who also have needs for these services. The B3 supports and services are not intended to meet all the individual's needs and preferences, as some needs may be better met by community and other natural supports.

Provider qualifications and service locations that are not otherwise identified in this section must meet the requirements identified in Sections 1 and 2 of this Chapter.

The B3 supports and services defined below are the supports and services that PIHPs are to provide from their Medicaid capitation.

1. Assistive Technology:

Assistive technology is an item or set of items that enable the individual to increase his or her ability to perform activities of daily living with a greater degree of independence than without them; to perceive, control, or communicate with the environment in which he/she lives. These are items that are not available through other Medicaid coverage or through other insurances. These items must be specified in the individual plan of service. All items must be ordered by a physician on a prescription or Certificate of Medical Necessity as defined in the General Information Section of this chapter. An order is valid for one year from the date it was signed.

Coverage includes:

- Adaptations to vehicles
- Items necessary for independent living (e.g., Lifeline, sensory integration equipment)
- Communication devices
- Special personal care items that accommodate the person's disability (e.g., reachers, full-spectrum lamp)
- Prostheses necessary to ameliorate negative visual impact of serious facial disfigurements and/or skin conditions
- Ancillary supplies and equipment necessary for proper functioning of assistive technology items
- Repairs to covered assistive technology that are not covered benefits through other insurances

Assessments by an appropriate health care professional and specialized training needed in conjunction with the use of the equipment, and warranted upkeep, shall be considered as part of the cost of the services.

Coverage excludes:

- Furnishings (e.g., furniture, appliances, bedding) and other non-custom items (e.g., wall and floor coverings, and decorative items) that are routinely found in a home.
- Items that are considered family recreational choices.
- The purchase or lease of a vehicle and any repairs or routine maintenance to the vehicle.
- Educational supplies that are required to be provided by the school as specified in the child's Individualized Education Plan.

Covered items must meet applicable standards of manufacture, design, and installation. There must be documentation that the best value in warranty coverage was obtained for the item at the time of purchase.

In order to cover repairs of assistive technology items, there must be documentation in the individual plan of services that the assistive technology continues to meet the criteria for B3 supports and services as well as those in paragraph one for this service. All applicable warranty and insurance coverages must be sought and denied before paying for repairs. The PIHP must document that the repair is the most cost-effective solution when compared with replacement or purchase of a new item. If the equipment requires repairs due to misuse or abuse, the PIHP must provide evidence of training in the use of the equipment to prevent future incidents.

2. **Community Living Supports**: are used to increase or maintain personal self-sufficiency, thus facilitating an individual's achievement of his/her goals. The supports may be provided in the participant's residence or in community settings (including but not limited to libraries, city pools, camps, etc.).

Coverage includes:

A. Assisting* [see note below], reminding, observing, guiding and/or training in the following activities:

- meal preparation
- laundry
- routine, seasonal, and heavy household care and maintenance
- activities of daily living such as bathing, eating, dressing, personal hygiene
- shopping for food and other necessities of daily living

B. Assistance, support and/or training with such activities as:

- money management
- non-medical care (not requiring nurse or physician intervention)
- socialization and relationship building
- transportation (excluding to and from medical appointments) from the beneficiary's residence to community activities, among community activities, and from the community activities back to the beneficiary's residence
- leisure choice and participation in regular community activities
- attendance at medical appointments
- acquiring or procuring goods other than those listed under shopping, and non-medical services

C. Reminding, observing and/or monitoring of medication administration

D. Staff assistance with preserving the health and safety of the individual in order that he/she may reside or be supported in the most integrated, independent community setting.

CLS may be provided in a licensed specialized residential setting as a complement to, and in conjunction with, state plan Personal Care services. Transportation to medical appointments is covered by Medicaid through FIA or the Medicaid Health Plan. Payment for CLS services may not be made, directly or indirectly, to responsible relatives (i.e., spouses, or parents of minor children).

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

CLS **assistance** with meal preparation, laundry, routine household care and maintenance, activities of daily living and/or shopping may be used to complement Home Help or Enhanced Home Help services when the individual's needs for this assistance have been officially determined by FIA or the Administrative Tribunal to exceed the FIA's allowable parameters. CLS may be used for those activities while the beneficiary awaits determination by FIA of the amount, scope and duration of Home Help or Enhanced Home Help. CLS may also be used for those activities while the beneficiary awaits the decision from a Fair Hearing of the appeal of an FIA decision.

3. **Enhanced Pharmacy:** Physician-ordered, nonprescription "medicine chest" items as specified in the person's plan of service. There must be documented evidence that the item is not available through Medicaid or other insurances and is the most cost-effective alternative to meet the beneficiary's need.
   The following items are covered only for adult beneficiaries living in independent settings (own home, apartment where deed or lease is signed by the beneficiary):

   - Cough, cold, pain, headache, allergy, and/or gastrointestinal distress remedies
   - First aid supplies (e.g., band-aids, iodine, rubbing alcohol, cotton swabs, gauze, antiseptic cleansing pads)

   The following items are covered for beneficiaries living in independent settings, with family, or licensed dependent care settings:

   - Special oral care products to treat specific oral conditions beyond routine mouth care (e.g., special toothpaste, tooth brushes, anti-plac rinses, antiseptic mouthwashes)

- Vitamins and minerals
- Special dietary juices, and foods that augment, but do not replace, a regular diet

Coverage excludes:

- Routine cosmetic products (e.g., make-up base, aftershave, mascara, and similar products)

4. Environmental Modifications: Physical adaptations to the beneficiary's own home or apartment and/or work place. There must be documented evidence that the modification is the most cost-effective alternative to meet the beneficiary's need/goal based on the results of a review of all options, including a change in the use of rooms within the home or alternative housing, or in the case of vehicle modification, alternative transportation. All modifications must be prescribed by a physician. Prior to the environmental modification being authorized, PIHP may require that the beneficiary apply to all applicable funding sources, such as housing commission grants, MSHDA, and community development block grants, for assistance. It is expected that the PIHP case manager/supports coordinator will assist the beneficiary in his/her pursuit of these resources. Acceptances or denials by these funding sources must be documented in the beneficiary's records. Medicaid is a funding source of last resort.

Coverage includes:

- The installation of ramps and grab-bars
- Widening of doorways
- Modification of bathroom facilities
- Special floor, wall or window covering that will enable the beneficiary more independence or control over his/her environment, and/or ensure health and safety
- Installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies necessary for the welfare of the beneficiary
- Assessments by a appropriate health care professional and specialized training needed in conjunction with the use of such environmental modifications
- Central air conditioning when prescribed by a physician and specified as to how it is essential in the treatment of the beneficiary's illness or condition. This supporting documentation must demonstrate the cost-effectiveness of central air compared to the cost of window units in all rooms that the beneficiary must use.

- Environmental modifications that are required to support proper functioning of medical equipment, such as electrical upgrades, limited to the requirements for safe operation of the specified equipment.
- Adaptations to the work environment limited to those necessary to accommodate the beneficiary's individualized needs

Coverage excludes:

- Adaptations or improvements to the home that are not of direct medical or remedial benefit to the beneficiary or do not support the identified goals of community inclusion and participation, independence or productivity.
- Adaptations or improvements to the home that are of general utility, or cosmetic value and are considered to be standard housing obligations of beneficiary. Examples of exclusions include, but are not limited to carpeting (see exception above), roof repair, sidewalks, driveways, heating, central air conditioning, garages, raised garage doors, storage and organizers, landscaping and general home repairs.
- Cost for construction in a new home or new construction (e.g., additions) in an existing home.
- Environmental modifications costs for improvements exclusively required to meet local building codes
- Adaptations to the work environment that are the requirements of Section 504 of the Rehabilitation Act, or the Americans with Disabilities Act; or the responsibilities of the Michigan Rehabilitation Services.

The PIHP must assure there is a signed contract with the builder for an environmental modification and the homeowner. It is the responsibility of the PIHP to work with the beneficiary and builder to ensure that the work is completed as outlined in the contract and that issues are resolved between all parties. In the event that the contract is terminated prior to the completion of the work, Medicaid capitation payments may not be used to pay for any additional costs resulting from the termination of the contract.

The existing structure must have the capability to accept and support the proposed changes. The "infrastructure" of the home (e.g., electrical system, plumbing, well/septic, foundation, heating/cooling, smoke detector systems, roof) must be in compliance with all local codes. If the home is not code compliant, other funding sources must be secured to bring the home into compliance.

The environmental modification must incorporate reasonable and necessary construction standards and comply with applicable state or local building codes. The adaptation cannot result in valuation of the structure significantly above comparable neighborhood real estate values.

Adaptations may be made to rental properties when the landowner agrees to the adaptation in writing. A written agreement between the landowner and the beneficiary must specify any requirements for restoration of the property to its original condition if the occupant moves and must indicate that Medicaid is not obligated for any restoration costs.

If a beneficiary purchases an existing home while receiving Medicaid services, it is the beneficiary's responsibility to assure that the home will meet basic needs, such as having a ground floor bath/bedroom if the beneficiary has mobility limitations. Medicaid funds may be authorized to assist with the adaptations noted above (e.g., ramps, grab bars, widening doorways, etc.) for a recently purchased existing home.

5. **Extended Observation Beds**: (23 Hours) This program, that must be pre-approved by MDCH (see Section 1.4 on Programs Requiring Special Approval), is a hospital-based service, less than 24 hours in duration, involving rapid diagnosis, treatment and stabilization of an individual with a psychiatric or substance abuse emergency, and that results in sufficient amelioration of the situation to allow the person to be discharged and transferred to an outpatient care service

6. **Family Support and Training**:
   Family-focused services provided to family (natural or adoptive parents, spouse, children, siblings, relatives, foster family, in-laws, and other unpaid caregivers) of persons with serious mental illness, serious emotional disturbance or developmental disability for the purpose of assisting the family in relating to and caring for a relative with one of these disabilities. The services target the family members who are caring for and/or living with an individual receiving mental health services. The service is to be used in cases where the beneficiary is hindered or at risk of being hindered in his/her ability to achieve goals of a) performing activities of daily living; b) perceiving, controlling, or communicating with the environment in which he/she lives; or c) improving his or her inclusion and participation in the community or productive activity, or opportunities for independent living. The training and counseling goals, content, frequency and duration of the training must be identified in the beneficiary's individual plan of service, along with the beneficiary's goal(s) that are being facilitated by this service.

   Coverage includes:

   - Education and training including instructions about treatment regimens, and use of assistive technology and/or medical equipment that are needed to

safely maintain the person at home specified in the individual plan of service.

- Counseling and peer support provided one-on-one or in group for assistance with identifying coping strategies for successfully caring for or living with a person with disabilities.

7. **Housing Assistance**: Assistance with short-term, interim, or one-time-only expenses that the individual's resources and other community resources could not cover.

Additional criteria for using Housing Assistance:

- The beneficiary must have in his/her individual plan of services a goal of independent living, and either live in a home/apartment that he/she owns, rents, or leases; or be in the process of transitioning to such a setting; and
- Documentation of the beneficiary's control (i.e., beneficiary-signed lease, rental agreement, deed) of his/her living arrangement in the individual plan of service; and
- Documentation of efforts (e.g., the person is on a waiting list) under way to secure other benefits, such as SSI, or public programs (e.g., governmental rental assistance, community housing initiatives and/or home ownership programs) so when these become available they will assume these obligations and provide the needed assistance.

Coverage includes:

- Assistance with utilities, insurance, and moving expenses where such expenses would pose a barrier to a successful transition to owning or leasing/renting a dwelling
- Limited term or temporary assistance with living expenses for beneficiaries transitioning from restrictive settings
- Interim assistance with utilities, insurance or living expenses when the beneficiary already living in an independent setting experiences a temporary reduction or termination of his/her own or other community resources
- Home maintenance when, without a repair to the home or replacement of a necessary appliance, the individual would be forced to leave for health and safety reasons.

Coverage excludes:

- Funding for on-going housing costs
- Long-term costs for room and board
- Home maintenance that is of general utility, or cosmetic, and are considered to be standard housing obligations of the beneficiary

Replacement or repairs of appliances should follow the general rules under Assistive technology. Repairs to the home must be in compliance with all local codes and be performed by the appropriate contractor (see general rules under Environmental Modifications). Replacement or repairs of appliances, and repairs to the home or

apartment do not need a prescription or order from a physician.

8. **Peer-Delivered or -Operated Support Services**: 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.

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

   b. 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:
      i. Staff and board of directors of the center is 100% primary consumers
      ii. PIHP allows consumers the autonomy and independence to make day-to-day decisions about the program
      iii. PIHP allows consumers the ability to handle the finances of the program
      iv. The drop-in center is at a non-CMH site
      v. The drop-in center has applied for 501(c)(3) non-profit status
      vi. There is a contract between the drop-in center and PIHP identifying the roles and responsibilities of each party

   c. Documentation: Individual plan of service identifies goals and how the program supports those goals; and the amount, scope and duration of the services to be delivered. Individual clinical record provides evidence that the services were delivered consistent with the plan.

   d. Qualifications: 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.

9. **Prevention-Direct Service Models**: Programs using individual, family and group interventions designed to reduce the incidence of behavioral, emotional or cognitive dysfunction, thus reducing the need for individuals to seek treatment

through the public mental health system. The direct prevention models are Children of Adults with Mental Illness/Integrated Services, Infant Mental Health when not enrolled as a Home-Based program, Parent Education, Child Care Expulsion Prevention and School Success Programs.

10. **Respite Care Services:** Services that are provided to assist in maintaining a goal of living in a natural community home by temporarily relieving the **unpaid** primary care giver. Decisions about the methods and amounts of respite should be decided during person-centered planning. PIHPs may not require active clinical treatment as a prerequisite for receiving respite care. These services do not supplant or substitute for community living support or other services of paid support/training staff.

    Respite care may be provided in the following settings:

    a. Beneficiary's home or place of residence
    b. Licensed family foster care home
    c. Facility approved by the State that is not a private residence, such as:
        i. Group home; or
        ii. Licensed respite care facility
    d. Home of a friend or relative chosen by the beneficiary and members of the planning team
    e. Licensed camp
    f. In community (social/recreational) settings with a respite worker trained, if needed, by the family

    Respite care may not be provided in:
    - day program settings
    - ICF/MR, nursing homes, or hospitals

    Respite care may not be provided by:
    - parent of a minor beneficiary receiving the service
    - spouse of the beneficiary served
    - individual's guardian
    - unpaid primary care giver

    Cost of room and board must not be included as part of the respite care unless provided as part of the respite care in a facility that is not a private residence.

11. **Skill-Building Assistance:** consists of activities that assist a beneficiary to increase his/her economic self-sufficiency and/or to engage in meaningful activities such as school, work, and/or volunteering. The services provide knowledge and specialized skill development and/or support. Skill-building assistance may be provided in the participant's residence or in community settings.

Documentation must be maintained by the PIHP that the beneficiary is not currently

eligible for sheltered work services provided by Michigan Rehabilitation Services (MRS). Information must be updated when the beneficiary's MRS eligibility conditions change.

Coverage includes:

a. Out-of-home adaptive skills training:

Assistance with acquisition, retention, or improvement in self-help, socialization, and adaptive skills; and supports services, including

- Aides helping the beneficiary with his/her mobility, transferring, and personal hygiene functions at the various sties where adaptive skills training is provided in the community.
- When necessary, helping the person to engage in the adaptive skills training activities (e.g., interpreting).

Services must be furnished on a regularly scheduled basis (several hours a day, one or more days a week) as determined in the individual plan of services and should be coordinated with any physical, occupational, or speech therapies listed in the plan of supports and services. Services may serve to reinforce skills or lessons taught in school, therapy, or other settings

b. Work preparatory services

Services aimed at preparing a beneficiary for paid or unpaid employment, but that are not job task-oriented. They include teaching such concepts as attendance, task completion, problem solving, and safety. Work preparatory services are provided to people not able to join the general workforce, or to participate in a transitional sheltered workshop within one year (excluding supported employment programs).

Activities included in these services are primarily directed at reaching habilitative goals, such as improving attention span and motor skills, not at teaching specific job skills. These services must be reflected in the person's person-centered plan and directed to habilitative or rehabilitative objectives rather than employment objectives.

c. Transportation from the beneficiary's place of residence to the skill building assistance training, between skills training sites if applicable, and back to the beneficiary's place of residence.

Coverage excludes:

Service that would otherwise be available to the beneficiary through the Rehabilitation Act of 1973, or Individuals with Disabilities Education Act (P.L. 94-142).

11. **Support and Service Coordination**: Functions performed by a supports coordinator, coordinator assistant, case manager assistant, supports and services broker, or otherwise designated representative of the PIHP that include assessing the need for support and service coordination, and assurance of the following:
    a. Planning and/or facilitating planning using person-centered principles
    b. Developing an individual plan of service using the person-centered planning process
    c. Linking to, coordinating with, follow-up of, advocacy with, and/or monitoring of Specialty Services and Supports and other community services/supports.
    d. Brokering of providers of services/supports
    e. Assistance with access to entitlements, and/or legal representation
    f. Coordination with the Medicaid Health plan, Medicaid fee-for-service, or other health care providers.

    Independent supports and service brokers may be used for item d. above. However, it is expected that the beneficiary will also have a supports coordinator or case manager who assures that the other functions above are in place.

    If a beneficiary has both a supports coordinator for some functions, and an assistant case manager or coordinator assistant, or broker for others, the individual plan of service must clearly identify the staff who is responsible for each function. The PIHP must assure that it is not paying for both staff to perform support coordination functions at the same time, or that both staff perform the same support coordination functions.

    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 related activities that assure:

    - The desires and needs of the beneficiary are determined
    - The supports and services desired and needed by the beneficiary are identified and implemented
    - Housing and employment issues are addressed
    - Social networks are developed
    - Appointments and meetings are scheduled

- Person-centered planning is provided, and independent facilitation of person-centered planning is made available
- Natural and community supports are used
- The quality of the supports and services, as well as the health and safety of the beneficiary, are monitored
- Income/benefits are maximized
- Activities are documented
- Plans of supports/services are reviewed at such intervals as are indicated during planning

While supports coordination as part of the overall plan implementation and/or facilitation may include initiation of other 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 the health and safety needs of the individual.

Qualifications of support coordinators: A minimum of a Bachelor's degree in a human services field and one year of experience working with people with developmental disabilities if supporting that population; or a Bachelor's degree in a human services field and one year of experience with people with mental illness if supporting that population.

Qualifications of support coordinator assistants, case management assistants, and supports and service brokers: minimum of a high school diploma and equivalent experience (I.e. possesses knowledge, skills and abilities similar to supports coordinator qualifications) and functions under the supervision of a qualified supports coordinator. Independent supports and service brokers must meet these qualifications and function under the guidance and oversight of a qualified supports coordinator or case manager.

12. **Supported/Integrated Employment Services**: Provide job development, initial and ongoing support services to assist persons obtain and maintain paid employment that would be otherwise unachievable without such supports. Support services are provided continuously as needed throughout the period of employment. Capacity to intervene to provide assistance to the individual and/or employer in episodic occurrences of need is included in this service. Supported/integrated employment must be provided in integrated work settings where the beneficiary works alongside people who do not have disabilities.

Coverage includes:

- Job development, job placement, job coaching, and long-term follow-along services required to maintain employment.
- Consumer-run businesses (e.g. vocational components of Fairweather Lodges, supported self-employment) Transportation provided from the beneficiary's place of residence to the site of the supported employment service, among the supported employment sites if applicable, and back to the beneficiary's place of residence.

Coverage excludes:

- Employment preparation.
- Services otherwise available to the beneficiary through the Rehabilitation Act of 1973, as amended, or under the Individuals with Disabilities Education Act (IDEA); or through Michigan Rehabilitation Services.

13. **Wraparound Services for Children and Adolescents**: is a highly individualized planning process performed by specialized case managers who coordinate the planning for and delivery of Wraparound services, and incidental non-staff items that are medically necessary for the child beneficiary. The planning process identifies strengths, needs, strategies (staffed services and non-staff items) 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 plan of service for the child beneficiary that consists of mental health specialty treatment, services and supports covered by the Medicaid mental health state plan, waiver, or B3 services. 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 beneficiary and family and is developed in partnership with other community agencies. This planning process tends to work more effectively with child beneficiaries who due to safety and other risk factors, require services from multiple systems and informal supports. The Community Team that consists of parents, agency representatives, and other relevant community members oversees wraparound.

Child beneficiaries served in wraparound shall meet two or more of the following:

- Children who are involved in multiple systems
- Children who are at risk of out-of-home placements or are currently in out-of-home placement
- Children who have been served through other mental health services with minimal improvement
- The risk factors exceed capacity for traditional community-based options

- Numerous providers are serving multiple children in a family and the outcomes are not being met.

Note: Wraparound planning is reported under Treatment Planning; intensive case management is reported as Targeted Case Management; and medically necessary non-staff items are reported as Wraparound in the encounter data system.

New Section 18: ADDITIONAL SUBSTANCE ABUSE SERVICES (B3s)

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

The PIHP may provide these services only when the service:

- Meets medical necessity criteria for the beneficiary (See MDCH/PIHP Contract Attachment P.3.2.1, Medical Necessity Criteria); and
- Is based on individualized determination of need; and
- IS cost effective; and
- Does not preclude the provision of a necessary state plan service; and
- Meets access standards contained in Section 12.1 of this Chapter, including a level of care (LOC) determination based on an evaluation of the 6 assessment dimensions of the current ASAM Patient Placement Criteria

1. Sub-Acute Detoxification

Sub-Acute Detoxification is defined as medically-supervised care for the purpose of managing the effects of withdrawal from alcohol and/or other drugs as part of a planned sequence of addiction treatment. Sub-Acute Detoxification must be staffed 24 hours per day, seven days per week by a licensed physician or by the designated representative of a licensed physician.

This service is limited to stabilization of the medical effects of the withdrawal and referral to necessary ongoing treatment and/or support services. This service, when clinically indicated, is an alternative to acute medical care provided by licensed health care professionals in a hospital setting.

Authorization Requirements:

- Symptom alleviation is not sufficient for purposes of admission. There must be documentation of current client status which provides evidence the admission is likely to directly assist the beneficiary in the adoption and pursuit of a plan for further appropriate treatment and recovery.

- Admission to Sub-Acute Detoxification must be made based on:

    - Medical Necessity Criteria
    - AAR service requirements found in Section 12.1 of this Chapter

- LOC determination based on an evaluation of the 6 assessment dimensions of the current ASAM Patient Placement Criteria.

- Initial length-of-stay authorizations may be for up to three days with additional days authorized if there is clinical evidence that detoxification is not successful or complete and authorization requirements continue to be met.

2. Residential Treatment

Residential Treatment is defined as intensive therapeutic service, which includes overnight stay and planned therapeutic, rehabilitative or didactic counseling to address cognitive and behavioral impairments for the purpose of enabling the beneficiary to participate and benefit from less intensive treatment. A program director is responsible for the overall management of the clinical program and treatment is provided by appropriate credentialed professional staff including substance abuse specialists. Residential treatment must be staffed 24 hours per day.

This intensive therapeutic service is limited to those beneficiaries who, because of specific cognitive and behavioral impairments, need a safe and stable environment in order to benefit from treatment.

Authorization requirements:

- The effects of the substance use disorder must be so significant and the resulting impairment so great that intensive outpatient and outpatient treatment have not been effective or cannot be safely provided and when the beneficiary provides evidence of willingness to participate in treatment.

- Admissions to Residential Treatment must be based on:

  - Medical Necessity Criteria
  - AAR service requirements found in Section 12.1 of this chapter
  - LOC determination based on an evaluation of the 6 assessment dimensions of the current ASAM Patient Placement Criteria

- The PIHP may authorize up to 22 days of treatment.

- Additional days may be authorized when authorization requirements continue to be met and if there is evidence of progress in achieving treatment plan goals and reauthorization is necessary to resolve cognitive and behavioral impairments which prevent the beneficiary from benefiting from less intensive treatment.

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