



HURON BEHAVIORAL HEALTH POLICY

Policy #: **ISP.1.01**
Issue Date: **08/08/01**
Rev. Date: **09/04/21**
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Title: Access to Services, Eligibility, Medical Necessity, and Referrals Policy

Prepared By: Clinical Director

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Purpose:

To define the protocols and guidelines for accessing mental health services through Huron Behavioral Health, for referrals to other resources, and for eligibility criteria.

Scope:

This policy applies to all employees (including full-time and part-time employees), contract providers, volunteers, students, and/or interns of Huron Behavioral Health (HBH). It also applies to all consumers (adults and minors, including consumers with co-occurring disorders) served by Huron Behavioral Health.

Information:

- In accordance with the non-discrimination rules under the Affordable Care Act section 1557, HBH shall not discriminate against any individuals in its provision of services based on the individual's race, color, religion, national origin, age, veteran or marital status, or sex (including pregnancy, sexual orientation, gender identity, transgender status, and/or sex stereotyping). However, all individuals must meet specific program eligibility requirements before services are rendered. HBH will provide assistance to persons with Limited English Proficiency (LEP) and will ensure effective communication for individuals with disabilities to assure meaningful access to services. (See also [LEP Accommodations Procedure RR.2.46](#)) Additionally, HBH strives to outreach under-served and hard-to-reach populations in the covered area.
- Individuals served who need visual or mobility accommodations, and/or language assistance receive the necessary assistance and/or accommodation to afford them meaningful access to services at no cost to the consumer. (See also "[Limited English Proficiency \(LEP\) Accommodation Policy](#)" RR.1.02.)
- HBH works with the community to minimize barriers which prevent individuals from accessing services (e.g. language, transportation, stigma, physical/architectural barriers, service fees, service location, etc.).
- To the extent possible, consumers are allowed to choose or change their provider/worker.
- All persons seeking services from HBH must first be screened and authorized by the contracted access screening center using the criteria defined in the policy section below and the Michigan Medicaid Provider Manual. The access/screening process is conducted by telephone via a toll-free number.
- HBH strives to comply with all state standards for timely access to care and services. HBH offers same-day access to services, but in no case shall an appointment for an intake assessment with a face-to-face professional assessment take more than fourteen (14) days following the initial request for service (per contractual requirements). This time frame is a state performance indicator requirement. Failure to comply will result in a case review by the Clinical Director. See also "[Intake Assessment Procedure](#)" (ISP.2.02).
- Individuals seeking services will be welcomed by HBH staff who listen to their situation, problems, and/or functional/behavioral difficulties using good customer service skills and in a manner that is welcoming and non-judgmental.
- A [Fee Assessment Form \(90-020\)](#) will be completed the same day as the professional assessment or sooner. If an individual's financial circumstances change, another [Fee Assessment \(90-020\)](#) or a [Fee Adjustment Form \(90-041\)](#) will be completed at that time.
- Priority is given to the most severe forms of serious mental illness, serious emotional disturbance, and intellectual/developmental disability, and co-occurring disorders and those in emergent or urgent situations.
- For individuals with a Substance Use Disorder (SUD), determination of service priority status includes:
 - Pregnant injecting drug user
 - Pregnant, other substance use disorder
 - Injecting drug user
 - Parents of children who have been or are at-risk of being removed from their home

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- Individuals receive information on recipient rights which includes their right to appeal a decision, and the right to a second opinion. In the event that a disagreement about services or eligibility determination occurs, the consumer may file an appeal or grievance to seek resolution (see also [“Appeals and Grievance Procedure” RR.2.36](#)).
- In the event that HBH is unable to provide a service requested, or the consumer and/or family cannot be served promptly, they will be given a list of qualified providers to assist them in selecting an appropriate alternative or they may be placed on a waiting list (NOTE: Medicaid and Healthy Michigan beneficiaries can NOT be placed on a waiting list for any necessary, needed, and covered service). (See also [“Waiting List Policy” SD.1.17.](#)) HBH staff will provide assistance as necessary to facilitate the referral on behalf of the consumer/family to assure that medically necessary specialty mental health provider is located. (See also [“Community Resource Listing Procedure” \(SD.2.01\).](#))
- If HBH cannot provide a particular medically necessary service to a consumer as mandated to provide under contract, HBH will expeditiously develop a contract with another provider to provide the needed service. If the cost of any contracted service is greater than the cost that HBH would have incurred to provide the service directly, the consumer will not be responsible for any additional costs beyond the amount determined by their ability to pay (see [ISP.2.04 Ability To Pay Procedure](#)).
- HBH collaborates with community coalitions and other SUD prevention partners in an effort to increase awareness and education of substance use disorder. Additionally, HBH provides general community education and awareness as well as outreach activities related to behavioral health, prevention, access, and treatment (see the “HBH Prevention Plan”).

Policy:

A. Access:

1. Access to HBH services is available 24/7/365 (that is twenty-four hours per day/ seven days per week/ 365 days per year) for all populations including adults and children with intellectual/developmental disabilities, mental illness, and co-occurring mental illness and substance use disorder. Individuals who are requesting treatment will contact Huron Behavioral Health or HBH’s contracted access screening provider. Individuals will be screened to determine if they are in crisis. If the individual is in crisis, HBH Emergency Services (ES) staff will provide crisis intervention treatment. Individuals who approach the access system receive timely and appropriate crisis intervention services. For non-emergent situations, the access screening provider will immediately conduct the initial eligibility screening and assessment and complete the referral (if appropriate). Per contractual requirements, on-hold times will not exceed three (3) minutes without being offered a call-back option. All non-emergent callbacks occur within one (1) business day of the initial contact. Individuals with routine needs are screened (or alternate arrangements are made) within thirty (30) minutes. Individuals are informed of available services and how to access them. Access staff also follow-up with the individual within two (2) business days to ensure service needs have been met or to re-engage if referral connections have not been made.
2. HBH will schedule an appointment or services in the appropriate program. If the individual is found to not be eligible during the screening process, they are informed immediately by the contracted access screening center verbally and in writing and provided with information on alternatives that may be available in their community. Decisions made by HBH to provide services in an amount, duration, or scope that is less than requested are made by healthcare professionals who possess the appropriate clinical expertise in treating the individual’s condition.

B. Screening:

1. Screening for access to services is conducted by a contracted Access/Customer Services Center at Bay-Arenac Behavioral Health who provides HBH with a screening report in the Electronic Medical Record (EMR) as well as entering the required demographic information into the EMR system.
2. The screening report provides the following information to HBH staff:
 - The presenting problem and the need for services and supports

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- Identification of the population group that qualifies the individual for services and supports
 - Eligibility and priority criteria
 - Urgent/emergent needs
 - Screening disposition/determination for services
 - Rationale for admission or denial of services and supports
3. If an individual is screened and meets the eligibility and medical necessity criteria for ongoing specialty mental health services, they will not be denied those services based on individual/family income and/or third party payor resources. There will be a warm handoff to the service provider for which the individual has been screened and determined eligible to receive.
 4. Individuals with behavioral health needs who are not eligible for Medicaid or Healthy Michigan may be referred to other community resources or may be placed on a waiting list with a written explanation related to the individual's service needs (consistent with Michigan Department of Health and Human Services/MDHHS waiting list guidelines and HBH policy "[Waiting List Policy](#)" SD.1.17). The individual and any referral source (with the individual's consent) are informed of the reason(s) for denial.

C. Eligibility:

1. Any person who is in Huron County and who is experiencing a mental health emergency, or substance use disorder and is experiencing an emergent or urgent mental health situation regardless of their insurance coverage or ability to pay will be given immediate access to crisis intervention services regardless of their county of legal residence (this also includes inpatient psychiatric hospitalization, crisis residential, and crisis stabilization).
2. Services provided through Huron Behavioral Health shall be directed to those individuals who have a Serious and Persistent Mental Illness (SPMI), Serious Emotional Disturbance (SED), or Intellectual/Developmental Disability (I/DD). (Mental Health Code 330.1208(1)) and contract requirements.
3. Eligibility for services, medical necessity, and level of care will be determined through an objective standardized assessment in which the clinician collects information for decision making, referrals, and required reporting data. All eligibility and admission decisions are based upon severity of medical necessity. Priority shall be given to providing services to individuals with the most severe forms of SPMI, or Co-Occurring Disorders (COD), SED, and I/DD (Mental Health Code 330.1208(3)).
4. Services may also be made available to individuals who have other mental health and/or co-occurring disorders that meet the criteria specified in the most recent Diagnostic and Statistical Manual (DSM) of mental health disorders (Mental Health Code 330.1208(2)), but are not considered to be serious mental illness, serious emotional disturbance, or intellectual/developmental disability. These services would be dependent upon available resources and funding.
5. HBH will implement the medical necessity criteria as specified by the MDHHS and the Pre-paid Inpatient Health Plan (PIHP) contractual requirements.
6. Any individual who does not meet eligibility criteria will be referred to an appropriate provider.
7. If a Medicaid beneficiary does not meet the medical necessity criteria for the priority population and/or the requested service, a written notice will be provided in a timely manner to the individual regarding the adverse action which will include the reason for the action and the beneficiary's options for appealing the action (see also "[Grievance and Appeals Procedure](#)" RR.2.36).

D. Medical Necessity for Medicaid Beneficiaries:

1. The following medical necessity criteria (as defined in the current Michigan Medicaid Provider Manual) applies to the HBH Medicaid behavioral health supports and services.
 - o **Medical Necessity Criteria is:**
 - i. Necessary for screening and assessing the presence of a mental illness, intellectual/developmental disability, substance use disorder, and/or

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- ii. Required to identify and evaluate a mental illness, intellectual/developmental disability, substance use disorder; and/or
- iii. Intended to treat, ameliorate, diminish, or stabilize the symptoms of mental illness, intellectual/developmental disability, substance use disorder; and/or
- iv. Expected to arrest or delay the progression of a mental illness, intellectual/developmental disability, substance use disorder; and/or
- v. Designed to assist the beneficiary to attain or maintain a sufficient level of functioning in order to achieve his/her goals of community inclusion and participation, independence, recovery, and/or productivity.
- o **Determination Criteria** - the determination of medically necessary supports, services, or treatments must be:
 - i. Based on information provided by the beneficiary, beneficiary's family, and/or other individuals (such as friends, personal assistants, etc.) who know the beneficiary;
 - ii. Based on clinical information from the beneficiary's primary care physician or healthcare professionals with relevant qualifications who have evaluated the beneficiary; and
 - iii. For beneficiaries with mental illness or intellectual/developmental disabilities, based on person-centered planning, and for beneficiaries with substance use disorders, individualized treatment planning; and
 - iv. Made by appropriately trained mental health and substance abuse professionals with sufficient clinical experience; and
 - v. Made within federal and state standards for timeliness; and
 - vi. Sufficient in amount, scope, and duration of services to reasonably achieve their purpose; and
 - vii. Based on documented evidence-based criteria for determination of scope, duration, and intensity; and
 - viii. Documented in the Individual Plan of Service (IPOS).
- o **Supports, Services, and Treatment** - which are authorized must be:
 - i. Delivered in accordance with federal and state standards for timeliness in a location that is accessible to the beneficiary; and
 - ii. Responsive to the particular needs of multi-cultural populations and furnished in a culturally sensitive/relevant manner; and
 - iii. Responsive to the particular needs of the beneficiary with sensory or mobility impairments and provided with necessary accommodations (see also "[Limited English Proficiency/LEP Accommodations Policy](#)" RR.1.02); and
 - iv. Provided in the least restrictive and most integrated setting. Inpatient, licensed residential, or other segregated settings shall be used only when less restrictive levels of treatment, service, or supports have been, for that beneficiary, unsuccessful or cannot be safely provided; and
 - v. Delivered consistent with (where they exist), available research findings, health care practice guidelines, best practices and/or standards of practice issued by professionally recognized organizations or government agencies.

HBH staff shall provide support and response to consumer complaints, including recipient rights complaints and grievances (see also "[Grievance and Appeal Procedure](#)" RR.2.36).
- o **Decisions** - Services may be denied if:
 - i. They are deemed to be ineffective for a given condition based upon professionally and scientifically recognized and accepted standards of care;
 - ii. They are experimental or investigative in nature (see also "[HBH Treatment Philosophy, Evidence-Based Practices, and Approved Methods Policy](#)" SD.1.11);

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- iii. There exists another more appropriate, efficacious, less-restrictive, and cost-effective service, setting, or support that otherwise satisfies the standards for medically necessary services; and/or
- iv. Using the criteria for medical necessity, HBH may employ various methods to determine that the amount, scope, and duration of services, including prior authorization for certain services, concurrent utilization reviews, centralized assessment, and referral, protocols, and guidelines.

Services may not be denied solely on preset limits of the cost, amount, scope, and duration of services. A determination of the need for services shall be conducted on an individualized basis.

E. Referrals:

1. When a consumer does not meet the eligibility criteria or the consumer requests an alternative provider, they will be referred to other community resources. When referrals are made to other providers, the referrals will be made to qualified providers:
 - without discrimination
 - in accordance with the eligibility criteria of the program the individual is referred to
 - at no additional cost to the consumer
2. Referrals to the appropriate mental health or substance use disorder provider will be made in a timely manner. The worker will assist the consumer in obtaining the necessary information to accommodate obtaining the medically necessary services. (See ["Community Resource Listing Procedure" SD.2.01](#))
3. The consumer's wishes and desires guide the referral process as long as the service is medically necessary and the receiving provider is appropriately qualified and has capacity.

Definitions/Acronyms:

Acronyms:

ASAM – American Society of Addiction Medicine
CFR – Code of Federal Regulations
DSM – Diagnostic and Statistical Manual
EMR – Electronic Medical Record
HBH – Huron Behavioral Health
I/DD – Intellectual/Developmental Disability
IPOS – Individual Plan of Service
LOC – Level of Care
MDHHS – Michigan Department of Health and Human Services
MSHN – Mid-State Health Systems
PCP – Person-Centered Plan
PIHP – Pre-paid Inpatient Health Plan
SED – Serious Emotional Disturbance
SPMI – Serious and Persistent Mental Illness
SUD – Substance Use Disorder

Definitions:

Intellectual/Developmental Disability – means either of the following:

- (1) If applied to an individual older than five (5) years, a severe, chronic condition that meets all of the following requirements:
 - Is attributable to a mental or physical impairment or a combination of mental/physical impairments; and
 - Is manifested before the individual is 22 years old; and
 - Is likely to continue indefinitely; and
 - Results in substantial functional limitations in three (3) or more of the following areas of major life activity:
 - Self care
 - Receptive and expressive language
 - Learning
 - Mobility
 - Self-direction
 - Capacity for independent living
 - Economic self-sufficiency

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- and; Reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services that are of a lifelong or extended duration and are individually planned and coordinated.
- (2) If applied to a minor from birth to age five (5), a substantial developmental delay or a specific congenital or acquired condition with a high probability of resulting in a developmental disability as defined in the subdivision above if services are not provided.

Medical Necessity – a determination that a specific service is medically (clinically) appropriate, necessary to meet the person's mental health needs, consistent with the person's diagnosis, symptomatology and functional impairments, is the most cost-effective option in the least restrictive environment, and is consistent with clinical standards of care.

Mental Illness – means:

- The beneficiary is currently or has recently been (within the last 12 months) seriously mentally ill or seriously emotionally disturbed as indicated by diagnosis, intensity of current signs and symptoms, and substantial impairment in the ability to perform daily living activities (or for minors, substantial interference in achievement or maintenance of developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills).
- The beneficiary does not have a current or recent (within the last 12 months) serious condition but was formerly seriously impaired in the past. Clinically significant residual symptoms and impairments exist and the beneficiary requires specialized services and supports to address residual symptomatology and/or functional impairments, promote recovery and or prevent relapse.
- The beneficiary has been treated by the health plan for mild/moderate symptomatology and temporary or limited functional impairments and has exhausted the 20-visit maximum for the calendar year.

Serious Emotional Disturbance – means a diagnosable mental, behavioral, or emotional disorder affecting a minor that exists or has existed during the past year for a period of time sufficient to meet diagnostic criteria specified in the most recent DSM, and that has resulted in functional impairment that substantially interferes with or limits the minor's role or functioning in family, school, or community activities. Substance abuse disorders and developmental disorders are included only if they occur in conjunction with another diagnosable serious emotional disturbance.

Serious Mental Illness – means a diagnosable mental, behavioral, or emotional disorder affecting an adult that exists or has existed within the past year for a period of time sufficient to meet diagnostic criteria specified in the most recent DSM, and that has resulted in functional impairment that substantially interferes with or limits one or more major life activities. Serious mental illness includes dementia and delusions, dementia with depressed mood, and dementia with behavioral disturbance but does not include any other dementia unless the dementia occurs in conjunction with another diagnosable serious mental illness. Substance abuse disorders and developmental disorders are included only if they occur in conjunction with another diagnosable serious mental illness.

Substance Use Disorder (SUD) – means:

- Determination of medical necessity (the presence or a likelihood of a substance use disorder).
- A provisional diagnostic impression of SUD dependence or abuse
- Determination of the initial Level of Care (LOC) based on the American Society of Addiction Medicine (ASAM) Patient Placement Criteria
- Determination of priority population status:
 - Pregnant injecting drug user
 - Pregnant, other substance use disorder
 - Injecting drug user
 - Parents of children who have been or are at-risk of being removed from their home **(3.14)**

Forms:

Ability-To-Pay Fee Assessment Form (in EMR)

[90-041](#) Fee Adjustment Request Form

Clinical Assessment Form (in EMR)

Initial Screening Form (in EMR)

Records:

Records of initial requests for services are retained by the contracted access screening center. Referrals, fee assessments, and eligibility records are retained in the consumer's case record in accordance with the [HBH Record Storage & Retention Policy \(QI.1.23\)](#).

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Reference(s) and/or Legal Authority

COA Standards

42CFR - Balanced Budget Act 438.12(a) @ http://www.access.gpo.gov/nara/cfr/waisidx_02/42cfr438_02.html

42CFR 438.206 Access Standards

42CFR 438.210 Enrollee Rights

Michigan Mental Health Code (330.1124/Waiting List and 330.1208/Individuals to whom service is directed @ <http://www.legislature.mi.gov/printDocument.aspx?objName=mcl-act-258-of-1974&version=txt>

Medicaid Provider Manual (Behavioral Health and Intellectual and Developmental Disability chapter)

MDHHS Bureau of Substance Abuse and Addiction Services, treatment policy

MSHN Policy "Utilization Management – Access System"

[ISP.2.02 Intake Assessment Procedure](#)

[QI.1.23 HBH Record Storage & Retention Policy](#)

[RR.2.36 - Appeals & Grievance Procedure](#)

[SD.1.17 Waiting List Policy](#)

[SD.2.01 Community Resource Listing Procedure](#)

[ORI.1.20 Compliance with PIHP Policies, Procedures, and Protocols Policy](#)

[RR.1.02 Limited English Proficiency \(LEP\) Accommodations Policy](#)

[RR.2.36 Grievance and Appeal Procedure](#)

[HBH Prevention Plan](#)

Affordable Care Act section 1557

Change History:

Change Letter	Date of Change(s)	Changes
A	02/03/04	Old policy brought into Controlled Documentation system with revisions to incorporate DCH Contract requirements (Medical Necessity; Service Selection Criteria); and Michigan Mental Health Code requirements.
B	02/04/05	In "Referral" section, added numbering, added third bullet under #1; added second bullet in "Information" section.
C	11/28/05	Added references to "Community Resource Listing Procedure SD.2.01" and "Intake Assessment Procedure ISP.2.02", added "adults and minors, including consumers with co-occurring disorders" to "Scope" section to further comply with the Childrens Diagnostic and Treatment Services Certification Interpretive Guidelines, added hyperlinks to government webpages.
C	03/09/06	Added last bullet in "Information" section
D	09/29/08	Added "or at their request..." to last bullet in "Information" section, to clarify for COA., removed specific COA chapter references (G1, G8, S38), added last sentence in "Records" section, added "EMR" in "Acronym" section
E	01/28/09	Reviewed and revised to comply with COA 8 th Edition Standards and present practices – added "and/or co-occurring" to "Eligibility" #4, added "or cannot be served promptly" to the 9 th bullet in "Information" section, added "On occasion,provider" to #1 in "Referral" section, added 2 nd bullet in "Information" section, in "Eligibility" section, added first and last sentences in #3.
F	02/28/12	Requested by Clinical Director. Eligibility- #7 added "or" after "coverage", removed statement after "payment" and added "will be...", removed #8, Records- removed last statement.
G	12/04/12	Reviewed and revised to comply with 8 th edition COA standards, made minor grammatical changes, added reference to ORI.1.20 (2 places), added hyperlinks, in "Eligibility" section \$5 removed "a", "b", & "c" as these points were no longer aligning with contract attachment numbers and added "as specified by the Michigan Department of Mental Health (MDCH) and AAM contractual requirements", added "and/or family" to 9 th bullet in "Information" section,
H	03/27/14	Removed "Eligibility #6" (In addition, Huron Behavioral Health will adhere to the AAM Clinical Protocols and Technical Requirements (see also "Compliance with AAM policies, Procedures, and Protocols Policy" (ORI.1.20)), changed "AAM Access Center" to "contracted access screening center" (3 places), 3 rd bullet in "Information" section added "HBH strives to provide same-day access,..." , Removed from "Reference" section "AAM Clinical Protocol Manual", Added 8 statements to comply with regional/MSHN policy (Access System approved 11-22-13) including: "Information" section last sentence in 1 st bullet, 5 th bullet, 1 st sentence in 8 th bullet, added "(NOTE:-->>)" in 9 th bullet, second sentence in "Access" section, 1 st sentence in #3 under "Eligibility", 1 st sentence in #1 under "Referrals", 1 st sentence #2 under "Referrals", Removed "EMR" from "Acronym" section and added "MSHN", added references "42 CFR 438.206 & 438.210, MI Mental Health Code (330.1124 & 330.1208), MDCH Medicaid Manual and MDCH Bureau of Substance Abuse...
I	06/11/14	Reviewed and revised to comply with MSHN – added last sentence in "Access" section, added "B" and "D" sections, added last parenthetical statement in "Eligibility" section, added to "Acronym" section "LOC", "ASAM", and "SUD", added to "References" section "RR.1.02" "SD.1.17", & "RR.2.36", added to "Definitions" section "Mental Illness" & "Substance Use Disorders", added C.7.
J	07/12/16	In "Information" section 1 st bullet added "sexual orientation" and last sentence, added 2 nd bullet, added 3 rd bullet, in 11 th bullet added reference to SD.1.17, in C.3 added "or SMI/Substance Use4 Disorder (SUD)", changed "MDCH" to "MDHHS" throughout document (9 places), in "Acronym" section added "PIHP", "MDHHS", & "SMI" and removed "MDCH", in "Forms" section added "Clinical Assessment Form" and "Initial Screening Form", made numerous wording/grammatical changes/corrections throughout document without changing sentence content.
K	09/06/16	In section C.1 added "or Substance Use Disorder emergency and is" as part of a Plan of Correction.
L	10/04/16	Reworded first bullet in "Information" section to include new Affordable Care Act language, in "References" section added "Affordable Care Act"
M	12/02/16	In B.3 removed "MiChild".
N	08/09/17	In "Information" section 6 th bullet added 1 st sentence, in 9 th bullet added "intellectual/" & "and co-occurring disorders", added 10 th bullet, and last bullet, in "Policy" section under "Access" added 1 st , 3 rd , & 4 th sentences and

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		added "Per contractual requirements,", in "B. Screening" added "as well as entering the required demographic information", in "D. Medical Necessity" under "Supports, Services, and Treatment" added vi, in "Definitions" section removed "SUD services are provided to priority population beneficiaries before any non-priority beneficiary is admitted..." To comply with MSHN Delegated Managed Care Audit Tool (3.2 – 3.17).
O	12/05/18	In "Policy" section A.2 added "verbally and in writing", in B.4 added last sentence.
P	12/18/18	In "Information" section 6 th bullet added "by the Clinical Director" and in 9 th bullet added "and those in emergent or urgent situations", in "Policy" section C.1 added "emergent or" and added "regardless of their insurance coverage or their ability to pay", in C.2 added contract reference, in C.3 removed sentence relating to giving priority to staff and families, in D added "for Medicaid Beneficiaries", in E.1 changed "specialty mental health service" to "eligibility" and E.2 changed "referral" to "medically necessary services", in "Acronym" section added "PCP" & "SED", made several additional minor wording/grammatical changes/corrections throughout document without changing sentence content.
Q	10/19/20	In "Policy" section C.2 changed "contract attachment C3.1.1 ("Access System Standards")" to "contract requirements", in "D – Determination Criteria" changed "Person Centered Plan (PCP)" to "Individual Plan of Service (IPOS)" in "Acronyms" section added "I/DD", "IPOS", "SPMI", made several minor wording/grammatical changes/corrections throughout policy without changing sentence content.
R	09/04/21	In "Policy" section B.3 added last sentence ("There will be a warm handoff.....receive.").