# Inpatient Affiliation Provider Manual
# LAKESHORE REGIONAL ENTITY

Allegan County Community Mental Health Services
Community Mental Health of Ottawa County
HealthWest
Kent County CMH Authority d/b/a Network180
West Michigan Community Mental Health System

# COMMUNITY INPATIENT PARTIAL HOSPITALIZATION AND ELECTROCONVULSIVE THERAPY SERVICES

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## SECTION I. PROGRAM SPECIFICATIONS

### A. Inpatient Hospitalization Services for Adults, Children, and Adolescents:

1. Psychiatric evaluations and reviews, including subsequent care days.
2. Coordination of treatment planning, including discharge planning.
3. Nursing care.
4. Group, individual, and family treatment.
5. Ancillary Services – including but not limited to: Lab, Radiology, Psychological Testing, and Dietary Evaluation.
6. History and Physical.
7. Medication.
8. Person-Centered treatment.
9. Advocacy and linking to community resources as needed.
10. Physical, and/or Occupational therapy.
11. Language interpreter and/or translation/interpreter services.
12. Services delivered will include all services required for an inpatient licensed hospital program.
13. Discharge prescriptions.

### B. Partial Hospitalization Services for Adults, Children, and Adolescents

1. Psychiatric evaluations and review, including subsequent care days.
2. Coordination of treatment planning, including discharge planning.
3. Group, individual, and family treatment.
4. Person-centered treatment.
5. Medication.
6. Advocacy and linking to community resources as needed.
7. Physical and/or Occupational therapy.
8. Language interpreter and/or translation/interpreter services.
9. Services delivered will include all services required for a licensed partial hospitalization program.

### C. Electroconvulsive Therapy (ECT) - Inpatient

1. Must be provided under contract and will follow the protocol and standards established by the American Psychiatric Association
2. Includes Physician and Anesthesia services.

### D. Electroconvulsive Therapy (ECT) - Outpatient

1. Must be provided under contract and will follow the protocol and standards established by the American Psychiatric Association.
2. Includes facility charge, Physician, and Anesthesia services.

## SECTION II. SERVICE ELIGIBILITY

**Medical Necessity Criteria**
The following Medical necessity criteria apply to Medicaid Mental Health, Developmental Disabilities and Substance Abuse Services. These are considered supports, services and treatment:

1. Necessary for screening and assessing the presence of a mental illness, developmental disability, or substance use disorder; and/or
2. Required to identify and evaluate a mental illness, developmental disability, or substance use disorder; and/or
3. Intended to treat, ameliorate, diminish, or stabilize the symptoms of mental illness, developmental disability, or substance use disorder; and/or
4. Expected to arrest or delay the progression of a mental illness, developmental disability, or substance use disorder; and/or
5. Designed to assist the beneficiary to attain or maintain a sufficient level of functioning in order to achieve his goals of community inclusion and participation, independence, recovery, or productivity.

**Determination Criteria**
The determination of medically necessary supports, services, or treatment must be:

1. Based on information provided by the beneficiary, beneficiary's family, and/or other individuals (e.g., friends, personal assistants/aides) who know the beneficiary; and
2. Based on clinical information from the beneficiary's primary care physician or health care professionals with relevant qualifications who have evaluated the beneficiary
3. For beneficiaries with mental illness or developmental disabilities, based on person-centered planning, and for beneficiaries with substance use disorders, individualized treatment planning; and
4. Made by appropriately trained mental health, developmental disabilities, or substance abuse professionals with sufficient clinical experience; and
5. Made within Federal and State standards for timeliness; and
6. Sufficient in amount, scope, and duration of the service(s) to reasonably achieve its/their purpose.
7. Documented in the individual plan of service.

**Supports, Services, and Treatment Authorized by the PIHP/CMHSP or its Administrator must be:**
1. Delivered in accordance with Federal and State standards for timeliness in a location that is accessible to the beneficiary; and
2. Responsive to particular needs of multi-cultural populations and furnished in a culturally relevant manner; and
3. Responsive to the particular needs of beneficiaries with sensory or mobility impairments and provided with the necessary accommodations; and
4. Provided in the least restrictive, most integrated setting. Inpatient, licensed residential, or other segregated settings shall be used only when less restrictive levels of treatment, service, or support have been, for that beneficiary, unsuccessful or cannot be safely provided; and
5. Delivered consistent with, where they exist, available research findings, health care practice guidelines, best practices, and standards of practice issued by professionally recognized organizations or government agencies.

**PIHP/CMHSP Decisions**
Using criteria for medical necessity, a PIHP/CMHSP or its Administrator may deny services that are:

1. Deemed ineffective for a given condition based upon professionally and scientifically recognized and accepted standards of care;

2. Experimental or investigational in nature; or
3. Services for which there exists another appropriate, efficacious, less-restrictive, and cost-effective service, setting, or support, that otherwise satisfies the standards for medically necessary services; and/or
4. Employ various methods to determine amount, scope, and duration of services, including prior authorization for certain services, concurrent utilization reviews, centralized assessment and referral, gatekeeping arrangements, protocols, and guidelines.

A PIHP/CMHSP may not deny services based **solely** on preset limits of the cost, amount, scope, and duration of services. Instead, determination of the need for services shall be conducted on an individualized basis.

**Legal Issues**

1. Adult involuntary admission of a person requiring treatment must meet the criteria specified in Section 401 (1) of the Michigan Mental Health Code, and be screened, evaluated, referred, and approved by the Payor for admission prior to admittance to the Hospital.
2. Voluntary admission of an eligible person requiring treatment must meet the criteria specified in Chapter 4 Civil Admission and Discharge Procedures: Mental Illness, or Chapter 4A Civil Admission and Discharge Procedures for Emotionally Disturbed Minors of the Michigan Mental Health Code; and be screened, evaluated, referred, and approved for psychiatric inpatient admission by the Payor prior to admittance, in accordance with Section 410 of the Mental Health Code. Other eligible consumers who meet the description in Section 401(2) of the Mental Health Code also may constitute informal or formal voluntary admissions hereunder; said individuals also must be screened, evaluated, and referred for psychiatric inpatient admission by the Payor prior to their admission to the Provider's inpatient unit, pursuant to Section 410 of the Mental Health Code.

## A. Inpatient Psychiatric Care Admission Criteria: Adult

Inpatient psychiatric care may be used to treat a person with a mental illness who requires care in a 24-hour medically structured and supervised facility. The Severity of Illness/Intensity of Service (SI/IS) criteria for admission are based upon the assumption that the beneficiary is displaying signs and symptoms of a serious psychiatric disorder, demonstrating functional impairments, and manifesting a level of clinical instability (risk) that, either individually or collectively, are of such severity that treatment in an alternative setting would be unsafe or ineffective.

Medicaid coverage is dependent upon active treatment being provided at the medically necessary level of care.

**CRITERIA:** The individual must meet all three outlined below:

**Diagnosis** – The beneficiary must be suffering from a mental illness reflected in a primary, validated, current version of DSM or ICD diagnosis (not including ICD-9 V-codes and ICD-10 Z-codes).

1. **Severity of Illness** - signs, symptoms, functional impairments, and risk potential. At least ONE of the following manifestations is present:

   **a) Severe Psychiatric Signs and Symptoms**

   **I.** Psychiatric symptoms - features of intensive cognitive/perceptual/affective disturbance (hallucinations, delusions, extreme agitation, profound depression) severe enough to cause seriously disordered and/or bizarre behavior (e.g., catatonia, mania, incoherence) or prominent psychomotor retardation, resulting in extensive interference with activities of daily living, so that the person cannot function at a lower level of care.

   **II.** Disorientation, seriously impaired reality testing, defective judgment, impulse control problems and/or memory impairment severe enough to endanger the welfare of the person and/or others.

   **III.** A severe, life-threatening psychiatric syndrome or an atypical or unusually complex psychiatric condition exists that has failed, or is deemed unlikely, to respond to less intensive levels of care, and has resulted in substantial current dysfunction.

   **b) Disruptions of Self-Care and Independent Functioning**

   **I.** The person is unable to attend to basic self-care tasks and/or to maintain adequate nutrition, shelter, or other essentials of daily living due to a psychiatric disorder.

   **II.** There is evidence of serious disabling impairment in interpersonal functioning (e.g., withdrawal from relationships; repeated conflictual interactions with family, employer, co-workers and neighbors) and/or extreme deterioration in the person's ability to meet current educational/occupational role performance expectations.

   **c) Harm to Self**

   **I.** Suicide: Attempt or ideation is considered serious by the intention, degree of lethality, extent of hopelessness, degree of impulsivity, level of impairment (current intoxication, judgment, and psychological symptoms), history of prior attempts, and/or existence of a workable plan.

   **II.** Self-Mutilation and/or Reckless Endangerment: There is evidence of current behavior, or recent history. There is a verbalized threat of a need or willingness to self-mutilate,

or to become involved in other high-risk behaviors; and intent, impulsivity, plan, and judgment would suggest an inability to maintain control over these ideations.

**III.** Other Self-Injurious Activity: The person has a recent history of drug ingestion with a strong suspicion of overdose. The person may not need detoxification but could require treatment of a substance induced psychiatric disorder.

**d) Harm to Others**

**I.** Serious assaultive behavior has occurred, and there is a risk of escalation or repetition of this behavior in the near future.

**II.** There is expressed intention to harm others and a plan and/or means to carry it out, and the level of impulse control is non-existent or impaired (due to psychotic symptoms, especially command or verbal hallucinations, intoxication, judgment, or psychological symptoms, such as persecutory delusions and paranoid ideation).

**e) Drug/Medication Complications or Co-Existing General Medical Condition Requiring Care**

**I.** There has been significant destructive behavior toward property that endangers others.

**II.** The person has experienced severe side effects from using therapeutic psychotropic medications.

**III.** The person has a known history of psychiatric disorder that requires psychotropic medication for stabilization of the condition, and the administration, adjustment, or re-initiation of medications requires close and continuous observation and monitoring, and this cannot be accomplished at a lower level of care due to the beneficiary's condition or to the nature of the procedures involved.

**IV.** There are concurrent significant physical symptoms or medical disorders which necessitate evaluation, intensive monitoring, and/or treatment during medically necessary psychiatric hospitalization, and the co-existing general medical condition would complicate or interfere with treatment of the psychiatric disorder at a less intensive level of care.

**Special Consideration: Concomitant Substance Abuse -** The underlying or existing psychiatric diagnosis must be the primary cause of the beneficiary's current symptoms or represent the primary reason observation and treatment is necessary in the psychiatric unit or hospital setting.

**2. Intensity of Service -** The person meets the intensity of service requirements if inpatient services are considered medically necessary for the beneficiary's treatment/diagnosis, and if the person requires at least **one** of the following:

**a)** Close and continuous skilled medical observation and supervision are necessary to make significant changes in psychotropic medications.

**b)** Close and continuous skilled medical observation is necessary due to otherwise unmanageable side effects of psychotropic medications.

**c)** Continuous observation and control of behavior (e.g., isolation, restraint, closed unit, suicidal/homicidal precautions) is needed to protect the beneficiary, others, and/or property, or to contain the beneficiary so that treatment may occur.

**d)** A comprehensive multi-modal therapy plan is needed, requiring close medical supervision and coordination, due to its complexity and/or the severity of the beneficiary's signs and symptoms.

## B. Inpatient Psychiatric Care Admission Criteria: Children Through Age 21

Inpatient psychiatric care may be used to treat a child or adolescent with mental illness or serious emotional disturbance who requires care in a 24-hour medically structured and supervised facility. The SI/IS criteria for admission are based on the assumption that the beneficiary is displaying signs and symptoms of a serious psychiatric disorder, demonstrating functional impairments, and manifesting a level of clinical instability (risk) that are, either individually or collectively, of such severity that treatment in an alternative setting would be unsafe or ineffective.

Medicaid coverage is dependent upon active treatment being provided at the medically necessary level of care.

**CRITERIA:** The individual must meet all three criteria outlined below:

1. **Diagnosis:** The beneficiary must be suffering from a mental illness reflected in a primary, validated, current version of DSM or ICD diagnosis (not including ICD-9 V-codes and ICD-10 Z-codes).

2. **Severity of Illness:** At least one of the following manifestations is present: (signs, symptoms, functional impairment, and risk potential)

   **a) Severe Psychiatric Signs and Symptoms**

   - **I.** Psychiatric symptoms - features of intense cognitive/perceptual/affective disturbance (hallucinations, delusions, extreme agitation, profound depression) severe enough to cause disordered and/or bizarre behavior (e.g., catatonia, mania, incoherence) or prominent psychomotor retardation, resulting in extensive interference with activities of daily living, so that the person cannot function at a lower level of care.
   - **II.** Disorientation, impaired reality testing, defective judgment, impulse control problems and/or memory impairment severe enough to endanger the welfare of the person and/or others.
   - **III.** Severe anxiety, phobic symptoms or agitation, or ruminative/obsessive behavior that has failed, or is deemed unlikely, to respond to less intensive levels of care and has resulted in substantial current dysfunction.

   **b) Disruptions of Self-Care and Independent Functioning**

   - **I.** Beneficiary is unable to maintain adequate nutrition or self-care due to a severe psychiatric disorder.
   - **II.** The beneficiary exhibits significant inability to attend to age-appropriate responsibilities, and there has been a serious deterioration/impairment of interpersonal, familial, and/or educational functioning due to an acute psychiatric disorder or severe developmental disturbance.

   **c) Harm to Self**

   - **I.** A suicide attempt has been made which is serious by degree of lethal intent, hopelessness, and impulsivity.
   - **II.** There is a specific plan to harm self with clear intent and/or lethal potential.
   - **III.** There is self-harm ideation or threats without a plan, which are considered serious due to impulsivity, current impairment, or a history of prior attempts.

**IV.** There is current behavior or recent history of self-mutilation, severe impulsivity, significant risk-taking, or other self-endangering behavior.

**V.** There is a verbalized threat of a need or willingness to self-mutilate, or to become involved in other high-risk behaviors; and intent, impulsivity, plan, and judgment would suggest an inability to maintain control over these ideations.

**VI.** There is a recent history of drug ingestion with a strong suspicion of intentional overdose. The person may not need detoxification but could require treatment of a substance-induced psychiatric disorder.

**d) Harm to Others** –

**I.** Serious assaultive behavior has occurred, and there is a clear risk of escalation or repetition of this behavior in the near future.

**II.** There is expressed intention to harm others and a plan and means to carry it out; the level of impulse control is non-existent or impaired.

**III.** There has been significant destructive behavior toward property which endangers others, such as setting fires.

**IV.** The person has experienced severe side effects from using therapeutic psychotropic medications

**e) Drug/Medication Complications or Co-Existing General Medical Condition Requiring Care**

**I.** The person has a known history of psychiatric disorder that requires psychotropic medication for stabilization of the condition, and the administration, adjustment, or re-initiation of medications requires close and continuous observation and monitoring, and this cannot be accomplished at a lower level of care due to the beneficiary's condition or to the nature of the procedures involved.

**II.** There are concurrent significant physical symptoms or medical disorders which necessitate evaluation, intensive monitoring, and/or treatment during medically necessary psychiatric hospitalization, and the co-existing general medical condition would complicate or interfere with treatment of the psychiatric disorder at a less intensive level of care.

**Special Consideration: Concomitant Substance Abuse** - The underlying or existing psychiatric diagnosis must be the primary cause of the beneficiary's current symptoms or represent the primary reason observation and treatment are necessary in the hospital setting.

**3. Intensity of Service:** The person meets the intensity of service requirements if inpatient services are considered medically necessary and if the person requires at least one of the following:

**a)** Close and continuous skilled medical observation and supervision are necessary to make significant changes in psychotropic medications.

**b)** Close and continuous skilled medical observation are needed due to otherwise unmanageable side effects of psychotropic medications.

**c)** Continuous observation and control of behavior (e.g., isolation, restraint, closed unit, suicidal/homicidal precautions) are needed to protect the beneficiary, others, and/or property, or to contain the beneficiary so that treatment may occur.

**d)** A comprehensive multi-modal therapy plan is needed, requiring close medical supervision and coordination, due to its complexity and/or the severity of the beneficiary's signs and symptoms.

## C. Inpatient Psychiatric Care – Continuing Stay Criteria: Adults, Adolescents and Children

After a beneficiary has been certified for admission to an inpatient psychiatric setting, services must be reviewed at regular intervals to assess the current status of the treatment process and to determine the continued necessity for care in an inpatient setting. Treatment within an inpatient psychiatric setting is directed at stabilization of incapacitating signs or symptoms, amelioration of severely disabling functional impairments, arrestment of potentially life-threatening self/other harm inclinations, management of adverse biologic reactions to treatment, and/or regulation of complicated medication situations. The continuing stay recertification process is designed to assess the efficacy of the treatment regimen in addressing these concerns, and to determine whether the inpatient setting remains the most appropriate, least restrictive, level of care for treatment of the patient's problems and dysfunctions.

Continuing treatment in an inpatient setting may be certified when signs, symptoms, behaviors, impairments, harm inclinations, or biologic/medication complications, similar to those which justified the patient's admission certification, remain present, and continue to be of such a nature and severity that inpatient psychiatric treatment is still medically necessary. It is anticipated that in those reviews which fall near the end of an episode of care, these problems and dysfunctions will have stabilized or diminished.

Discharge planning must begin at the onset of treatment in the inpatient unit. Payment cannot be authorized for continued stays that are due solely to placement problems or the unavailability of aftercare services.

**CRITERIA:** The individual must meet all three criteria outlined below:

1. **Diagnosis:** The beneficiary has a validated current version of DSM or ICD mental disorder (excluding ICD-9 V-codes and ICD-10 Z-codes) that remains the principal diagnosis for purposes of care during the period under review.

2. **Severity of Illness:** At least one of the following manifestations is present. (signs, symptoms, functional impairments, and risk potential)

    **a)** Persistence/intensification of signs/symptoms, impairments, harm inclinations, or biologic/medication complications which necessitated admission to this level of care, and which cannot currently be addressed at a lower level of care:
    **b)** Continued severe disturbance of cognition, perception, affect, memory, behavior, or judgment.
    **c)** Continued gravely disabling or incapacitating functional impairments or severely and pervasively impaired personal adjustment.
    **d)** Continued significant self/other harm risk.
    **e)** Use of psychotropic medication at dosage levels necessitating medical supervision, dosage titration of medications requiring skilled observation, or adverse biologic reactions requiring close and continuous observation and monitoring.
    **f)** Emergence of new signs/symptoms, impairments, harm inclinations, or medication complications, meeting admission criteria.

3. **Intensity of Service:**

    **a)** The beneficiary requires close observation and medical supervision due to the severity of signs and symptoms, to control risk behaviors or inclinations, to assure basic needs are met, or to manage biologic/medication complications.
    **b)** The beneficiary is receiving active, timely, treatment delivered according to an individualized plan of care.
    **c)** Active treatment is directed toward stabilizing or diminishing those symptoms, impairments, harm inclinations, or biologic/medication complications that necessitated admission to inpatient care.

**d)** The beneficiary is making progress toward treatment goals as evidenced by a measurable reduction in signs/symptoms, impairments, harm inclinations, or biologic/medication complications or, if no progress has been made, there has been a modification of the treatment plan and therapeutic program, and there is a reasonable expectation of a positive response to treatment.

Discharge criteria and aftercare planning are documented in the beneficiary's record.

**D.** Partial Hospitalization **Criteria - Adult**

Partial hospitalization services may be used to treat a mentally ill person who requires intensive, highly coordinated, multi-modal ambulatory care with active psychiatric supervision. Treatment, services, and supports are provided for six or more hours per day, five days a week, in a licensed setting. The use of partial hospitalization as a setting of care presumes that the beneficiary does not currently need treatment in a 24-hour protective environment. Conversely, the use of partial hospitalization implies that routine outpatient treatment is of insufficient intensity to meet the beneficiary's present treatment needs. The Severity of Illness (SI)/Intensity of Services (IS) criteria for admission assume that the beneficiary is displaying signs and symptoms of a serious psychiatric disorder, demonstrating significant functional impairments in self-care, daily living skills, interpersonal/social and/or educational/vocational domains, and is exhibiting some evidence of clinical instability. However, the level of symptom acuity, extent of functional impairments and/or the estimation of risk (clinical instability) do not justify or necessitate treatment at a more restrictive level of care.

Medicaid coverage is dependent upon active treatment being provided at the medically necessary level of care.

**CRITERIA** - Must meet all three:

**1.** Diagnosis: The beneficiary must be suffering from a mental illness, reflected in a primary, validated, current version of DSM or ICD Diagnosis (not including ICD-9 V-codes and ICD-10 Z-codes).

**2.** Severity of Illness: **(signs, symptoms, functional impairments, and risk potential).** At least two of the following manifestations are present:

**a) Psychiatric Signs and Symptoms**

**I.** Some prominent disturbance of thought processes, perception, affect, memory, consciousness, somatic functioning (due to a mental illness), or behavior exists (e.g., intermittent hallucinations, transient delusions, panic reactions, agitation, obsessions/ruminations, severe phobias, depression, etc.) and is serious enough to cause disordered or aberrant conduct, impulse control problems, questionable judgment, psychomotor acceleration or retardation, withdrawal or avoidance, compulsions/rituals, impaired reality testing, and/or impairments in functioning and role performance. The disordered or aberrant conduct or activity and/or the level of agitation are not so severe, extreme, or unstable so as to require frequent restraints or to pose a danger to others.

**b) Disruptions of Self-Care and Independent Functioning**

**I.** The person seriously neglects self-care tasks (hygiene, grooming, etc.) and/or does not sufficiently attend to essential aspects of daily living (does not shop, prepare meals, maintain adequate nutrition, pay bills, complete housekeeping chores, etc.) due to a mental disorder.

**II.** Beneficiary is able to maintain adequate nutrition, shelter, or other essentials of daily living only with structure and supervision for a significant portion of the day, and with family/community support when away from the partial hospitalization program.

**III.** The person's interpersonal functioning is significantly impaired (seriously dysfunctional communication, extreme social withdrawal, etc.).

**IV.** There has been notable recent deterioration in meeting educational/occupational responsibilities and role performance expectations.

**c) Danger to Self**

I. There is modest danger to self-reflected in intermittent self-harm ideation, expressed ambivalent inclinations without a plan, non-intentional threats, mild and infrequent self-harm gestures (low lethality/intent), or self-mutilation, passive death wishes, or slightly self-endangering activities.
II. The beneficiary has not made any recent significant (by intent or lethality) suicide attempts, nor is there any well-defined plan for such activity, or, if there have been recent significant actions, these inclinations/behaviors are now clearly under control and the person no longer needs/requires 24-hour supervision to contain self-harm risk.

**d) Danger to Others**

**I.** Where assaultive tendencies exist, there have been no overt actions and there is reasonable expectation, based upon history and recent behavior, that the beneficiary will be able to curb these inclinations.
**II.** There have been destructive fantasies described and mild threats verbalized, but the beneficiary appears to have impulse control, judgment, and reality orientation sufficient to suppress urges to act on these imaginings or expressions.
**III.** There has been minor destructive behavior toward property without endangerment of others.

**e) Drug/Medication Complications**

**I.** The beneficiary has experienced side effects of atypical complexity resulting from psychotropic drugs and regulation/correction/monitoring of these circumstances cannot be accomplished at a lower level of care due to the beneficiary's condition or to the nature of the procedures involved.
**II.** The beneficiary needs evaluation and monitoring due to significant changes in medication or because of problems with medication regimen compliance.

**3. Intensity of Service:** The person meets the intensity of service requirements if partial hospitalization services are considered medically necessary and the person requires at least one of the following:

**a)** The person requires intensive, structured, coordinated, multi-modal treatment and supports with active psychiatric supervision to arrest regression and forestall the need for inpatient care.
**b)** The beneficiary has reached a level of clinical stability (diminished risk) obviating the need for continued care in a 24-hour protective environment but continues to require active, intensive treatment and support to relieve/reverse disabling psychiatric symptomatology and/or residual functional impairments.
**c)** Routine medical observation and supervision required to effect significant regulation of psychotropic medications and/or to minimize serious side effects.

## E. Partial Hospitalization Admission Criteria: Children and Adolescents

Partial hospitalization services may be used to treat a child or adolescent with mental illness or serious emotional disturbance who requires intensive, highly coordinated, multi-modal ambulatory care with active psychiatric supervision. Treatment, services, and supports are provided for six or more hours per day, five days a week, in a licensed setting. The use of partial hospitalization as a setting of care presumes that the beneficiary does not currently need treatment in a 24-hour protective environment. Conversely, the use of partial hospitalization implies that routine outpatient treatment is of insufficient intensity to meet the beneficiary's present treatment needs. The SI/IS criteria for admission assume that the beneficiary is displaying signs and symptoms of a serious psychiatric disorder, demonstrating significant functional impairments in either self-care, daily living skills, interpersonal/social and/or educational/vocational domains, and is exhibiting some evidence of clinical instability. However, the level of symptom acuity, extent of functional impairments, and/or the estimation or risk (clinical instability) do not justify or necessitate treatment at a more restrictive level of care.

Medicaid coverage is dependent upon active treatment being provided at the medically necessary level of care.

**CRITERIA:** Must meet all three criteria outlined below:

1. **Diagnosis**: The beneficiary must be suffering from a mental illness, reflected in a primary, validated, current version of DSM or ICD diagnosis (not including ICD-9 V-codes and ICD-10 Z-codes).

2. **Severity of Illness**: (signs, symptoms, functional impairments, and risk potential). At least two of the following manifestations are present:

    **a) Psychiatric Signs and Symptoms**

    **I.** Some prominent disturbance of thought processes, perception, affect, memory, consciousness, somatic functioning (due to a mental illness), or behavior exists (e.g., intermittent hallucinations, transient delusions, panic reactions, agitation, obsessions/ruminations, severe phobias, depression, etc.) and is serious enough to cause disordered or aberrant conduct, impulse control problems, questionable judgment, psychomotor acceleration or retardation, withdrawal or avoidance, compulsions/rituals, impaired reality testing, and/or impairments in functioning and role performance. The disordered or aberrant conduct or activity and/or the level of agitation is not so severe, extreme, or unstable so as to require frequent restraints or to pose a danger to others.

    **b) Disruption of Self-Care and Independent Functioning**

    **I.** The child/adolescent exhibits significant impairments in self-care skills (feeding, dressing, toileting, hygiene/bathing/grooming, etc.), in the ability to attend to age-appropriate responsibilities, or in self-regulation capabilities, due to a mental disorder or emotional illness.

    **II.** The child/adolescent is able to maintain adequate self-care and self-regulation only with structure and supervision for a significant portion of the day, and with family/community support when away from the partial hospitalization program.

    **III.** There is recent evidence of serious impairment/incapacitation in the child/adolescent's interpersonal and social functioning (seriously dysfunctional communication, significant social withdrawal and isolation, repeated disruptive, inappropriate, or bizarre behavior in social settings, etc.).

**IV.** There is recent evidence of considerable deterioration in functioning within the family and/or significant decline in occupational/educational role performance due to a mental disorder or emotional illness.

**c) Danger to Self**

**I.** There is modest danger to self, reflected in: non-accidental self-harm gestures or self-mutilation actions which are not life-threatening in either intent or lethal potential; intermittent self-harm ideation; expressed ambivalent inclinations without a plan; non-intentional threats; passive death wishes; or slightly self-endangering activities.

**II.** The beneficiary has not made any recent significant (by intent or lethality) suicide attempts, nor is there any well-defined plan for such activity, or, if there have been recent significant actions, these inclinations/behaviors are now clearly under control, and the person no longer needs/requires 24-hour supervision to contain self-harm risk.

**d) Danger to Others**

**I.** Assaultive tendencies exist, and some assaultive behavior may have occurred, but any overt actions have been without any serious or significant injury to others, and there is reasonable expectation, based upon history and recent behavior, that the beneficiary will be able to curb any serious expression of these inclinations.

**II.** There have been destructive fantasies described and mild threats verbalized, but the beneficiary appears to have adequate impulse control, judgment, and reality orientation sufficient to suppress urges to act on these imaginings or expressions.

**III.** There has been minor destructive behavior toward property without endangerment of others.

**e) Drug/Medication Complications**

**I.** The beneficiary has experienced side effects of atypical complexity resulting from psychotropic drugs and regulation/correction/monitoring of these circumstances cannot be accomplished at a lower level of care due to the consumer's condition or to the nature of the procedures involved.

**II.** The beneficiary needs evaluation and monitoring due to significant changes in medication or because of problems with medication regimen compliance.

**3. Intensity of Service**: The person meets the intensity of service requirements if partial hospitalization services are considered medically necessary and the person requires at least one of the following:

**a)** The person requires intensive, structured, coordinated, multi-modal treatment and supports with active psychiatric supervision to arrest regression and forestall the need for inpatient care.

**b)** The beneficiary has reached a level of clinical stability (diminished risk) obviating the need for continued care in a 24-hour protective environment but continues to require active, intensive, treatment and support to relieve/reverse disabling psychiatric symptomatology and/or residual functional impairments.

**c)** Routine medical observation and supervision is required to effect significant regulation of psychotropic medications and/or to minimize serious side effects.

## F. Partial Hospitalization: Continuing Stay Criteria for Adults, Adolescents and Children

After a beneficiary has been certified for admission to a partial hospitalization program, services will be reviewed at regular intervals to assess the current status of the treatment process and to determine the continued necessity for care in a partial hospitalization setting. Treatment within a partial hospitalization program is directed at resolution or stabilization of acute symptoms, elimination or amelioration of disabling functional impairments, maintenance of self/other safety, and/or regulation of precarious or complicated medication situations. The continuing stay recertification process is designed to assess the efficacy of the treatment regimen in addressing these concerns, and to determine whether the partial program remains the most appropriate, least restrictive, level of care for treatment of the beneficiary's problems and dysfunctions.

Continuing treatment in the partial program may be certified when symptoms, impairments, harm inclinations, or medication complications, similar to those which justified the beneficiary's admission certification, remain present, and continue to be of such a nature and severity that partial hospitalization treatment is still medically necessary. It is anticipated that in those reviews which fall near the end of an episode of care, these problems and dysfunctions will have stabilized or diminished.

Discharge planning must begin at the onset of treatment in the program. Payment cannot be authorized for continued stays that are due solely to placement problems or the unavailability of aftercare services.

**CRITERIA -** Must meet <u>all</u> three criteria outlined below:

1. **Diagnosis:** The beneficiary has a validated current version of DSM or ICD mental disorder (excluding ICD-9 V-codes and ICD-10 Z-codes), which remains the principal diagnosis for purposes of care during the period under review.

2. **Severity of Illness:** (signs, symptoms, functional impairments, and risk potential)

   **a)** Persistence of symptoms, impairments, harm inclinations, or medication complications which necessitated admission to this level of care, and which cannot currently be addressed at a lower level of care.
   **b)** Emergence of new symptoms, impairments, harm inclinations, or medication complications meeting admission criteria.
   **c)** Progress has been made in ameliorating admission symptoms or impairments, but the treatment goals have not yet been fully achieved and cannot currently be addressed at a lower level of care.

3. **Intensity of Service:**

   **a)** The beneficiary is receiving active, timely, intensive, structured multi-modal treatment delivered according to an individualized plan of care.
   **b)** Active treatment is directed toward stabilizing or diminishing those symptoms, impairments, harm inclinations, or medication complications that necessitated admission to the program.
   **c)** The beneficiary is making progress toward treatment goals, or, if no progress has been made, the treatment plan and therapeutic program have been revised accordingly, and there is a reasonable expectation of a positive response to treatment.

   Discharge criteria and aftercare planning are documented in the beneficiary's record.

## SECTION III. AUTHORIZATIONS, REAUTHORIZATIONS, ADMISSIONS, DISCHARGES

### A. Authorizations

CMHSP has contractual responsibility to "prescreen" all Medicaid covered and indigent persons seeking or being referred for psychiatric care with PROVIDER. CMHSP's obligation is to authorize reimbursement for all individuals enrolled in Medicaid or indigent as defined in this Provider Manual utilizing the Inpatient Affiliation's level of care protocols. Pre-screenings are conducted by clinicians who are credentialed by CMHSP to assess the mental health needs of individuals experiencing psychiatric crises to determine the level of care most appropriate for their assessed treatment need. This service is routinely provided by the CMHSP's Emergency Services clinicians.

**1.** CMHSP must prescreen all persons enrolled in Medicaid as primary insurance or indigent who present in psychiatric crisis, are referred due to psychiatric crisis, or come to PROVIDER independently seeking psychiatric hospitalization.

**2.** If the CMHSP determines that inpatient/partial hospitalization is the most appropriate level of care to address the person's psychiatric crisis, PROVIDER will be given an authorization which supports reimbursement for Medicaid beneficiaries or indigent individuals for an identified number of days. Authorized days to cover the stay until the next business day (typically not to exceed three consecutive days).

**3.** Prior-authorized and approved continued stay review inpatient and partial hospitalization days may be subject to retrospective review by the Lakeshore Regional Entity. ***Retrospective review is defined as the process of approving or denying payment for inpatient/partial hospitalization care after the individual has been discharged.*** In the event that documentation does not support level of care and/or is not consistent with information provided during the continued stay review, services may be subject to recoupment.

**4.** Medicaid funds may only be used for inpatient stays that meet criteria as outlined in the Michigan Medicaid Provider Manual. **All other funding sources must be exhausted prior to accessing Medicaid funds**.

**a)** In circumstances where an individual in foster care placement no longer meets criteria for hospitalization and there is no safe, effective, or appropriate discharge, residence, or alternative level of care available, PROVIDER is responsible for coordinating funding options with the foster care agency.

**5.** Electroconvulsive Therapy (ECT) requires prior authorization from CMHSP.

### B. Admissions

**1.** CMHSP will assume the following responsibilities:

**a)** Complete Involuntary Commitment Petition/Application with, or prior to, admission.

**b)** Provide identification data such as: service individual's name, age, marital status, financial information, etc.; and history of circumstances surrounding the present difficulties. *

**c)** Provide past medical and psychiatric history, minimally including allergies, alcohol and drug use, current medications, any pertinent medical conditions, and any pertinent past psychiatric history. *

**d)** Summarize the mental status examination completed by a mental health professional and provide a diagnostic impression of psychiatric and medical conditions. *

**e)** Provide an initial management/treatment plan stating the individual's problems, potential problems, and possible interventions. *

**f)** Participate in individual's deferred treatment process.
**g)** Contact the psychiatric unit admission staff to ascertain bed availability and provide a verbal report of the information available on the individual referred by CMHSP. If there is a bed available and the admission staff has accepted the CMHSP referral, the CMHSP staff shall be responsible for making arrangements for transportation of the individual to PROVIDER psychiatric unit.
**h)** Maintain all necessary contacts with the Court system regarding involuntary patients, inform PROVIDER regarding those contacts, and complete alternative treatment arrangements when necessary.

***To be completed and received by the inpatient facility prior to or, at least within 24 hours.***

**2.** PROVIDER will assume the following responsibilities:
**a)** Accept or deny the individual referred by CMHSP based on bed availability and clinical appropriateness. PROVIDERs shall not distinguish between referrals from CMHSP and other referral sources in the quality of care and access to services.
**b)** Emergency access, admission, and all treatment services will be available twenty-four (24) hours daily and seven (7) days a week. Provide a 24-hour contact telephone number for admissions.
**c)** Inform authorizing agency (LRE or CMHSP) of all Medicaid/Medicare admissions or when Medicaid is secondary to another third-party insurance during business hours or the next business day.
**d)** Coordinate the services provided with CMHSP. Notify Medicaid Health Plan and/or Primary Care Physician regarding medical and mental health issues.
**e)** Contact CMHSP for coordination of care and to arrange discharge planning and response to treatment updates. PROVIDER and CMHSP staff, functioning as an interdisciplinary treatment team, shall conduct discharge procedures and aftercare planning.
**f)** Prepare all transfer materials in the event that the individual is transferred to a medical or State Facility.
**g)** Provide complete preliminary discharge information to CMHSP and the Primary Care Physician within forty-eight (48) hours of discharge.
**h)** Notify CMHSP of the deferred treatment plan that will be presented to the individual and his/her attorney at the deferred treatment conference.
**i)** If the individual and his/her attorney reject the deferred treatment plan, the individual's need for treatment and type of treatment will be determined by the Probate Court. If all parties agree, the deferred treatment plan has the same effect as a Probate Court order for a maximum period of ninety (90) days.
**j)** Any relocation of individuals involving PROVIDER and another inpatient facility must have the prior authorization of the CMHSP.

**3.** Involuntary Admissions - Provider shall be liable for adhering to The Michigan Mental Health Code Act 258 of 1974 (Section 330.1401 – Section 330-1473) as related to Involuntary Admissions. CMHSPs reserves the right to request medical records in the event of an involuntary admission to ensure adherence to the Michigan Mental Health Code. CMHSPs also reserves the right to deny payment and/or authorization of services if it is determined that any portion of the Michigan Mental Health code was not followed within the required timelines.

## C. Re-Authorizations

LRE and/or CMHSP has responsibility to complete "continued stay reviews" (CSR) for Medicaid covered and indigent individuals hospitalized through the prescreening process. Medicaid Provider Manual criteria for continued stay will be utilized to determine the need for continued hospitalization beyond the number of days authorized at prescreening or authorized by LRE and/or CMHSP following subsequent continued stay reviews completed by LRE or CMHSP staff.

1. PROVIDER will notify CMHSP's designated contact person if PROVIDER decides to discharge the patient prior to the expiration of days authorized at prescreening or from a subsequent continued stay review and if PROVIDER believes the person is ready for discharge.

2. PROVIDER's assigned continued stay review clinician will contact authorizing agency (LRE or CMHSP) to complete continued stay reviews for patients for whom PROVIDER is seeking inpatient care beyond the days authorized by either the initial prescreening or a subsequent continued stay review.

3. Authorizing agency's assigned continued stay review clinician will be provided access to the patient and all pertinent PROVIDER clinical records for determining the necessity for continued inpatient care. If access to PROVIDER records is denied, no further inpatient days will be authorized.

4. PROVIDER and/or treating psychiatrist has the right to request a claims reconsideration of the authorizing agency's continued stay review decision as outlined in Section V.E of the Inpatient Provider Manual.

5. Discharge planning/coordination of care for all Medicaid covered and indigent individuals shall involve CMHSP staff for the purpose of clarifying, coordinating, and implementing aftercare services.

## D. Coordination of Care/Discharge Planning

1. Coordination of Care/Discharge planning to commence from time of admission. PROVIDER and CMHSP to coordinate all after-care activities.
2. At the time of discharge, PROVIDER will communicate the individual's discharge information to the authorizing agency within one (1) business day. Discharge information must include:
   - **a)** Discharge date
   - **b)** Discharge diagnosis(es)
   - **c)** Medications prescribed at the time of discharge
   - **d)** Individual's discharge presentation
   - **e)** Legal Status at time of discharge
   - **f)** Aftercare plans, including:
     - **I.** Appointment dates
     - **II.** Appointment times
     - **III.** Aftercare provider agencies
     - **IV.** Name of aftercare provider/clinician
     - **V.** Living arrangements
     - **VI.** Means of transportation
   - **g)** Challenges/barriers to completing aftercare plan

3. PROVIDER will provide CMHSP with a complete discharge packet within three (3) business days of the date of discharge. The discharge packet shall include the diagnosis and an interdisciplinary team summary of the individual's course of treatment, nature of significant family or interpersonal relationship issues, current medications, prognosis, and recommendations.

4. At discharge, PROVIDER shall provide the individual with a minimum of a two (2)-week prescription for medication with one (1) refill. PROVIDER shall be responsible for the prior authorization of all prescribed medications.

5. For indigent patients, PROVIDER agrees to prescribe medications within the authorizing CMHSP's medication formulary if one is made available to the Provider.

## E. Continued Stay Review

**1.** LRE (or their Administrator)/CMHSP will:

**a)** Conduct continued stay review for inpatient admissions and partial hospitalization to:

**I.** Verify that medical necessity criteria are met

**II.** Verify that coordination of care/discharge planning is occurring from time of admission

**III.** Authorize payment for days of care based on medical necessity criteria as defined in the Medicaid Provider Manual

**b)** Communicate CSR decision to the inpatient provider.

**2.** PROVIDER will:

**a)** Provide clinical information to authorizing agency to determine continued stay appropriateness.

**b)** Report ongoing coordination of care/discharge planning to authorizing agency

**c)** Coordinate with authorizing agency regarding frequency of and schedule for continued stay review.

**d)** Communicate any concerns to the authorizing agency regarding clinical barriers that may impact over or under utilization of service length of stay or discharge.

## F. Dispute Resolution Process for Denial of Inpatient/Partial Hospitalization Days

**1.** In circumstances where authorizing agency had denied authorization for payment of continued stay for a current inpatient/partial inpatient placement based on medical necessity, the facility has the option to request an expedited formal review by a physician identified by the authorizing agency**.**

**a)** Should the provider choose to engage in the expedited formal review, a Request for Formal Appeal (RFA) form must be completed and submitted by the facility to the authorizing agency within one business day of denial of authorization.

**b)** If the RFA form is not received within one business day of denial of authorization, it is understood that the facility agrees with the initial determination and does not wish to request a reconsideration of the initial determination.

**c)** Upon receipt of the RFA, authorizing agency will coordinate the physician-to- physician review process

**2.** In circumstances where authorizing agency has denied authorization for payment of continued stay based on medical necessity for an individual who has been discharged from the facility:

**a)** The facility may submit an RFA form within seven (7) business days of the initial determination to the authorizing agency.

**b)** If the RFA form is not received within seven (7) business days, it is understood that the facility agrees with the initial determination and does not wish to request a reconsideration of the initial determination.

**c)** Upon receipt of the RFA, the authorizing agency will coordinate review of the clinical documentation with the identified physician reviewer.

## SECTION IV. ACCESS TO CLINICAL SERVICES IN THE COMMUNITY MENTAL HEALTH SYSTEM

**Allegan County Community Mental Health** - Emergency services are available 24 hours a day, 7 days a week and can be reached through the following phone numbers.
269-673-6617
800-795-6617

**Community Mental Health of Ottawa County** - Emergency services are available 24 hours a day, 7 days a week and can be reached through the phone numbers listed below.

| | |
|---|---|
| Monday through Friday, 8:00 a.m. to 5:00 p.m. | 877-588-4357 |
| All Other Days and Times | 866-512-4357 |

**HealthWest** Emergency services are available 24 hours a day, 7 days a week and can be reached through the phone numbers listed below. Call and ask for the Emergency Services worker on staff that day, or walk in.

| | |
|---|---|
| Monday through Friday, 8:00 a.m.-5 00 p.m. | 231-720-3200 |
| After hours/weekends/holidays | 231-722-4357 |

**Kent County CMH Authority d/b/a Network180** -Emergency services are available 24 hours a day, 7 days a week and can be reached through the phone number: 616-336-3909

**West Michigan Community Mental Health** - Emergency services are available 24 hours a day, 7 days a week and can be reached through the phone numbers listed below.

| | |
|---|---|
| Ludington Site | 231-845-6294 |
| Baldwin Site | 231-745-4659 |
| Hart Site | 231-873-2108 |

## INPATIENT DISCHARGE INSTRUCTION SHEETS, PACKETS CONTACTS

### ALLEGAN COUNTY COMMUNITY MENTAL HEALTH

Michell Truax
P.O. Drawer 130 Phone: 269-673-6617
Allegan, MI 49010 Fax: 269-673-2738

### COMMUNITY MENTAL HEALTH OF OTTAWA COUNTY

Chris Madden
12265 James Street Phone: 616-494-5450
Holland, MI 49424 Fax: 616-393-5653

### HEALTHWEST

Access Center
376 E. Apple Avenue Phone: 231-720-3200
Muskegon, MI 49442 Fax: 231-720-3299

### KENT COUNTY CMH AUTHORITY D/B/A NETWORK 180

Access Center Medical Records
790 Fuller NE Phone: 616-336-3909
Grand Rapids, MI 49503 Fax: 616-336-2475

**In addition to sending discharge packets to Network180, Provider discharge packets can be sent directly to the following sites:**

### Adults with Mental Illness:

**Cherry Street Health Services**
100 Cherry, SE
Grand Rapids, MI 49503
Phone: 616-965-8200
Fax: 616-940-5367

**InterAct of Michigan**
1131 Ionia, NE
Grand Rapids, MI 49503
Phone: 616-259-7900
Fax: 616-259-7909

**Hope Network Behavioral Health**
3075 Orchard Vista Drive SE
Grand Rapids, MI 49546
Phone: 616-301-8000
Fax: 616-235-2066

**Pine Rest Community Case Management**
339 S. Division
Grand Rapids, MI 49502
Phone: 616-222-4570
Fax: 616-222-4571

## Children/Adolescents:

**Bethany Christian Services**
901 Eastern N.E.
Grand Rapids MI 49503
Phone: 616-224-7617
Fax: 616- 224-7593

**Spectrum Community Services**
3353 Lousma Dr. S.E.
Wyoming MI 49548
Phone: 616-719-4263
Fax: 616-719-4267

**Wedgwood Christian Services**
3300-36th S.E.
Grand Rapids MI 49512
Phone: 616-942-2110
Fax: 616- 942-0589

**Family Outreach Center**
1939 S. Division
Grand Rapids, MI 49507
Phone: 616-247-3815
Fax: 616-245-0450

**D.A. Blodgett - St. John's**
805 Leonard, NE
Grand Rapids, MI 49503
Phone: 616-451-2021
Fax: 616-451-8936

**Arbor Circle**
1115 Ball, NE
Grand Rapids, MI 49505
Phone: 616-456-7775
Fax: 616-456-8568

**Easter Seals**
4065 Saladin Drive
Grand Rapids, MI 49546
Phone: 616-942-2081
Fax: 616-942-5932

## WEST MICHIGAN COMMUNITY MENTAL HEALTH

Tracy Bonstell
920 Diana
Ludington, MI 49431
Phone: 231-843-5420
Fax: 231-845-7095

## SECTION V. FINANCE

### A. Financial Responsibility

1. A person eligible for Board services is defined as an individual who receives, or is eligible to receive, a CMHSP subsidy, or who is eligible for Medicaid services under the Medicaid Provider Manual in the Behavioral Health and Intellectual and Developmental Disabilities Supports and Services Section, or who is enrolled in the MI Child program. Access referral and authorization procedures are found in Section B.
2. The CMHSP will determine the financial eligibility of the consumer for CMHSP services, based on the individual's insurance and ability to pay. In some situations, the CMHSP will not have all the necessary financial information at the point of an intake/authorization. The Hospital will provide evidence of efforts to establish consumer eligibility and will assist the consumer with completing an application for Medicaid coverage.
3. CMHSP may deny payment for any inpatient or partial hospitalization days of care when there is not **documentation** of the Hospital's efforts to establish a consumer's eligibility and/or application for Medicaid coverage. CMHSP may **not** deny payment when the Hospital has provided evidence that: (1) an individual's primary coverage other than Medicaid is found to be invalid; **and** (2) there is no ability to pay; **and** (3) admission meets Medicaid Medical Necessity and the Affiliation's Service Selection Guidelines.
4. If a consumer has more than one insurance policy, the consumer will be asked to verify which insurance is primary, secondary, etc. If the consumer is unable to verify his/her insurance, a call will be placed to the insurance company(ies) to ensure proper billing.

If a consumer has Medicaid along with another insurance, Medicaid is always secondary to the other insurance. Verification of benefits is obtained by calling MediFAX/MPHI.

## Contacts for the Medicaid application and information relating to benefits

**Allegan County Community Mental Health**

P.O. Drawer 130
Allegan, MI 49010
269-673-6617

**Community Mental Health of Ottawa County**

For Medicaid applications:
Customer Services
12265 James Street
Holland, MI 49424
(616) 494-5545

For Facility Admission Notice:
Chris Madden
12265 James Street
Holland, MI 49424
(616) 494-5450

**HealthWest**

376 E. Apple Avenue
Muskegon, MI 49442
231-724-3633

**Kent County CMH Authority d/b/a Network 180**

Senior Claims Examiner
Network180 Reimbursement Department
Kent County CMH Authority d/b/a network180
790 Fuller NE
Grand Rapids, MI 49503
616-336-3909

**West Michigan Community Mental Health**

Reimbursement Department
920 Diana Street
Ludington, MI 49431
231-845-6294

## B. Billing and Payment Conditions

**1.** The payment is considered to be an all-inclusive rate as described in Section A. Services not prior authorized will not be reimbursed. The rate will be effective based on the first day of the episode and not the service date. Inpatient stays of less than one (1) day will be paid at the per diem rate, and the code required for the claim is **762-Extended Observation Day.**

**2**. Valid claims shall be electronically submitted for CMHSP authorized consumers on HIPAA-compliant transactions (837 submissions) within 180 days from the end of the month in which the consumer was discharged. Business to business testing of transactions may be necessary. A clean claim will contain the required consumer data and the ability to pay and reimbursement information. The codes required for the claims are **100-Inpatient** and **912-Partial Hospitalization**. Appropriate documentation of service delivery must also exist in the medical record.

**3.** For individuals with Medicaid and/or other insurance, a claim is filed to the primary insurance according to the procedure of the Hospital. Once a payment is received from primary insurance, a contractual allowance (if any) is taken. A claim is then sent to the secondary insurer, with a copy of the primary explanation of benefits as appropriate. If a rejection is received from the primary insurance, a determination is made based on the reason for denial. Only the amount listed as copay or deductible will be sent to the secondary insurer. There will be 90 days allowed for the submission of claims after Medicaid or indigent status is no longer pending third party approval.

**4.** "Clean" Claims for authorized services provided by the CMHSP Boards of Allegan, Kent, Muskegon, Ottawa, and West Michigan Community Mental Health will be processed and paid within 30 days of receipt of complete and accurate claims.

**5.** Payment from the CMHSP is considered payment in full and will not exceed the contracted per diem. The Hospital agrees not to bill, charge, collect a deposit from, seek compensation from, seek reimbursement from, surcharge, or have any recourse against a consumer or persons acting on behalf of a consumer, except to the extent the applicable Health Plan specifies a co-payment, coinsurance, consumer fee based on the ability to pay and deductibles.

**6.** Questions regarding payments and claims status should be directed to the contact person listed for each CMHSP.

**7.** The Hospital will at least annually audit their claims to ensure billing integrity. A Plan of Correction will be required, and additional audits will be performed if there are significant findings. The audits and Plans of Correction will be available to CMHSP staff upon request. The Hospital is required to prepare a claim adjustment for any claim determined to have been inappropriately billed during the Hospital audit.

*** All claims should be sent to the following addresses:**

**Allegan County Community Mental Health**
P.O. Drawer 130
Allegan, MI 49010
269-673-6617

**Community Mental Health of Ottawa County**
12265 James Street
Holland, MI 49424
616-393-5673

**HealthWest (previously CMHS of Muskegon County)**
Claims Department
376 E. Apple Avenue
Muskegon, MI 49442
231-724-1174

**Kent County CMH Authority d/b/a Network 180**
Senior Claims Examiner
Claims Unit
790 Fuller NE
Grand Rapids, MI 49503
616-336-3909

**West Michigan Community Mental Health**
Claims Processing Department
920 Diana Street
Ludington, MI 49431
231-845-6294

## C. Authorization and Payment Procedures

### 1. Inpatient and Partial Hospitalization Services

| Benefit Structure | Authorization | Payment |
|---|---|---|
| Medicare/Medicaid<br><br>Medicare Deductible and co-insurance amounts covered by Medicaid. | Pre-authorizations are not required, but **notification is required within 15 days of discharge.** | Payment is to be made based on Michigan Medicaid Provider Manual rules in effect at the time of the admission. |
| Medicare/Medicaid<br><br>Medicare days expired during the inpatient stay. | No pre-authorization, but **notification is required within 15 days of discharge**. Billing office notifies CMHSP when Medicare days have expired. If medical necessity criteria are met, authorization back to the Medicare expiration will be completed and CSR process will be in place, or a retrospective review will be completed if notification occurs post-discharge. | CMHSP will pay the balance of contracted per diem not covered by insurance up to the contracted amount. |
| Commercial Insurance/Medicaid:<br><br>Commercial Insurance pays percentage of per diem. | No pre-authorization. Provider must request retrospective review after determination that CMHSP has a financial obligation.* | CMHSP will pay the balance of the Third Party Liability (TPL) deductible and co-insurance, if the TPL allowed amount (Provider payment plus contract adjustment) is less than the total contracted per diem rate. |
| Commercial Insurance/Medicaid:<br><br>Commercial Insurance pays for specified number of days, or dollar amount, and Medicaid pays the remainder. | No pre-authorization, but notification is requested. Billing office notifies CMHSP when Commercial insurance is non-existent or commercial insurance days have expired. If medical necessity criteria are met, authorization back to the expiration of the commercial insurance will be completed and CSR process will be in place, or a retrospective review will be completed if notification occurs post-discharge. | CMHSP will pay the balance of contracted per diem not covered by the TPL that meets criteria or the full per diem if the insurance is non-existent. |
| **Benefit Structure** | **Authorization** | **Payment** |

| | | |
|---|---|---|
| Commercial Insurance with Medicaid or Medicaid eligibility received retroactively. | Retrospective review * following Medicaid eligibility and notification to CMHSP. | CMHSP will pay the balance of the TPL deductible and co-insurance, if the TPL allowed amount (Provider payment plus contract adjustment) is less than the total contracted per diem rate. |
| Medicare Insurance Only. | No pre-authorization or retrospective authorizations necessary. | No CMHSP payment. |
| Commercial Insurance Only:<br><br>Days expired during the inpatient stay. | No authorization or CSR process. | CMHSP funds will not be authorized. CMHSP does not supplement insurances. |
| Commercial Insurance Only:<br><br>Policy terminated prior to admission **or** policy does not have a provision for inpatient mental health benefit **AND** no ability to pay.<br><br>(This does not include people who have used up their inpatient days on their policy.) | Hospital Billing office notifies CMHSP. Hospital staff completes an ability to pay with the consumer. If medical necessity is met, authorization back to the date of admission will be completed, and CSR process will be in place, or a retrospective review will be completed if notification occurs post-discharge. | CMHSP funds will be authorized for approved days of care per review. |

**** Retrospective reviews will be completed by CMHSP within 30 days of receipt of documentation.***

NOTE: **CMHSP or its Administrator may deny payment for any inpatient or partial hospitalization days of care when there is no documentation of the Hospital's efforts to establish a consumer's eligibility and/or application for Medicaid coverage. CMHSP may not deny payment when the Hospital has provided evidence that: (1) an individual's primary coverage other than Medicaid is found to be invalid; (2) there is no ability to pay; and (3) admission meets Medicaid Medical Necessity and the Affiliation's Service Selection Guidelines.**

## D. CMHSP's Process for Responding to a CMHSP denied claim.

**1.** Any claims to be resubmitted must be resubmitted within **120 days** of the date of the Denied Claims Report for CMHSP process. If a Hospital error was made in billing, the Hospital will make the necessary correction(s) and resubmit the claim. If after checking for errors the Hospital believes that the claim was rejected due to an error in the CMHSP claims processing system, the Hospital will submit the reason for the appeal in writing to CMHSP, along with any copies of backup evidence. The Hospital should send this information to CMHSP to the attention of the following individual:

| | |
|---|---|
| **ALLEGAN** | Allegan County Community Mental Health<br>P.O. Drawer 130<br>Allegan, MI 49010 |
| **MUSKEGON** | Mental Health Comptroller<br>HealthWest<br>376 E. Apple Avenue<br>Muskegon, MI 49442 |
| **OTTAWA** | Mental Health Financial Manager<br>CMH of Ottawa County<br>12265 James Street<br>Holland, MI 49424 |
| **KENT** | Claims Appeal Department<br>Attn: Reimbursement Manager<br>Kent County CMH Authority d/b/a network180<br>790 Fuller NE<br>Grand Rapids, MI 49503 |
| **WEST MICHIGAN** | Claims Processing Department<br>West Michigan Community Mental Health<br>920 Diana Street<br>Ludington, MI 49431 |

**2.** CMHSP may deny payment based on denial of admission, denial of continued stay, and retrospective review. In these cases, the initial request for CMHSP authorization for payment of an admission, additional days during a continued stay review, or a retrospective review (defined as the process of approving payment for inpatient care after the individual has been discharged) may be denied by the Utilization Management Department, e.g., master's level clinician. In cases of denial, the CMHSP staff must clearly identify in writing the utilization management criteria used for making the decision and the alternative service offered. If CMHSP denies payment based on any one of these reasons, the facility may submit a Request for Claims Reconsideration Form C060P. (See form at the end of this section.) CMHSP then sends a decision to the inpatient facility.

3. Within **seven (7) business** days of the CMHSP or PIHP decision to deny a claim, the inpatient facility may then file an appeal of that decision through the process detailed below.
   **a)** Facility will complete the Request for Claims Reconsideration Form (C060P). (See form at the end of this section.)

   Complete all fields and fax the completed form to Inpatient Appeals.

   | | |
   |---|---|
   | **Allegan County Community Mental Health:** | **(269) 673-2738** |
   | **HealthWest:** | **(231) 724-4545** |
   | **Community Mental Health of Ottawa County:** | **(616) 393-5653** |
   | **Kent County CMH Authority d/b/a Network 180:** | **(616) 336-8830** |
   | **West Michigan Community Mental Health System:** | **(231) 845-7095** |

   **b)** For clinically-based appeals, clearly identify the symptoms and functioning documentation for Medical Necessity and Clinical Appropriateness to support the service being requested as defined by the service eligibility criteria for inpatient/partial hospitalization care. (Part III)

   **c)** The facility may request an expedited review for denied urgent care, e.g., admissions denials or denied continued stay days, by checking the section on the bottom of the form. An expedited review is defined as a request to change a denial for urgent care in which the typical time frame for reviews seriously jeopardizes the life or health or ability of the consumer to regain maximum function. It must be supported by information cited in Part III.

4. CMH will document the review of the request for reconsideration by completing the Reconsideration Decision Form (C010P). (See form at the end of this section.)
   **a)** A CMHSP Master's level staff person not involved in the prior adverse decision is appointed to review the appeal. They have the authority to approve services for which there are explicit criteria, however, in the case of clinical issues, they do not have the authority to deny.
   **b)** Stay-days, a same specialty practitioner must do the review (a practitioner with similar credentials and licensure as those who typically treat the condition or health problem in question in the appeal), for example, a child psychiatrist reviewing a child case appeal.
   **c)** The reviewing psychiatrist will review the request and may contact the requesting facility psychiatrist. The reviewing psychiatrist will document his/her findings in the Summary of Peer Contact section of the form (Part IV) and fax the form to the inpatient facility.
   **d)** Within **thirty (30) days** of receipt of the facility request, a decision on an appeal for a retrospective review will be completed by CMHSP.
   **e)** Within **forty-eight (48) hours** of receipt of the facility request, a decision on an expedited request for continued stay days will be completed by CMHSP.
   **f)** Within **three (3) business days, excluding Sundays and legal holidays**, a denial of admissions that is not a retrospective review will be completed by CMHSP.

## E. Reconsideration Decision

| PART I: TO BE COMPLETED BY CMHSP | |
|---|---|
| **Consumer Name**: Click here to enter text. | **Date of Review**: Click here to enter text. |
| **Consumer DOB:** Click here to enter text. | **Identified CMHSP:** Click here to enter text. |
| **Facility**: Click here to enter text. | **CMHSP Clinical Record #**: Click here to enter text. |
| **Admission Authorization #** | **Attending Physician**: Click here to enter text. |
| **Admission Date**: Click here to enter text. | **Discharge Date**: Click here to enter text. |
| **Denied Dates – From**: Click here to enter text. | **Denied Dates – To**: Click here to enter text. |

**PART II: TYPE OF REVIEW (CHECK ONLY ONE)**

**Admission**

☐ Inpatient Hospitalization ☐ Partial Hospitalization ☐ Crisis Residential

**Continued Stay Review**

☐ Inpatient Hospitalization ☐ Partial Hospitalization ☐ Crisis Residential

**Retrospective Review**

☐ Inpatient Hospitalization ☐ Partial Hospitalization ☐ Crisis Residential

**PART III: DECISION**

Date of Decision: Insert date.

☐ Approved; Approved For: **(insert number)** days, Beginning **(insert date)** and Ending **(insert date)**

☐ Denied; Date of Decision: Click here to enter text.

☐ Denied; THE REQUEST WAS NOT RECEIVED BY **(Insert Date)** AS INDICATED VERBALLY TO **(Insert Name)** AND IN THE INITIAL DETERMINATION LETTER SENT ON **(Insert Date).** THE RECONSIDERATION REQUEST IS NOT A TIMELY REQUEST AND WILL NOT BE REVIEWED.

**PART IV: RATIONALE FOR DECISION**

Click here to enter text.

Name of Reviewer and Credentials: Click here to enter text. Date: 2/28/2017

Reviewer Signature:

**PART V: PHYSICIAN/PSYCHIATRIC REVIEW (REQUIRED ONLY FOR A RECONSIDERATION DENIAL DECISION)**

Summary of Peer Contact:

Physician/Psychiatrist Signature: Please see attached report

Date:

**PART VI: CMHSP STAFF CONTACT**

Authorizing Signature: Date:

Phone Number: Fax Number:

**REQUEST FOR CLAIMS RECONSIDERATION**

*To be completed by Hospital*

**TYPE OF PROGRAM:** Date: _____

☐ Inpatient ☐ Partial Hospitalization ☐ Crisis Residential

**Facility Name:** _____ **Identified CMHSP**_____

**PART I:**

| | | |
|---|---|---|
| Client Name: | Date of Birth: | CMHSP ID#: |
| Admit Date: | Discharge Date: | Diagnosis: |
| Attending Physician: | | |
| Reconsideration Request Dates: | From: | To: |
| Dates of Care Authorized: | From: | To: |

**PART II: TYPE OF RECONSIDERATION REQUEST** (Check only one)

| | | |
|---|---|---|
| **(1) Denial of Admission** | | |
| ☐ Inpatient Hospitalization | ☐ Partial Hospitalization | ☐ Crisis Residential |
| **(2) Denial of Continued Stay** | | |
| ☐ Inpatient Hospitalization | ☐ Partial Hospitalization | ☐ Crisis Residential |
| **(3) Retrospective Review** | | |
| ☐ Inpatient Hospitalization | ☐ Partial Hospitalization | ☐ Crisis Residential |

**PART III: RATIONALE FOR RECONSIDERATION**

_____

_____

_____

_____

_____

_____

Check if this is an Expedited Request ☐

Signature _____ _____ _____ AM/PM

Physician/Psychiatrist Date Time

## SECTION VI. QUALITY INDICATORS / PERFORMANCE STANDARDS

1. Average Length of Stay (ALOS): CMHSP will measure ALOS per episode for individuals for whom CMHSP is financially responsible. ALOS will be calculated by dividing total patient days by total discharges per month.

2. Access to Services: CMHSP will track the numbers and reasons for inpatient hospitalization denials.

## SECTION VII. PROVIDER OBLIGATIONS TO RECIPIENT RIGHTS PROTECTION (LICENSED PSYCHIATRIC HOSPITAL/UNIT)

The responsibilities of the Provider in relationship to the Rights of the Recipients served under the authority granted by this contract include the following:

**A.** The Provider agrees that recipients under contract will be protected from recipient rights violations while receiving inpatient or partial hospitalization services, in compliance with Chapter 7 and 7a of the Mental Health Code and with other Federal and State laws and regulations applicable to its services.

**B.** The Provider agrees to annually provide copies of their Recipient Rights policies and procedures for review by the Payor's Recipient Rights Officer. At a minimum, the Provider agrees to submit all policies and procedures required by the Michigan Mental Health Code, MCLA 330.1752 and the additional policies listed below as follows:

1. Recipient Rights complaint and appeal processes.
2. Informed consent to treatment and services.
3. Family Planning.
4. Fingerprinting, photographing, audio taping, one-way glass.
5. Abuse and neglect.
6. Confidentiality and disclosure.
7. Treatment by spiritual means.
8. Qualifications and training for recipient rights staff.
9. Change in type of treatment.
10. Medication procedures.
11. Use of psychotropic drugs.
12. Use of restraint.
13. Right to be treated with dignity and respect.
14. Least restrictive setting.
15. Services suited to condition.
16. Right to entertainment material, information, and news.
17. Comprehensive examinations.
18. Property and funds.
19. Freedom of movement.
20. Resident labor.
21. Communication and visits.
22. Use of seclusion.
23. Individual Plan of Service.

24. Person-Centered Planning.
25. Grievance and Appeal.

**C**. The Provider agrees that all of its employees will receive training in Recipient Rights protection within 30 days of hire and **at least every three (3) years** thereafter if requested by the Payor's Recipient Rights Officer, but minimally upon substantive revisions to Federal and/or State law, rules, or regulations.

**D**. The Provider will monitor the safety and welfare of recipients while they are under its service supervision pursuant to the contract and provide immediate comfort and protection to and assure immediate medical treatment for a recipient who has suffered physical injury.

**E**. The Provider agrees that its Recipient Rights Advisor and Alternate will receive the education, training, and experience necessary to fulfill its responsibilities and have successfully completed the following DCH-ORR training within ninety (90) days of hire: Basic Skills I and II Training and Developing Effective Training.

**F.** The Provider agrees to immediately notify the Payor's Office of Recipient Rights of all incidents of apparent or suspected abuse, neglect, serious injury, or death of a recipient while receiving services. The Provider agrees to comply with reporting requirements in regard to death, serious injury, suspected abuse or neglect, and all other alleged rights violations concerning a recipient while they are under the contractor's service supervision, as well as legally mandated reporting to CIS Licensing, Protective Services (Adults & Children), law enforcement, and other public agencies as applicable.

**G.** The Provider agrees to furnish to the Payor's Office of Recipient Rights, immediately upon receipt, copies of any and all recipient rights complaints or any allegation of suspected or apparent recipient rights violation and subsequently, upon completion, copies of all acknowledgement letters, Investigative Reports, Intervention Letters, Summary Reports, including documentation of remedial action or other corrective action taken in response to complaints. The Provider agrees to the jurisdiction for all Appeals of Recipient Rights complaints made by or on behalf of recipients served by the Payor by the Payor's Recipient Rights Advisory Committee and agrees to comply with any recommendations resulting from appeals. The Provider agrees to forward, upon receipt, any and all appeal requests to the Payor's Office of Recipient Rights. The Provider can appoint their own Appeals Committee, and they will need to adhere to MHC 330.1774.

**H.** The Provider agrees to provide the Payor's Office of Recipient Rights unimpeded access to the Provider's premises, staff, records, and recipients of services under contract. The Payor acknowledges that the Provider's Recipient Rights Office will maintain immediate jurisdiction over the recipient rights protection system for recipients receiving inpatient or partial hospitalization services, but that the Payor's Office of Recipient Rights will retain final jurisdiction for monitoring and coordinating rights protection. The Provider acknowledges that this may be accomplished through coordination with another CMHSP's Recipient Rights Office. The Provider agrees to implement corrective action in a timely manner for any and all deficiencies found as a result of monitoring activities conducted by the Payor or by another CMHSP Office of Recipient Rights.

**I.** The Provider will implement appropriate remedial action in consideration of the recommendations of either the Provider or Payor's Office of Recipient Rights resulting from Recipient Rights investigation and appeal processes, whether allegations are substantiated or not substantiated. The Provider also agrees to implement corrective actions resulting from monitoring or other prevention activities as recommended by the Payor's Office of Recipient Rights. The Provider understands that the Payor reserves the right to take contract action for failure to remedy violations or correct deficiencies appropriately.

**J**. To maintain the confidentiality of information regarding recipients in compliance with Sections 748 and 750 of the MHC.

**K**. The Provider agrees to assure that appropriate action is taken to ensure protection for complainants and Recipient Rights staff if evidence of harassment or retaliation occurs regarding an alleged recipient rights violation or recipient rights complaint.

## SECTION VIII. MDHHS GRIEVANCE AND APPEAL TECHNICAL REQUIREMENT

# GRIEVANCE AND APPEAL TECHNICAL REQUIREMENT PIHP GRIEVANCE AND APPEAL SYSTEM FOR MEDICAID BENEFICIARIES

**OCT. 2017**

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## I. PURPOSE AND BACKGROUND

This Technical Advisory is intended to facilitate Prepaid Inpatient Health Plan (PIHP) compliance with the Medicaid Enrollee Grievance and Appeal System requirements contained in Part 11, 6.3.1 of the Medicaid Managed Specialty Supports and Services contract with the Michigan Department of Health and Human Services (MDHHS). These requirements are applicable to all PIHPs, Community Mental Health Services Programs (CMHSPs) and their provider networks.

Although this technical advisory specifically addresses the federal Grievance and Appeal System processes required for Medicaid Enrollees, other dispute resolution processes available to all Mental Health consumers are identified and referenced.

Under the Due Process Clause of the U.S. Constitution, Medicaid Enrollees are entitled to "due process" whenever their Medicaid benefits are denied, reduced or terminated. Due process requires that Enrollees receive: (1) prior written notice of the adverse action; (2) a fair hearing before an impartial decision maker; (3) continued benefits pending a final decision; and (4) a timely decision, measured from the date the complaint is first made. Nothing about managed care changes these due process requirements. The Medicaid Enrollee Grievance and Appeal System provides a process to help protect Medicaid Enrollee due process rights.

Consumers of mental health services who are Medicaid Enrollees eligible for Specialty Supports and Services have various avenues available to them to resolve disagreements or complaints. There are three processes under authority of the Social Security Act and its federal regulations that articulate federal requirements regarding grievance and appeals for Medicaid beneficiaries who participate in managed care:

- State fair hearings through authority of 42 CFR 431.200 et seq.
- PIHP appeals through authority of 42 CFR 438.400 et seq.
- Local grievances through authority of 42 CFR 438.400 et seq.

Medicaid Enrollees, as public mental health consumers, also have rights and dispute resolution protections under authority of the State of Michigan Mental Health Code, Chapters 7,7A, 4 and 4A, including:

- Recipient Rights complaints through authority of the Mental Health Code (MCL 330.1772 et seq.).
- Medical Second Opinion through authority of the Mental Health Code (MCL 330.1705).

## II. DEFINITIONS

**The following terms and definitions are utilized in this Technical Requirement.**

**Adverse Benefit Determination:** A decision that adversely impacts a Medicaid Enrollee's claim for services due to: *(42 CFR 438.400)*

- Denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit. *42 CFR 438.400 (b)(1).*
- Reduction, suspension, or termination of a previously authorized service. *42 CFR 438.400(b)(2).*
- Denial, in whole or in part, of payment for a service. *42 CFR 438.400(b)(3).*
- Failure to make a standard Service Authorization decision and provide notice about the decision within **14 calendar days** from the date of receipt of a standard request for service. *42 CFR 438.210(d)(1*).
- Failure to make an expedited Service Authorization decision within **seventy-two (72) hours** after receipt of a request for expedited Service Authorization. *42 CFR 438.210(d)(2).*
- Failure to provide services within **14 calendar days** of the start date agreed upon during the person centered planning and as authorized by the PIHP. *42 CFR 438.400(b)(4).*
- Failure of the PIHP to resolve standard appeals and provide notice within **30 calendar days** from the date of a request fora standard appeal. *42 CFR 438.400(b)(5); 42 CFR 438.408(b)(2).*
- Failure of the PIHP to resolve expedited appeals and provide notice within **72 hours** from the date of a request for an expedited appeal. *42 CFR 438.400(b)(5); 42 CFR 438.408(b)(3).*
- Failure of the PIHP to resolve grievances and provide notice within **90 calendar days** of the date of the request. *42 CFR 438.400(b)(5); 42 CFR 438.408(b)(1).*
- For a resident of a rural area with only one MCO, the denial of an Enrollee's request to exercise his or her right, under *§ 438.52(b)(2)(ii)*, to obtain services outside the network. *42 CFR 438.400(b)(6).*
- Denial of an Enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Enrollee financial responsibility. *42 CFR 438.400(b)(7).*

**Adequate Notice of Adverse Benefit Determination:** Written statement advising the Enrollee of a decision to deny or limit authorization of Medicaid services requested, which notice must be provided to the Medicaid Enrollee on the same date the Adverse Benefit Determination takes effect. *42 CFR 438.404(c)(2).*

**Advance Notice of Adverse Benefit Determination:** Written statement advising the Enrollee of a decision to reduce, suspend or terminate Medicaid services currently provided, which notice must be provided/mailed to the Medicaid Enrollee at least **10 calendar days prior** to the proposed date the Adverse Benefit Determination is to take effect. *42 CFR 438.404(c)(1); 42 CFR 431.211*.

**Appeal: A review at the local level by a PIHP of an Adverse Benefit Determination, as defined above. *42 CFR 438.400*.**

**Authorization of Services:** The processing of requests for initial and continuing service delivery. *42 CFR 438.210(b).*

**Consumer: Broad, inclusive reference to an individual requesting or receiving mental health services delivered and/or managed by the PIHP, including Medicaid beneficiaries, and all other recipients of PIHP/CMHSP services.**

**Enrollee: A** Medicaid beneficiary who is currently enrolled in an MCO, PIHP, PAHP, PCCM, or PCCM entity in a given managed care program. *42 CFR 438.2*.

**Expedited Appeal: T**he expeditious review of an Adverse Benefit Determination, requested by an Enrollee or the Enrollee's provider, when the appropriate party determines that taking the time for a standard resolution could seriously jeopardize the Enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function. If the Enrollee requests the expedited review, the PIHP determines if the request is warranted. If the Enrollee's provider makes the request, or supports the Enrollee's request, the PIHP must grant the request. *42 CFR 438.410(a).*

**Grievance: E**nrollee's expression of dissatisfaction about PIHP/CMHSP service issues, other than an Adverse Benefit Determination. Possible subjects for grievances include, but are not limited to, quality of care or services provided, aspects of interpersonal relationships between a service provider and the Enrollee, failure to respect the Enrollee's rights regardless of whether remedial action is requested, or an Enrollee's dispute regarding an extension of time proposed by the PIHP to make a service authorized decision. *42 CFR 438.400*.

**Grievance Process:** Impartial local level review of an Enrollee's Grievance**.**

**Grievance and Appeal System:** The processes the PIHP implements to handle Appeals of Adverse Benefit Determinations and Grievances, as well as the processes to collect and track information about them. *42 CFR 438.400***.**

**Medicaid Services: S**ervices provided to an Enrollee under the authority of the Medicaid State Plan, 1915(c) Habilitation Supports Waiver, and/or Section 1915(b)(3) of the Social Security Act.

**Notice of Resolution:** Written statement of the PIHP of the resolution of a Grievance or Appeal, which must be provided to the Enrollee as described in *42 CFR 438.408*.

**Recipient Rights Complaint:** Written or verbal statement by a Enrollee, or anyone acting on behalf of the Enrollee, alleging a violation of a Michigan Mental Health Code protected right cited in Chapter 7, which is resolved through the processes established in Chapter 7A.

**Service Authorization:** PIHP processing of requests for initial and continuing authorization of services, either approving or denying as requested, or authorizing in an amount, duration, or scope less than requested, all as required under applicable law, including but not limited to *42 CFR 438.210.*

**State Fair Hearing:** Impartial state level review of a Medicaid Enrollee's appeal of an adverse benefit determination presided over by a MDHHS Administrative Law Judge. Also referred to as "Administrative Hearing". The State Fair Hearing Process is set forth in detail in Subpart E of 42 CFR Part 431.

## III. GRIEVANCE AND APPEAL SYSTEM GENERAL REQUIREMENTS

Federal regulation *(42 CFR 438.228)* requires the State to ensure through its contracts with PIHPs, that each PIHP has a grievance and appeal system in place for Enrollee's that complies with Subpart F of Part 438.

The Grievance and Appeal System must provide Enrollees:

- An Appeal process (one level, only) which enables Enrollees to challenge Adverse Benefit Determinations made by the PIHP or its agents.
- A Grievance Process.
- The right to concurrently file an Appeal of an Adverse Benefit Determination and a Grievance regarding other service complaints.
- Access to the State Fair Hearing process to further appeal an Adverse Benefit Determination, after receiving notice that the Adverse Benefit Determination has been upheld by the PIHP level Appeal.
- Information that if the PIHP fails to adhere to notice and timing requirements as outlined in PHIP Appeal Process, the Enrollee is deemed to have exhausted the PIHP's appeals process. The Enrollee may initiate a State fair hearing.
- The right to request, and have, Medicaid covered benefits continued while a local PIHP Appeal and/or State Fair Hearing is pending.
- With the written consent from the Enrollee, the right to have a provider or other authorized representative, acting on the Enrollee's behalf, file an Appeal or Grievance to the PIHP, or request a State Fair Hearing. The provider may file a grievance or request a state fair hearing on behalf of the Enrollee since the State permits the provider to act as the Enrollee's authorized representative in doing so. Punitive action may not be taken by the PIHP against a provider who acts on the Enrollee's behalf with the Enrollee's written consent to do so.

## IV. NOTICE OF ADVERSE BENEFIT DETERMINATION

A PIHP is required to provide timely and "adequate" notice of any Adverse Benefit Determination. *42 CFR 438.404(a)*.

*A. Content & Format:* The notice of Adverse Benefit Determination must meet the following requirements: *(42 CFR 438.404(a)-(b))*

1. Enrollee notice must be in writing, and must meet the requirements of 42 CFR 438.10 (i.e., "…manner and format that may be easily understood and is readily accessible by such enrollees and potential enrollees," meets the needs of those with limited English proficiency and or limited reading proficiency);

2. Notification that *42 CFR 440.230(d)* provides the basic legal authority for an agency to place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures;

3. Description of Adverse Benefit Determination;

4. The reason(s) for the Adverse Benefit Determination, and policy/authority relied upon in making the determination;

5. Notification of the right of the Enrollee to be provided upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the Enrollee's Adverse Benefit Determination (including medical necessity criteria, any processes, strategies, or evidentiary standards used in setting coverage limits);

6. Notification of the Enrollee's right to request an Appeal, including information on exhausting the PIHP's single local appeal process, and the right to request a State Fair Hearing thereafter;

7. Description of the circumstances under which an Appeal can be expedited, and how to request an Expedited Appeal;

8. Notification of the Enrollee's right to have benefits continued pending resolution of the Appeal, instructions on how to request benefit continuation, and a description of the circumstances (consistent with State policy) under which the Enrollee may be required to pay the costs of the continued services (only required when providing "Advance Notice of Adverse Benefit Determination";

9. Description of the procedures that the Enrollee is required to follow in order to exercise any of these rights; and

10. An explanation that the Enrollee may represent him/herself or use legal counsel, a relative, a friend or other spokesman.

*B.* Timing of Notice: *(42 CFR 438.404(c))*

1. Adequate Notice of Adverse Benefit Determination:

   *a.* For a denial of payment for services requested (not currently provided), notice must be provided to the Enrollee at the time of the action affecting the claim. *42 CFR 438.404(c)(2).*

b. For a Service Authorization decision that denies or limits services, notice must be provided to the Enrollee within 14-days following receipt of the request for service for standard authorization decisions, or within 72-hours after receipt of a request for an expedited authorization decision. *42 CFR 438.210(d)(1)-(2); 42 CFR 438.404(c)(3)&(6).*

*c.* For Service Authorization decisions not reached within 14-days for standard request, or 72-hours for an expedited request, (which constitutes a denial and is thus an adverse benefit determination), on the date that the timeframes expire. *42 CFR 438.404(c)(5).*

• NOTE, however, that the PIHP may be able to extend the standard (14 calendar day) or expedited (72-hour) Service Authorization timeframes for up to an additional 14 calendar days if either the Enrollee requests the extension, or if the PIHP can show that there is a need for additional information and that the extension is in the Enrollee's best interest *(42 CFR 438.210(d)(1)(ii)).* If the PIHP extends the time not at the request of the Enrollee, the PIHP must: (i) make reasonable efforts to give the Enrollee prompt oral notice of the delay; (ii) within 2 calendar days, provide the Enrollee written notice of the reason for the decision to extend the timeframe and inform the Enrollee of the right to file a Grievance if he or she disagrees with that decision; and (ii) issue and carry out its determination as expeditiously as the Enrollee's health condition requires and no Later than the date the extension expires. *42 CFR 438.404(c)(4).*

2. <u>Advance Notice of Adverse Benefit Determination:</u>

a. Required for reductions, suspensions or terminations of previously authorized/ currently provided Medicaid Services.

*b.* Must be provided to the Enrollee at least ten (10) calendar days prior to the proposed effective date**.** *42 CFR 438.404(c)(1); 42 CFR 431.211.*

*c.* <u>Limited Exceptions</u>: The PIHP may mail an adequate notice of action, not later than the date of action to terminate, suspend or reduce previously authorized services, IF *(42 CFR 431.213; 42 CFR 431.214)*

i. The PIHP has factual information confirming the death of an Enrollee;

ii. The PIHP receives a clear written statement signed by an Enrollee that he no longer wishes services, or that gives information that requires termination or reduction of services and indicates that the Enrollee understands that this must be the result of supplying that information;

iii. The Enrollee has been admitted to an institution where he is ineligible under the plan for further services;

iv. The Enrollee's whereabouts are unknown and the post office returns agency mail directed to him indicating no forwarding address;

v. The PIHP establishes that the Enrollee has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth;

vi. A change in the level of medical care is prescribed by the Enrollee's physician;

vii. The notice involves an adverse determination made with regard to the preadmission screening requirements of section 1919(e)(7) of the Act;

viii. The date of action will occur in less than 10 calendar days.

ix. The PIHP has facts (preferably verified through secondary sources) indicating that action should be taken because of probable fraud by the Enrollee (in this case, the PIHP may shorten the period of advance notice to 5 days before the date of action).

C. Required Recipients of Notice of Adverse Benefit Determination:

*1.* The Enrollee must be provided written notice. *42 CFR 438.404(a); 42 CFR 438.210(c).*

*2.* The requesting provider must be provided notice of any decision by the PIHP to deny a Service Authorization request or to authorize a service in an amount, duration or scope that is less than requested. Notice to the provider does NOT need to be in writing. *42 CFR 438.210(c).*

3. If the utilization review function is not performed within an identified organization, program or unit (access centers, prior authorization unit, or continued stay units), any decision to deny, suspend, reduce, or terminate a service occurring outside of the person centered planning process still

constitutes an adverse benefit determination, and requires a written notice of action.

## V. MEDICAID SERVICES CONTINUATION OR REINSTATEMENT

A. If an Appeal involves the termination, suspension, or reduction of previously authorized services that were ordered by an authorized provider, the PIHP MUST continue the Enrollee's benefits if all of the following occur: *42 CFR 438.420*

1. The Enrollee files the request for Appeal timely (within 60 calendar days from the date on the Adverse Benefit Determination Notice); *42 CFR 438.402(c)(2)(ii);*

2. The Enrollee files the request for continuation of benefits timely (on or before the latter of (i) 10 calendar days from the date of the notice of Adverse Benefit Determination, or (ii) the intended effective date of the proposed Adverse Benefit Determination). *42 CFR 438.420(a)*; and

3. The period covered by the original authorization has not expired.

B. Duration of Continued or Reinstated Benefits *(42 CFR 438.420(c))*. If the PIHP continues or reinstates the Enrollee's benefits, at the Enrollee's request, while the Appeal or State Fair Hearing is pending, the PIHP must continue the benefits until one of following occurs:

1. The Enrollee withdraws the Appeal or request for State Fair Hearing;

2. The Enrollee fails to request a State Fair Hearing and continuation of benefits within 10 calendar days after PIHP sends the Enrollee notice of an adverse resolution to the Enrollee's Appeal;

3. A State Fair Hearing office issues a decision adverse to the Enrollee.

C. If the final resolution of the Appeal or State Fair Hearing upholds the PIHP's Adverse Benefit Determination, the PIHP may, consistent with the state's usual policy on recoveries and as specified in the PIHP's contract, recover the cost of services furnished to the Enrollee while the Appeal and State Fair Hearing was pending, to the extent that they were furnished solely because of these requirements. *42 CFR 438.420(d)*.

D. If the Enrollee's services were reduced, terminated or suspended without an advance notice, the PIHP must reinstate services to the level before the action.

E. If the PIHP, or the MDHHS fair hearing administrative law judge reverses a decision to deny authorization of services, and the Enrollee received the disputed services while the appeal was pending, the PIHP or the State must pay for those services in accordance with State policy and regulations. *42 CFR 438.424(b)*

F. If the PIHP, or the MDHHS fair hearing administrative law judge reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the PIHP must authorize or provide the disputed services promptly, and as expeditiously as the Enrollee's health condition requires, but no later than 72 hours from the date it receives notice reversing the determination. *42 CFR 438.424(a).*

## VI. PIHP APPEAL PROCESS

A. Upon receipt of an adverse benefit determination notification, federal regulations 42 CFR 400 et seq., provide Enrollees the right to appeal the determination through an internal review by the PIHP. Each PIHP may only have one level of appeal. Enrollees may request an internal review by the PIHP, which is the first of two appeal levels, under the following conditions:

1. The Enrollee has **60 calendar days** from the date of the notice of Adverse Benefit Determination to request an Appeal. *42 CFR 438.402(c)(2)(ii).*
2. The Enrollee may request an Appeal either orally or in writing. Unless the Enrollee requests and expedited resolution, an oral request for Appeal must be followed by a written, signed request for Appeal. *42 CFR 438.402(c)(3)(ii).*

NOTE: Oral inquiries seeking to appeal an Adverse Benefit Determination are treated as Appeals (to establish the earliest possible filing date for the Appeal). *42 CFR 438.406(b)(3).*

3. In the circumstances described above under the Section entitled "Continuation of Benefits," the PIHP will be required to continue/reinstate Medicaid Services until one of the events described in that section occurs.

.

B. PIHP Responsibilities when Enrollee Requests an Appeal:

1. Provide Enrollees reasonable assistance to complete forms and to take other procedural steps. This includes but is not limited to auxiliary aids and services upon request, such as providing interpreter services and toll free numbers that have adequate TTY/TTD and interpreter capability. *42 CFR 438.406(a).*

2. Acknowledge receipt of each Appeal. *42 CFR 438.406(b)(1).*

3. Maintain a record of appeals for review by the State as part of its quality strategy. *42 CFR 438.416*.

4. Ensure that the individual(s) who make the decisions on Appeals: *42* CFR 438.406(b)(2).

    a. Were not involved in any previous level of review or decision-making, nor a subordinate of any such individual;

b. When deciding an Appeal that involves either (i) clinical issues, or (ii) a denial based on lack of medical necessity, are individual(s) who have the appropriate clinical expertise, as determined by the State, in treating the Enrollee's condition or disease.

c. Take into account all comments, documents, records, and other information submitted by the Enrollee or their representative without regard to whether such information was submitted or considered in the initial Adverse Benefit Determination.

5. Provide the Enrollee a reasonable opportunity to present evidence, testimony and allegations of fact or law in person and in writing, and inform the Enrollee of the limited time available for this sufficiently in advance of the resolution timeframe for Appeals; *42 CFR 438.406(b)(4).*

6. Provide the Enrollee and his/her representative the Enrollee's case file, including medical records and any other documents or records considered, relied upon, or generated by or at the direction of the PIHP in connection with the Appeal of the Adverse Benefit Determination. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for appeals. *42 CFR 438.406(b)(5).*

7. Provide opportunity to include as parties to the appeal the Enrollee and his or her representative, or the legal representative of a deceased Enrollee's estate; *42 CFR 438.406(b)(6*).

8. Provide the Enrollee with information regarding the right to request a State Fair Hearing and the process to be used to request one.

C. Appeal Resolution Timing and Notice Requirements:

1. Standard Appeal Resolution (timing): The PIHP must resolve the Appeal and provide notice of resolution to the affected parties as expeditiously as the Enrollee's health condition requires, but not to exceed **30 calendar days** from the day the PIHP receives the Appeal.

2. Expedited Appeal Resolution (timing):

*a.* Available where the PIHP determines (for a request from the Enrollee) or the provider indicates (in making a request on the Enrollee's behalf or supporting the Enrollee's request) that the time for a standard resolution could seriously jeopardize the Enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function. *42 CFR 438.410(a).*

*b.* The PIHP may not take punitive action against a provider who requests an expedited resolution or supports an Enrollee's appeal. *42*

*CFR 438.410(b).*

c. If a request for expedited resolution is denied, the PIHP must:

i. Transfer the appeal to the timeframe for standard resolution. 42 CFR 438.410(c)(1).

ii. Make reasonable efforts to give the Enrollee prompt oral notice of the denial. *42 CFR 438.408(c)(2), 438.410(c)(2)*.

*iii.* Within 2-calendar days, give the Enrollee written notice of the reason for the decision to extend the timeframe and inform the Enrollee of the right to file a Grievance if they disagree with the decision**.** *42 CFR 438.408(c)(2), 438.410(c)(2).*

iv. Resolve the Appeal as expeditiously as the Enrollee's health condition requires but not to exceed 30 calendar days.

d. If a request for expedited resolution is granted, the PIHP must resolve the Appeal and provide notice of resolution to the affected parties no longer than **72-hours** after the PIHP receives the request for expedited resolution of the Appeal. *42 CFR 438.408*.

3. Extension of Timeframes: The PIHP may extend the resolution and notice timeframe by up to **14 calendar days** if the Enrollee requests an extension, or if the PIHP shows to the satisfaction of the State that there is a need for additional information and how the delay is in the Enrollee's interest. *42 CFR 438.408(c).*

*a.* If the PIHP extends resolution/notice timeframes, it must complete all of the following: *42 CFR 438.408(c)(2)*

i. Make reasonable efforts to give the Enrollee prompt oral notice of the delay;

ii. Within 2-calendar days, give the Enrollee written notice of the reason for the decision to extend the timeframe and inform the Enrollee of the right to file a Grievance if they disagree with the decision.

iii. Resolve the Appeal as expeditiously as the Enrollee's health condition requires and not later than the date the extension expires.

4. Appeal Resolution Notice Format:

*a.* The PIHP must provide Enrollees with written notice of the resolution of their Appeal, and must also make reasonable efforts to provide oral notice in the case of an expedited resolution. *42 CFR 438.408(d)(2).*

b. Attached to this agreement are recommended notice templates for grievance and appeals. They are titled, Exhibit A "Notice of Adverse Benefit Determination", Exhibit B "Notice of Receipt of Appeal/Grievance", Exhibit C Notice of Appeal Approval", and Exhibit D "Notice of Appeal Denial". These templates incorporate the information needed to meet the requirement of grievance and appeal recordkeeping in 42 CFR 438.416. Specifically, 42 CFR 438.416 indicates the State must require the PIHP maintain records with (at minimum) the following information:

(1) A general description of the reason for the appeal or grievance.
(2) The date received.
(3) The date of each review or, if applicable, review meeting.
(4) Resolution at each level of the appeal or grievance if applicable.
(5) Date of resolution at each level, if applicable.
(6) Name of the covered person for whom the appeal or grievance was filed.

Further this recordkeeping must be "accurately maintained in a manner accessible to the state and available upon request to CMS."

c. Enrollee notice must meet the requirements of *42 CFR 438.10* (i.e., "…in a manner and format that may be easily understood and is readily accessible by such enrollees and potential enrollees," meets the needs of those with limited English proficiency and or limited reading proficiency).

5. Appeal Resolution Notice Content: *42 CFR 438.408(e)*

a. The notice of resolution must include the results of the resolution and the date it was completed.

b. When the appeal is not resolved wholly in favor of the Enrollee, the notice of disposition must also include notice of the Enrollee's:
   i. Right to request a state fair hearing, and how to do so;
   ii. Right to request to receive benefits while the state fair hearing is pending, and how to make the request; and

   iii. Potential liability for the cost of those benefits if the hearing decision upholds the PIHP's Adverse Benefit Determination

## VII. LOCAL GRIEVANCE PROCESS

A. Federal regulations provide Enrollees the right to a grievance process to seek resolution to issues that are not Adverse Benefit Determinations. *(42 CFR 438.228)*

B. Generally:

1. Enrollees must file Grievances with the PIHP organizational unit approved and administratively responsible for facilitating resolution of Grievances.

2. Grievances may be filed at any time by the Enrollee, guardian, or parent of a minor child or his/her legal representative. *42 CFR 438.402(c)(2)(i)*.

3. Enrollee's access to the State Fair Hearing process respecting Grievances is only available when the PIHP fails to resolve the grievance and provide resolution within **90 calendar days** of the date of the request. This constitutes an "Adverse Benefit Determination", and can be appealed to the MDHHS Administrative Tribunal using the State Fair Hearing process. *42 CFR 438.400(b)(5); 42 CFR 438.408(b)(1).*

C. PIHP Responsibility when Enrollee Files a Grievance:

1. Provide Enrollees reasonable assistance to complete forms and to take other procedural steps. This includes but is not limited to auxiliary aids and services upon request, such as providing interpreter services and toll free numbers that have adequate TTY/TTD and interpreter capability. *42 CFR 438.406(a).*

2. Acknowledge receipt of the Grievance. *42 CFR 438.406(b)(1).*

3. Maintain a record of grievances for review by the State as part of its quality strategy.

4. Submit the written grievance to appropriate staff including a PIHP administrator with the authority to require corrective action, none of who shall have been involved in the initial determination. *42 CFR 434.32*

5. Ensure that the individual(s) who make the decisions on the Grievance:

   a. Were not involved in any previous level review or decision-making, nor a subordinate of any such individual. *42 CFR 438.406(b)(2)(i).*

   b. When the Grievance involves either (i) clinical issues, or (ii) denial of expedited resolution of an Appeal, are individual(s) who have appropriate clinical expertise, as determined by the State, in treating the Enrollee's condition or disease.

c. Take into account all comments, documents, records, and other information submitted by the Enrollee or their representative without regard to whether such information was submitted or considered in the initial Adverse Benefit Determination

D. Grievance Resolution Timing and Notice Requirements

1. Timing of Grievance Resolution: Provide the Enrollee a written notice of resolution not to exceed **90 calendar days** from the day the PIHP received the Grievance.

2. Extension of Timeframes: The PIHP may extend the grievance resolution and notice timeframe by up to **14 calendar days** if the Enrollee requests an extension, or if the PIHP shows to the satisfaction of the State that there is a need for additional information and how the delay is in the Enrollee's interest. *42 CFR 438.408(c).*

   a. If the PIHP extends resolution/notice timeframes, it must complete all of the following: *42 CFR 438.408(c)(2)*

      i. Make reasonable efforts to give the Enrollee prompt oral notice of the delay;

      ii. Within 2-calendar days, give the Enrollee written notice of the reason for the decision to extend the timeframe and inform the Enrollee of the right to file a Grievance if they disagree with the decision; and

      iii. Resolve the Appeal as expeditiously as the Enrollee's health condition requires

3. Format and Content of Notice of Grievance Resolution:

   a. Enrollee notice of Grievance resolution must meet the requirements of 42 CFR 438.10 (i.e., "…in a manner and format that may be easily understood and is readily accessible by such enrollees and potential enrollees," meets the needs of those with limited English proficiency and or limited reading proficiency).

   b. The notice of Grievance resolution must include:
      i. The results of the Grievance process;
      ii. The date the Grievance process was concluded;
      iii. Notice of the Enrollee's right to request a State Fair Hearing, if the notice of resolution is more than **90-days** from the date of the Grievance; and

      iv. Instructions on how to access the State Fair Hearing process, if applicable.

## VIII. STATE FAIR HEARING APPEAL PROCESS

A. Federal regulations provide an Enrollee the right to an impartial review by a state level administrative law judge (a State Fair Hearing), of an action of a local agency or its agent, in certain circumstances:

1. After receiving notice that the PIHP is, after Appeal, upholding an Adverse Benefit Determination. *42 CFR 438.408(f)(1);*

2. When the PIHP fails to adhere to the notice and timing requirements for resolution of Grievances and Appeals, as described in *42 CFR 438.408. 42 CFR 438.408(f)(1)(i).*

*B.* The State may offer or arrange for an external medical review in connection with the State Fair Hearing, if certain conditions are met (e.g., it must be optional to the Enrollee, free to Enrollee, independent of State and PIHP, and not extend any timeframes or disrupt continuation of benefits). *42 CFR 438.408(f)(1)(ii).*

C. The PIHP may not limit or interfere with an Enrollee's freedom to make a request for a State Fair Hearing.

*D.* Enrollees are given **120 calendar days** from the date of the applicable notice of resolution to file a request for a State Fair Hearing. *42 CFR 438.408(f)(2).*

E. The PIHP is required to continue benefits, if the conditions described in Section V, MEDICAID SERVICES CONTINUATION OR REINSTATEMENT are satisfied, and for the durations described therein.

F. If the Enrollee's services were reduced, terminated or suspended without advance notice, the PIHP must reinstate services to the level before the Adverse Benefit Determination.

G. The parties to the State Fair Hearing include the PIHP, the Enrollee and his or her representative, or the representative of a deceased Enrollee's estate. A Recipients Rights Officer shall not be appointed as Hearings Officer due to the inherent conflict of roles and responsibilities.

H. Expedited hearings are available.

**Detailed information and instructions for the Department of Licensing and Regulatory Affairs Michigan Administrative Hearing System Fair Hearing process can be found on the MDHHS website at:**

**www.Michigan.gov/mdhhs>>AssistancePrograms>>Medicaid>>MedicaidFair Hearings**
**http://www.michigan.gov/mdhhs/0,5885,7-339-71547_4860-16825--,00.html**

**OR**

**Department of Licensing and Regulatory Affairs Michigan Administrative Hearing System Fair Hearing**
**http://www.michigan.gov/lara/0,4601,7-154-10576_61718_77732---,00.html**

## IX. RECORDKEEPING REQUIREMENTS

**The PIHP is required to maintain records of Enrollee Appeals and Grievances, which will be reviewed by the PIHP as part of its ongoing monitoring procedures, as well as by State staff as part of the State's quality strategy.**

**A PIHP's record of each Grievance or Appeal must contain, at a minimum:**

A. A general description of the reason for the Grievance or Appeal;
B. The date received;
C. The date of each review, or if applicable, the review meeting;
D. The resolution at each level of the Appeal or Grievance, if applicable;
E. The date of the resolution at each level, if applicable;
F. Name of the covered person for whom the Grievance or Appeal was filed.

**PIHPs must maintain such records accurately and in a manner accessible to the State and available upon request to CMS.**

## X. RECIPIENT RIGHTS COMPLAINT PROCESS

**Enrollees, as recipients of Mental Health Services, have rights to file recipient rights complaints under the authority of the State Mental Health Code. Recipient Rights complaint requirements are articulated in CMHSP Managed Mental Health Supports and Services contract, Attachment C6.3.2.1 - CMHSP Local Dispute Resolution Process.**

**Exhibit A**

# NOTICE OF ADVERSE BENEFIT DETERMINATION

**<Health Plan/CMHSP-PIHP name/ MI Choice Waiver Agency name>**

**Important:** This notice explains your internal appeal rights. Read this notice carefully. If you need help with this notice or asking for an appeal, you can call one of the numbers listed on the last page under "Get help & more information."

**Mailing Date:** <Mailing Date>

**Member ID:** <Member's Plan ID Number>

**Name:** <Member's Name>

**Beneficiary ID:** <Member's Medicaid ID Number>

***[If the plan uses the Beneficiary (Medicaid) ID Number as its Plan ID Number, replace the two fields above with one field formatted as follows: Member/Beneficiary ID: <Member's Medicaid ID Number>.]***

**This is to tell you that the following action has been taken:**

***[Enter information regarding the adverse benefit determination taken to deny, reduce, suspend or terminate a covered benefit or payment with effective dates]***

**This action is based on the following:**

***[Include citations with descriptions that are understandable to the member of applicable State and Federal rule, law, and regulation that support the action. You may also include Evidence of Coverage/Member Handbook provisions as well as Plan policies/procedures or assessment tools used to support the decision.***

**You can share a copy of this decision with your provider so you and your provider can discuss next steps. If your provider asked for coverage on your behalf, we have sent a copy of this decision to your provider.**

## If you don't agree with our action, you have the right to an Internal Appeal

You have to ask <Health Plan/CMHSP-PIHP/MI Choice Waiver Agency name> for an internal appeal within 60 calendar days of the date of this notice. You, your representative or your doctor {provider} can send in your request that must include:

- Your Name
- Address
- Member number
- Reason for appealing
- Whether you want a standard or fast appeal (for an expedited or fast appeal, explain why you need one).
- Any evidence you want us to review, such as medical records, doctors' letters or other information that explains why you need the item or service. If you are asking for a fast appeal you will need a doctor's supporting statement. Call your doctor if you need this information.

Please keep a copy of everything you send us for your records.
**There are 2 kinds of internal appeals:**
**Standard Appeal –** We'll give you a written decision on a standard appeal within **30 calendar days** after we get your appeal. Our decision might take longer if you ask for an extension, or if we need more information about your case. We'll tell you if we're taking extra time and will explain why more time is needed. If your appeal is for payment of a service you've already received, we'll give you a written decision within **60 calendar days**. If you want to ask for an internal appeal, you can either call or send in a written request to:

**<Health Plan / CMHSP-PIHP / MI Choice Waiver Agency name>**
**Address**
**Phone Number TTY Phone Number**
**Fax Number**

**Expedited or Fast Appeal** – We'll give you a decision on a fast appeal within **72 hours** after we get your appeal. You can ask for a fast appeal if you or your doctor believe your health could be seriously harmed by waiting up to 30 calendar days for a decision. **We'll automatically give you a fast appeal if a doctor asks for one for you or if your doctor supports your request.** If you ask for a fast appeal without support from a doctor, we'll decide if your request requires a fast appeal. If we don't give you a fast appeal, we'll give you a decision within 30 calendar days. To ask for a Fast Appeal, you must call: {**Phone Number} {TTY Phone #}**

## Continuation of services during an Internal Appeal

If you are receiving a Michigan Medicaid service and you file your appeal within 10 calendar days of this Notice of Adverse Benefit Determination <insert 10 calendar day date>, you may continue to receive your same level of services while your internal appeal is pending. You have the right to request and receive benefits while the internal appeal is pending, and should submit your request to the (Health Plan / CMHSP-PIHP / MI Choice Waiver Agency name.)

Your benefits for that service will continue if you request an internal appeal within **10 calendar days** from the date of this notice or from the intended effective date of the proposed adverse action whichever is later.

**If you want someone else to act for you**
**You can name a relative, friend, attorney, doctor, or someone else to act as your representative. If you want someone else to act for you, call us at: <number(s)> to learn how to name your representative. TTY users call <number>. Both you and the person you want to act for you must sign and date a statement confirming this is what you want. You'll need to mail or fax this statement to us. Keep a copy for your records**

### Access to Documents

You and/or your authorized representative are entitled to reasonable access to and a free copy of all documents relevant to your appeal any time before or during the appeal. You must submit the request in writing.

### What happens next?

- If you ask for an internal appeal and we continue to deny your request for coverage or payment of a service, we will send you a written Notice of Appeal Denial. If the service is covered by Michigan Medicaid, you can ask for a Medicaid State Fair Hearing. [*Licensed health plans in Michigan must also insert*: You can also ask for an External Review under the Patient Right to Independent Review Act (PRIRA) with the Department of Insurance and Financial Services (DIFS).]
- The Notice of Appeal Denial will give you additional information about the State Fair Hearings process [or Patient Right to Independent Review Act] and how to file the request.
- If you do not receive a notice or decision about your internal appeal within the timeframes listed above, you may also seek a State Fair Hearing with the Michigan Administrative Hearing System.

### Get help & more information

- {Health Plan / CMHSP-PIHP / MI Choice Waiver Agency name}: If you need help or additional information about our decision and the internal appeal process, call Member Services at: {phone number} (TTY: {TTY number}), {hours of operation}. You can also visit our website at {plan website}.
- Michigan Department of Health and Human Services (MDHHS) Beneficiary Help Line: 1-800-642-3195. TTY users call 1-866-501-5656 or 1-800-975-7630 (if calling from an internet based phone service).
- [*If applicable, insert other state or local aging/disability waiver resources contact information.*]

[*Add language and disclaimer notice requirements under Section 1557 of the Affordable Care Act. For more information, refer to https://*www.hhs.gov/civil-rights/for-individuals/section-1557.*]*

**Exhibit B**

# NOTICE OF RECEIPT OF APPEAL/GRIEVANCE

**<Health Plan/CMHSP-PIHP/MI Choice Waiver Agency name>**

**Important:** Read this notice carefully. If you need help, you can call one of the numbers listed on the next page under "Get help & more information."

**Mailing Date:** <Mailing Date>

**Member ID:** <Member's Plan ID Number>

**Name:** <Member's Name>

**Beneficiary ID:** <Member's Medicaid ID Number>

[*If the plan uses the Beneficiary (Medicaid) ID Number as its Plan ID Number, replace the two fields above with one field formatted as follows:* Member/Beneficiary ID: <Member's Medicaid ID Number>.]

**This Notice is in response to a request that we received on <date received>.**

☐ **You Filed a Grievance**

**We received your grievance on <date received> about <subject of grievance>. We take your concerns seriously. Thank you for taking the time to bring this to our attention.**

## WHAT THIS MEANS

**We will review your grievance by <date received plus 30 calendar days>. A letter will be mailed to you within two (2) calendar days after we complete our investigation telling you what we found and what (if any) action we will take, or have taken.**

☐ **You Filed An Internal Appeal**

**We received your request for an internal appeal on <date received>. You are appealing our decision to <description of subject of appeal>.**

## WHAT THIS MEANS

**A decision on this appeal will be made by <date received plus thirty (30) days>. A letter will be mailed to you telling you what our decision is and why we made that decision.**

**<The appeal was received within ten (10) calendar days of the decision that you are appealing. Therefore, the service(s) you have been receiving may continue while the appeal is being reviewed.> You have the right to request and receive benefits while the internal appeal is pending, and should submit your request to the (Health Plan / CMHSP-PIHP / MI Choice Waiver Agency name.)**

Your benefits for that service will continue if you qualified for continuation of benefits during your internal appeal and you ask for a State Fair Hearing from MAHS within **10 calendar days** from the date of this notice or from the intended effective date of the proposed adverse action whichever is later. MAHS must receive your State Fair Hearing by <insert 10 calendar day date from this notice> and you should state in your request that you are asking for your service(s) to continue.

We may contact you for more information or if we have more questions. If you have any questions or additional information to provide please call <list an appeals specific phone number/fax number>.

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**FOR BOTH GRIEVANCES AND APPEALS**

**If you want someone to represent you**

**At any time during the process you may have another person act for you or help you. This person will be your representative. If you want someone to act for you, you must tell us that in writing.**

**If you already have someone to represent you, or if you have a legal guardian, power of attorney, or someone authorized to make health care decisions on your behalf, you do not have to do anything else.**

**Get help & more information**

- {Health plan / CMHSP-PIHP / MI Choice Waiver Agency name}: If you need help or additional information about our decision and the internal appeal process, call Member Services at: {phone number} (TTY: {TTY number}),{hours of operation}.
- Michigan Department of Health and Human Services (MDHHS) Beneficiary Help Line: 1-800-642-3195. TTY users call 1-866-501-5656 or 1-800-975-7630 (if calling from an internet based phone service).

[*Add language and disclaimer notice requirements under Section 1557 of the Affordable Care Act. For more information, refer to https://www.hhs.gov/civil-rights/for-individuals/section-1557.]*

# Exhibit C

# NOTICE OF APPEAL APPROVAL

**<Health Plan/CMHSP-PIHP / MI Choice Waiver Agency name>**

**Important:** This notice explains the results of your appeal. Read this notice carefully. If you need help, you can call one of the numbers listed on the last page under "Get help & more information."

**Mailing Date:** <Mailing Date>

**Member ID:** <Member's Plan ID Number>

**Name:** <Member's Name>

**Beneficiary ID:** <Member's Medicaid ID Number>

[*If the plan uses the Beneficiary (Medicaid) ID Number as its Plan ID Number, replace the two fields above with one field formatted as follows:* Member/Beneficiary ID: <Member's Medicaid ID Number>.]

**This Notice is in response to the internal appeal request that we received on <date appeal received>**

**Your appeal was approved**

**Your appeal was thoroughly considered. This is to inform you that we approved your appeal for the service/item listed below:**

## What this means:

Because your Level 1 Appeal decision was approved, you may receive the following services as of <date authorized>: [*List the services that were approved, including any applicable information about coverage amount, duration, etc. Include citations with descriptions that are understandable to the member of applicable State and Federal rule, law, and regulation that support the action. You may also include Evidence of Coverage/Member Handbook provisions as well as Plan policies/procedures or assessment tools used to support the decision.*]

**If you do not receive the services, or if the services are wrongly stopped or reduced, tell us immediately using the contact information below:**

**<Health Plan / CMHSP-PIHP / MI Choice Wavier Agency name>**
**<Name of Appeals/Grievance Department>**
**<Mailing Address for Appeals/Grievance Department>**
**Phone: <phone number> TTY: <TTY number> Fax: <fax number>**

### Getting your case file

You can ask to see the medical records and other documents we reviewed during your appeal. You can also ask for a copy of the guidelines we used to make our decision. You and/or your authorized representative are entitled to reasonable access to and a free copy of all documents relevant to your appeal any time before or during the appeal. You must submit the request in writing.

### Get help & more information

- {Health Plan / CMHSP-PIHP / MI Choice Waiver Agency name}: If you need help or additional information about our decision and the appeal process, call Member Services at: {phone number} (TTY: {TTY number}), {hours of operation}.
- Michigan Department of Health and Human Services (MDHHS) Beneficiary Help Line: 1-800-642-3195. TTY users call 1-866-501-5656 or 1-800-975-7630 (if calling from an internet based phone service).

[*Add language and disclaimer notice requirements under Section 1557 of the Affordable Care Act. For more information, refer to https://www.hhs.gov/civil-rights/for-individuals/section-1557.]*

**Exhibit D**

# NOTICE OF APPEAL DENIAL

**<Health Plan/ CMHSP-PIHP / MI Choice Waiver Agency name>**

**Important:** This notice explains your additional appeal rights. Read this notice carefully. If you need help, you can call one of the numbers listed on the last page under "Get help & more information."

**Mailing Date:** <Mailing Date>

**Member ID:** <Member's Plan ID Number>

**Name:** <Member's Name>

**Beneficiary ID:** <Member's Medicaid ID Number>

[*If the plan uses the Beneficiary (Medicaid) ID Number as its Plan ID Number, replace the two fields above with one field formatted as follows:* Member/Beneficiary ID: <Member's Medicaid ID Number>.]

**This Notice is in response to the internal appeal request that we received on <date appeal received>.**

**Your internal appeal was denied**
**Your appeal was thoroughly considered. This is to inform you that we [*denied* or *partially denied*] your internal appeal for the service/item listed below:**

## Why did we deny your appeal?

We [*denied* or *partially denied*] your internal appeal for the service/item listed above because: [*Include citations with descriptions that are understandable to the member of applicable State and Federal rule, law, and regulation that support the action. You may also include Evidence of Coverage/Member Handbook provisions as well as Plan policies/procedures or assessment tools used to support the decision.*]

**You should share a copy of this decision with your provider so you and your provider can discuss next steps. If your provider requested coverage on your behalf, we have sent a copy of this decision to your provider.**

## If you don't agree with our decision, you have the right to further appeal

You have the right to an External Appeal. The External Appeal is reviewed by an independent organization that is not connected to us. You can file an External Appeal yourself.

[*Health plans must insert:* There are two ways to make an External Appeal: 1) State Fair Hearing with the Michigan Administrative Hearing System (MAHS) and/or 2) External Review under the Patient Right to Independent Review Act (PRIRA) with the Department of Insurance and Financial Services (DIFS).] [*PIHP and MI Choice Waiver Agency must insert:* You can do this by asking for a State Fair Hearing with the Michigan Administrative Hearing System (MAHS).]

Below is information on how to request a State Fair Hearing with MAHS [*Health Plans must insert:* and an External Review with DIFS].

## How to ask for a State Fair Hearing with MAHS

To ask for a Medicaid State Fair Hearing you must follow the directions on the enclosed Request for State Fair Hearing form. You must ask for a State Fair Hearing within **120 calendar days** from the mailing date of this notice. If your request is not received at MAHS by <insert 120 calendar day date>, you will not be granted a hearing. If you need another copy of the form, you can ask for one by calling <Health Plan/ CMHSP-PIHP/ MI Choice Waiver Agency name> Member Services at <phone number> or the Michigan Department of Health and Human Services Beneficiary Help Line: 1-800-642-3195. TTY users call 1-866-501-5656 or 1-800-975-7630 (if calling from an internet based phone service).

## What happens next?

MAHS will schedule a hearing. You will get a written "Notice of Hearing" telling you the date and time. Most hearings are held by telephone, but you can ask to have a hearing in person. During the hearing, you'll be asked to tell an Administrative Law Judge why you disagree with our decision. You can ask a friend, relative, advocate, provider, or lawyer to help you. You'll get a written decision within 90 calendar days from the date your Request for Hearing was received by MAHS. The written decision will explain if you have additional appeal rights.

If the standard timeframe for review would jeopardize your life or health, you may be able to qualify for a fast (also known as an expedited) State Fair Hearing. Your request must be in writing and clearly state that you are asking for a fast State Fair Hearing. Your request can be mailed or faxed to MAHS (see the enclosed Request for Hearing form for the address and fax number). If you qualify for a fast State Fair Hearing, MAHS must give you an answer within 72 hours. However, if MAHS needs to gather more information that may help you, it can take up to 14 more calendar days.

If you have any questions about the State Fair Hearings process, including the fast State Fair Hearing, you can call MAHS at 1-877-833-0870.

[*PIHP and MI Choice are not subject to PRIRA and should therefore delete the following section on filing with DIFS.*]

## How to ask for an External Review with DIFS

To ask for an External Review under the Patient Right to Independent Review Act (PRIRA) from DIFS, you must complete the Health Care Request for External Review form. The form is included with this notice. You can also get a copy of the form by calling DIFS at 1-877-999-6442. Complete the form and send it with all supporting documentation to the address or fax number listed on the form. You must submit your request within **60 calendar days** of your receipt of this appeal decision notice. You have the right to request and receive benefits while the hearing is pending, and should submit your request to the (Health Plan / CMHSP-PIHP / MI Choice Waiver Agency name.)

## What happens next?

DIFS will review your request. If your case does not require medical record review, DIFS will issue a decision within 14 calendar days after your request is accepted. If your case involves issues of medical necessity or clinical review criteria, DIFS will issue a decision within 21 calendar days.

If the standard timeframe for review would jeopardize your life or health, you may be able to qualify for a fast (also known as an expedited) External Review. To ask for a fast External Review, you can call DIFS at 1-877-999-6442. A fast External Review is completed within 72 hours after your request has been accepted.

### Continuation of Services

If we previously approved coverage for a service but then decided to change or stop the service before the authorization ended, you can continue your benefits during External Appeals in some cases.

> Your benefits for that service will continue if you qualified for continuation of benefits during your internal appeal and you ask for a State Fair Hearing from MAHS within **10 calendar days** from the date of this notice or from the intended effective date of the proposed adverse action whichever is later. MAHS must receive your State Fair Hearing by <insert 10 calendar day date from this notice> and you should state in your request that you are asking for your service(s) to continue.

If your benefits are continued during your appeal, you can keep getting the service until one of the following happens: 1) you withdraw the External Appeal; or 2) all entities that got your appeal decide "no" to your request.

### Access to Documents

You and/or your authorized representative are entitled to reasonable access to and a free copy of all documents relevant to your appeal any time before or during the appeal. You must submit the request in writing.

### Get help & more information

- {Health Plan / CMHSP-PIHP / MI Choice Waiver Agency name}: If you need help or additional information about our decision and the appeal process, call Member Services at: {phone number} (TTY: {TTY number}), {hours of operation}. You can also visit our website at {plan website}.
- MDHHS Beneficiary Help Line: 1-800-642-3195. TTY users call 1-866-501-5656 or 1- 800-975-7630 (if calling from an internet based phone service).
- [*If applicable, insert other state or local aging/disability resources contact information.*]

[*Add language and disclaimer notice requirements under Section 1557 of the Affordable Care Act. For more information, refer to https://www.hhs.gov/civil-rights/for-individuals/section-1557.]*

## SECTION IX. MDHHS PERSON-CENTERED PLANNING POLICY

### MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
### BEHAVIORAL HEALTH AND DEVELOPMENTAL DISABILITIES ADMINISTRATION
### PERSON CENTERED PLANNING POLICY
### June 5, 2017

***"Person-centered planning" means a process for planning and sup- porting the individual receiving services that builds upon the individual's capacity to engage in activities that promote community life and that honors the individual's preferences, choices, and abilities."*** **MHC 330.1700(g)**

## I. WHAT IS THE PURPOSE OF THE MICHIGAN MENTAL HEALTH SYSTEM?

The purpose of the community mental health system is to support adults and children with intellectual and developmental disabilities, adults with serious mental illness and co-occurring disorders (including co-occurring substance abuse disorders), and children with serious emotional disturbance to live successfully in their communities—achieving community inclusion and participation, independence, and productivity. Person-Centered Planning (PCP) enables individuals to identify and achieve their personal goals. As described below, PCP for minors (family-driven and youth-guided practice) involves the whole family.

PCP is a way for people to plan their lives in their communities, set the goals that they want to achieve, and develop a plan for how to accomplish them. PCP is required by state law [the Michigan Mental Health Code (the Code)] and federal law [the Home and Community Based Services (HCBS) Final Rule and the Medicaid Managed Care Rules] as the way that people receiving services and supports from the community mental health system plan how those supports are going to enable them to achieve their life goals. The process is used to plan the life that the person aspires to have, considering various options—taking the individual's goals, hopes, strengths, and preferences and weaving them into plans for the future. Through PCP, a person is engaged in decision making, problem solving, monitoring progress, and making needed adjustments to goals and supports and services provided in a timely manner. PCP is a process that involves support and input from those people who care about the person doing the planning. The PCP process is used any time an individual's goals, desires, circumstances, choices, or needs change. While PCP is the required planning approach for mental health and I/DD services provided by the CMHSP system, PCP can include planning for other public supports and privately-funded services chosen by the person.

The HCBS Final Rule requires that Medicaid-funded services and supports be integrated in and support full access to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving such services and supports. 42 CFR 441.700 et. seq. The HCBS Final Rule also requires that PCP be used to identify and reflect choice of services and supports funded by the mental health system.

Through the PCP process, a person and those he or she has selected to support him or her:

**a.** Focus on the person's life goals, interests, desires, choices, strengths and abilities as the foundation for the PCP process.

**b.** Identify outcomes based on the person's life goals, interests, strengths, abilities, desires and choices.

**c.** Make plans for the person to achieve identified outcomes.

**d.** Determine the services and supports the person needs to work toward or achieve outcomes including, but not limited to, services and supports available through the community mental health system.

**e.** After the PCP process, develop an Individual Plan of Services (IPOS) that directs the provision of supports and services to be provided through the community mental health services program (CMHSP).

PCP focuses on the person's goals, while still meeting the person's basic needs [the need for food, shelter, clothing, health care, employment opportunities, educational opportunities, legal services, transportation, and recreation as identified in the Code]. As appropriate for the person, the PCP process may address Recovery, Self-Determination, Positive Behavior Supports, Treatment of Substance Abuse or other Co- Occurring Disorders, and Transition Planning as described in the relevant MDHHS policies and initiatives.

PCP focuses on services and supports needed (including medically necessary services and supports funded by the CMHSP) for the person to work toward and achieve their personal goals.

For minor children, the concept of PCP is incorporated into a family-driven, youth- guided approach (see the MDHHS Family-Driven and Youth-Guided Policy and Practice Guideline). The needs of the child are interwoven with the needs of the family, and therefore supports and services impact the entire family. As the child ages, services and supports should become more youth-guided especially during transition into adulthood. When the person reaches adulthood, his or her needs and goals become primary.

There are a few circumstances where the involvement of a minor's family may be not appropriate:

a. The minor is 14 years of age or older and has requested services without the knowledge or consent of parents, guardian or person in loco parentis within the restrictions stated in the Code.

b. The minor is emancipated.

c. The inclusion of the parent(s) or significant family members would constitute a substantial risk of physical or emotional harm to the minor or substantial disruption of the planning process. Justification of the exclusion of parents shall be documented in the clinical record.

## II. HOW IS PCP DEFINED IN LAW?

PCP, as defined by the Code, "means a process for planning and supporting the person receiving services that builds upon his or her capacity to engage in activities that pro- mote community life and that honors the person's choices, and abilities. The PCP process involves families, friends, and professionals as the person desires or requires." MHC 330.1700(g).

The Code also requires use of PCP for development of an Individual Plan of Services: "(1) The responsible mental health agency for each recipient shall ensure that a PCP process is used to develop a written individual plan of services in partnership with the recipient. A preliminary plan shall be developed within 7 days of the commencement of services or, if an individual is hospitalized for less than 7 days, before discharge or release. The individual plan of services shall consist of a treatment plan, a support plan, or both. A treatment plan shall

establish meaningful and measurable goals with the recipient. The individual plan of services shall address, as either desired or required by the recipient, the recipient's need for food, shelter, clothing, health care, employment opportunities, educational opportunities, legal services, transportation, and recreation. The plan shall be kept current and shall be modified when indicated. The person in charge of implementing the plan of services shall be designated in the plan." MCL 330.1712.

The HCBS Final Rule does not define PCP, but does require that the process be used to plan for Medicaid-funded services and supports. 42 CFR 441.725. The HCBS Final Rule also sets forth the requirements for using the process. These requirements are included in the PCP Values and Principles and Essential Elements below.

## III. WHAT ARE THE VALUES AND PRINCIPLES THAT GUIDE THE PCP PROCESS?

PCP is an individualized process designed to respond to the unique needs and desires of each person. The following values and principles guide the PCP process whenever it is used.

a. Every person is presumed competent to direct the planning process, achieve his or her goals and outcomes, and build a meaningful life in the community. PCP should not be constrained by any preconceived limits on the person's ability to make choices.

b. Every person has strengths, can express preferences, and can make choices. The PCP approach identifies the person's strengths, goals, choices, medical and support needs and desired outcomes. In order to be strength-based, the positive attributes of the person are documented and used as the foundation for building the person's goals and plans for community life as well as strategies or interventions used to support the person's success.

c. The person's choices and preferences are honored. Choices may include: the family and friends involved in his or her life and PCP process, housing, employment, culture, social activities, recreation, vocational training, relationships and friendships, and transportation. Individual choice must be used to develop goals and to meet the person's needs and preferences for supports and services and how they are provided.

d. The person's choices are implemented unless there is a documented health and safety reason that they cannot be implemented. In that situation, the PCP process should include strategies to support the person to implement their choices or preferences over time.

e. Every person contributes to his or her community, and has the right to choose how supports and services enable him or her to meaningfully participate and contribute to his or her community.

f. Through the PCP process, a person maximizes independence, creates connections and works towards achieving his or her chosen outcomes.

g. A person's cultural background is recognized and valued in the PCP process. Cultural background may include language, religion, values, beliefs, customs, dietary choices

and other things chosen by the person. Linguistic needs, including ASL interpretation, are also recognized, valued and accommodated.

## IV. WHAT ARE THE ESSENTIAL ELEMENTS OF THE PERSON- CENTERED PLANNING PROCESS?

The following elements are essential to the successful use of the PCP process with a person and the people invited by the person to participate.

a. **Person-Directed.** The person directs the planning process (with necessary sup- ports and accommodations) and decides when and where planning meetings are held, what is discussed, and who is invited.

b. **Person-Centered.** The planning process focuses on the person, not the system or the person's family, guardian, or friends. The person's goals, interests, desires, and choices are identified with a positive view of the future and plans for a meaningful life in the community. The planning process is used whenever there are changes to the person's needs or choices, rather than viewed as an annual event.

c. **Outcome-Based.** The person identifies outcomes to achieve in pursuing his or her goals. The way that progress is measured toward achievement of outcomes is identified.

d. **Information, Support and Accommodations.** As needed, the person receives complete and unbiased information on services and supports available, community resources, and options for providers, which are documented in the IPOS. Support and accommodations to assist the person to participate in the process are provided. The person is offered information on the full range of services available in an easy-to-understand format.

e. **Independent Facilitation.** Individuals have the information and support to choose an independent facilitator to assist them in the planning process.

f. **Pre-Planning.** The purpose of pre-planning is for the person to gather the information and resources necessary for effective PCP and set the agenda for the PCP process. Each person must use pre-planning to ensure successful PCP. Pre-planning, as individualized for the person's needs, is used anytime the PCP process is used.

The following items are addressed through pre-planning with sufficient time to take all needed actions (e.g. invite desired participants):

1. When and where the meeting will be held.

2. Who will be invited (including whether the person has allies who can provide desired meaningful support or if actions need to be taken to cultivate such support).

3. Identify any potential conflicts of interest or potential disagreements that

may arise during the PCP for participants in the planning process and making a plan for how to deal with them. (What will be discussed and not discussed.

4. The specific PCP format or tool chosen by the person to be used for PCP.

5. What accommodations the person may need to meaningfully participate in the meeting (including assistance for individuals who use behavior as communication).

6. Who will facilitate the meeting.

7. Who will take notes about what is discussed at the meeting.

g. **Wellness and Well-Being**. Issues of wellness, well-being, health and primary care coordination support needed for the person to live the way he or she want to live are discussed and plans to address them are developed. People are allowed the dignity of risk to make health choices just like anyone else in the community (such as, but not limited to, smoking, drinking soda pop, eating candy or other sweets). If the person chooses, issues of wellness and well-being can be ad- dressed outside of the PCP meeting.

PCP highlights personal responsibility including taking appropriate risks. The plan must identify risks and risk factors and measures in place to minimize them, while considering the person's right to assume some degree of personal risk. The plan must assure the health and safety of the person. When necessary, an emergency and/or back-up plan must be documented and encompass a range of circumstances (e.g. weather, housing, support staff).

h. **Participation of Allies**. Through the pre-planning process, the person selects allies (friends, family members and others) to support him or her through the PCP process. Pre-planning and planning help the person explore who is currently in his or her life and what needs to be done to cultivate and strengthen desired relationships.

## V. WHAT IS INDEPENDENT FACILITATION?

An Independent Facilitator is a person who facilitates the person-centered planning process in collaboration with the person. In Michigan, individuals receiving support through the community mental health system have a right to choose an independent or external facilitator for their person-centered planning process. The terms independent and external mean that the facilitator is independent of or external to the community mental health system. It means that the person has no financial interest in the outcome of the supports and services outlined in the person-centered plan. Using an independent facilitator is valuable in many different circumstances, not just situations involving disagreement or conflict.

The PIHP/CMHSP must contract with a sufficient number of independent facilitators to ensure availability and choice of independent facilitators to meet their needs. The independent facilitator is chosen by the individual and serves as the individual's guide (and for some individuals, assisting and representing their voice) throughout the process, making sure that his or her hopes, interests, desires, preferences and concerns are heard and addressed. The independent facilitator must not have any other role within the PIHP/CMHSP. The role of the independent facilitator is to:

**a.** Personally know or get to know the individual who is the focus of the planning, including what he or she likes and dislikes, personal preferences, goals, methods of communication, and who supports and/or is important to the person.

**b.** Help the person with all pre-planning activities and assist in inviting participants chosen by the person to the meeting(s).

**c.** Assist the person to choose planning tool(s) to use in the PCP process.

**d.** Facilitate the PCP meeting(s) or support the individual to facilitate his or her own PCP meeting(s).

**e.** Provide needed information and support to ensure that the person directs the process.

**f.** Make sure the person is heard and understood.

**g.** Keep the focus on the person.

**h.** Keep all planning participants on track.

**i.** Develop an individual plan of service in partnership with the person that expresses the person's goals, is written in plain language understandable by the person, and provides for services and supports to help the person achieve their goals.

The Medicaid Provider Manual (MPM) permits independent facilitation to be provided to Medicaid beneficiaries as one aspect of the coverage called "Treatment Planning" (MPM MH&SAA Chapter, Section 3.25.) If the independent facilitator is paid for the provision of these activities, the PIHP/CMHSP may report the service under the code H0032.

An individual may use anyone he or she chooses to help or assist in the person- centered planning process, including facilitation of the meeting. If the person does not meet the requirements of an Independent Facilitator, he or she cannot be paid, and responsibility for the Independent Facilitator duties described above falls to the Supports Coordinator/Case Manager. A person may choose to facilitate his or her planning process with the assistance of an Independent Facilitator.

## VI. HOW IS PERSON CENTERED PLANNING USED TO WRITE AND CHANGE THE INDIVIDUAL PLAN OF SERVICE?

The Code establishes the right for all people to develop Individual Plans of Services (IPOS) through the PCP process. The PCP process must be used at any time the person wants or needs to use the process, but must be used at least annually to review the IPOS. The agenda for each PCP meeting should be set by the person through the pre- planning process, not by agency or by the fields or categories in a form or an electronic medical record

Assessments may be used to inform the PCP process, but is not a substitute for the process. Functional assessments must be undertaken using a person-centered approach. The functional assessment and the PCP process together should be used as a basis for identifying goals, risks, and needs; authorizing services, utilization

management and review. No assessment scale or tool should be utilized to set a dollar figure or budget that limits the person-centered planning process.

While the Code requires that PCP be used to develop an Individual Plan of Services (IPOS) for approved community mental health services and supports, the purpose of the PCP process is for the person to identify life goals and decide what medically necessary services and supports need to be in place for the person to have, work toward or achieve those life goals. The person or representative chooses what services and supports are needed. Depending on the person, community mental health services and supports may play a small or large role in supporting him or her in having the life he or she wants. When a person is in a crisis situation, that situation should be stabilized before the PCP process is used to plan the life that he or she desires to have.

People are often at different points in the process of achieving their life goals. The PCP process should be individualized to meet each person's needs of the person for whom planning is done, i.e. meeting a person where he or she is. Some people may be just beginning to define the life they want and initially the PCP process may be lengthy as the person's goals, hopes, strengths, and preferences are defined and documented and a plan for achieving them is developed. Once an IPOS is developed, subsequent use of the PCP process, discussions, meetings, and reviews will work from the existing IPOS to amend or update it as circumstances and preferences change. The extent to which an IPOS is updated will be determined by the needs and desires of the person. If and when necessary, the IPOS can be completely redeveloped. The emphasis in using PCP should be on meeting the needs of the person as they arise.

An IPOS must be prepared in person-first singular language and be understandable by the person with a minimum of clinical jargon or language. The person must agree to the IPOS in writing. The IPOS must include all of the components described below:

a. A description of the individual's strengths, abilities, plans, hopes, interests, preferences and natural supports.

b. The goals and outcomes identified by the person and how progress toward achieving those outcomes will be measured.

c. The services and supports needed by the person to work toward or achieve his or her outcomes including those available through the CMHSP, other publicly funded programs (such as Home Help, Michigan Rehabilitation Services (MRS)), community resources, and natural supports.

d. The setting in which the person lives was chosen by the person and what alternative living settings were considered by the person. The chosen setting must be integrated in and support full access to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving services and sup- ports from the mental health system. The PIHP/CMHSP is responsible for ensuring it meets these requirements of the HCBS Final Rule.

e. The amount, scope, and duration of medically necessary services and supports authorized by and obtained through the community mental health system.

f. Documentation that the IPOS prevents the provision of unnecessary supports or inappropriate services and supports.

g. Documentation of any restriction or modification of additional conditions must meet the standards.

h. The services which the person chooses to obtain through arrangements that support self-determination.

i. The estimated/prospective cost of services and supports authorized by the community mental health system pursuant to Contract Attachment P.6.3.2.1B.ii.

j. The roles and responsibilities of the person, the supports coordinator or case manager, the allies, and providers in implementing the IPOS.

k. The person or entity responsible for monitoring the plan.

l. The signatures of the person and/or representative, his or her case manager or support coordinator, and the support broker/agent (if one is involved).

m. The plan for sharing the IPOS with family/friends/caregivers with the permission of the person.

n. A timeline for review.

o. Any other documentation required by Section R 330.7199 Written plan of services of the Michigan Administrative Code.

Once a person has developed an IPOS through the PCP process, the IPOS shall be kept current and modified when needed (reflecting changes in the intensity of the person's needs, changes in the person's condition as determined through the PCP process or changes in the personal preferences for support).

The person and his or her case manager or supports coordinator should work on and review the IPOS on a routine basis as part of their regular conversations. A person or his/her guardian or authorized representative may request and review the IPOS at any time. A formal review of the IPOS with the person and his/her guardian or authorized representative, if any, shall occur not less than annually. Reviews will work from the existing IPOS to review progress on goals, assess personal satisfaction and to amend or update the IPOS as circumstances, needs, preferences or goals change or to develop a completely new plan, if the person desires to do so. The review of the IPOS at least annually is done through the PCP process.

The PCP process often results in personal goals that aren't necessarily supported by the CMHSP services and supports. Therefore, the PCP process must not be limited by program specific functional assessments. The plan must describe the services and sup- ports that will be necessary and specify what HCBS are to be provided through various resources including natural supports, to meet the goals in the PCP. The specific person or persons, and/or provider agency or other entity providing services and supports must be documented. Non-paid supports, chosen by the person and agreed to by the unpaid provider, needed to achieve the goals must be documented. With the permission of the person, the IPOS should be discussed with family/friends/caregivers chosen by the person so that they fully understand it and their role(s).

The person must be provided with a written copy of his or her IPOS within 15 business days of conclusion of the PCP process. This timeframe gives the case manager/ supports coordinator a sufficient amount of time to complete the documentation described above.

## VII. HOW MUST RESTRICTIONS ON A PERSON'S RIGHTS AND FREEDOMS BE DOCUMENTED IN THE IPOS

Any effort to restrict the certain rights and freedoms listed in the HCBS Final Rule must be justified by a specific and individualized assessed health or safety need and must be addressed through the PCP process and documented in the IPOS.

The rights and freedoms listed in the HCBS Final Rule are:

a. A lease or residency agreement with comparable responsibilities and protection from eviction that tenants have under Michigan landlord/tenant law.

b. Sleeping or living units lockable by the individual with only appropriate staff having keys.

c. Individuals sharing units have a choice of roommate in that setting.

d. Individuals have the freedom to furnish and decorate their sleeping or living unites within the lease or other agreement.

e. Individuals have the freedom and support to control their own schedules and activities and have access to food at any time.

f. Individuals are able to have visitors of their choosing at any time.

1. The specific and individualized assessed health or safety need.

2. The positive interventions and supports used prior to any modifications or additions to the IPOS regarding health or safety needs.

3. Documentation of less intrusive methods of meeting the needs, that have been tried, but were not successful.

4. A clear description of the condition that is directly proportionate to the specific assessed health or safety need.

5. A regular collection and review of data to measure the ongoing effectiveness of the modification.

6. Established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.

7. Informed consent of the person to the proposed modification.

8. An assurance that the modification itself will not cause harm to the person.

## VIII. WHAT DO PIHPS, CMHSPS AND OTHER ORGANIZATIONS NEED TO DO TO ENSURE SUCCESSFUL USE OF THE PERSON-CENTERED PLANNING PROCESS?

Successful implementation of the PCP Process requires that agency policy, mission/ vision statements, and procedures incorporate PCP standards. A process for monitoring PCP should be implemented by both the PIHPs and CMHSP, along with the monitoring process through the MDHHS site review.

The following elements are essential for organizations responsible implementing the PCP process:

a. **Person-Centered Culture**. The organization provides leadership, policy direction, and activities for implementing PCP at all levels of the organization. Organizational language, values, allocation of resources, and behavior reflect a person-centered orientation.

b. **Individual Awareness and Knowledge.** The organization provides easily understood information, support and when necessary, training, to people using services and supports, and those who assist them, so that they understand their right to and the benefits of PCP, know the essential elements of PCP, the benefits of this approach and the support available to help them succeed (including, but not limited, pre-planning and independent facilitation).

c. **Conflict of Interest.** The organization ensures that the conflict of interest requirements of the HCBS Final Rule are met and that the person responsible for the PCP process is separate from the eligibility determination, assessment, and service provision responsibilities.

d. **Training.** All Staff receive competency-based training in PCP so that they have consistent understanding of the process. Staff who are directly involved in IPOS services or supports implementation are provided with specific training.

e. **Roles and Responsibilities.** As an individualized process, PCP allows each person to identify and work with chosen allies and other supports. Roles and responsibilities for facilitation, pre-planning, and developing the IPOS are identified; the IPOS describes who is responsible for implementing and monitoring each component of the IPOS.

f. **System wide Monitoring.** The Quality Assurance/Quality Management (QA/QM) System includes a systemic approach for measuring the effectiveness of PCP and identifying barriers to successful use of the PCP process. The best practices for supporting individuals through PCP are identified and implemented (what is working and what is not working in supporting individuals). Organizational expectations and standards are in place to assure that the person directs the PCP process and ensures that PCP is consistently followed.

## IX. WHAT DISPUTE RESOLUTION OPTIONS ARE AVAILABLE?

Individuals who have a dispute about the PCP process or the IPOS that results from the process have the rights to grievance, appeals and recipient rights as set forth in detail in the Contract Attachment 6.4.1.1 Grievance and Appeal Technical Requirement/PIHP Grievance System for Medicaid Beneficiaries. As described in this Contract Attachment, some of the dispute resolution options are limited to Medicaid beneficiaries and limited in the scope of the grievance (such as a denial, reduction, suspension or termination of services). When a person is receiving services and no agreement on IPOS can be made through the person-centered planning process during the annual review, services shall continue until a notice of a denial, reduction, suspension, or termination is given in which case the rights and procedures for grievance and appeals take over. Other options are available to all recipients of Michigan mental health services and supports. Supports Coordinators, Case Managers and Customer Services at PIHP/CMHSPs must be prepared to help people understand and negotiate the dispute resolution processes
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## SECTION X. NOTIFICATION PROVISION CONTACTS

It is agreed that written communication and/or notification pursuant to this Agreement shall be deemed to have been duly given if delivered or mailed, postage prepaid, to the respective Party outlined in the Inpatient Provider Manual under Section X Notification Provision Contacts.

These are the contact people who will be notified of termination, breach, or any other significant issues. If one of these contact people changes, that Party must inform the other.

Written communication is required for notice of termination, breach and/or other significant issues (e.g., investigations by Federal or State authorities, Michigan Protection and Advocacy Services, Inc., etc.).

| | | | |
|---|---|---|---|
| **Person/Title:** | **Donald Avery** | **Person/Title:** | **Tori Alvarado** |
| **CMHSP** | **West Michigan** | **CMHSP:** | **Ottawa** |
| **Address:** | **920 Diana Street** | **Address:** | **12265 James Street** |
| **City/State/Zip:** | **Ludington, MI 49431** | **City/State/Zip:** | **Holland, MI 49424** |
| **Fax #:** | **231-845-7095** | **Fax #:** | **616-393-5687** |
| **E-mail:** | **donalda@wmcmhs.org** | **E-mail:** | **talvarado@miottawa.org** |
| **CC:** | **LisaH@WMCMHS.org** | **CC:** | **ldoyle@miottawa.org** |

| | | | |
|---|---|---|---|
| **Person/Title:** | **Stacey O'Toole, Director, Contract Administration** | **Person/Title:** | **Adam Burger** |
| **CMHSP** | **Network 180** | **CMHSP:** | **HealthWest** |
| **Address:** | **3310 Eagle Park #100** | **Address:** | **376 East Apple Avenue** |
| **City/State/Zip:** | **Grand Rapids, MI 49525** | **City/State/Zip:** | **Muskegon, MI 49442** |
| **Fax #:** | **616-336-3593** | **Fax #:** | **231-724-6074** |
| **E-mail:** | **Stacey.otoole@network180.org** | **E-mail:** | **adam.burger@healthwest.net** |
| **CC:** | **William.ward@network180.org** | **CC:** | **julia.rupp@healthwest.net** |

| | |
|---|---|
| **Person/Title:** | **Nikki McLaughlin** |
| **CMHSP** | **Allegan** |
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