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DETROIT WAYNE MENTAL HEALTH AUTHORITY

PROVIDER MANUAL

FOR OPERATIONS AND PROCEDURES

PROVIDER MANUAL

Welcome

Welcome to the DWMHA Comprehensive Provider Network. As a contractor and DWMHA partner, you will assist DWMHA in meeting its mission of service to Consumers with or at risk for developing serious emotional disturbances, severe mental illness, intellectual/development disabilities, and substance use disorders.

This manual documents and clarifies contractual requirements for participants in the DWMHA provider network. The manual is intended to assist the MCPNs, their subcontractors, and other DWMHA contractors to perform day-to-day operational activities. In some instances, the manual may direct you to a specific policy or an additional document(s) that provides more detail.

Updates and revisions will be disseminated as existing policies, procedures, and processes are revised, or new ones are developed. All comments and feedback that will assist DWMHA in making this manual more useful are appreciated. Comments should be submitted electronically to pihpprovidernetwork.com.

Federal and State law, the Michigan Department of Health and Human Services (MDHHS)/Prepaid Inpatient Health Plan (PIHP) and Community Mental Health Service Provider (CMHSP) contracts, DWMHA/MCPN and Direct Contracted Providers contracts govern DWMHA network relationships and respective duties. To the extent that there is any apparent/perceived contradiction between this Manual and the governing authorities, DWMHA shall resolve the issue and amend the manual as necessary.

For direct services provided by our Integrated Partnership Network call 1-800-241-4949, TTY/TDD Line 1-866-870-2599 (Hearing Impaired) 24 hours a day 365 day per year.

Detroit Wayne Mental Health Authority
Mission Statement

We are a safety net organization that provides access to a full array of services and supports to empower persons within the Detroit Wayne County behavioral health system.

Vision

To be recognized as a national leader that improves the behavioral and overall health status of the people in our community.

Values

- We are a person-centered, family and community focused organization
- We are an outcome, data driven and evidenced-based organization
- We respect the dignity and diversity of individuals, providers, staff, and communities
- We are culturally sensitive and competent
- We are fiscally responsible and accountable with the highest standards of integrity
- We achieve our mission and vision through partnerships and collaboration

See something that does not align with our Mission, Vision, and Values, call the confidential compliance hotline at 313-833-3502.

Detroit-Wayne Mental Health Authority Background

The Detroit Wayne County Community Mental Health Agency, now Detroit Wayne Mental Health Authority (DWMHA), was created pursuant to Michigan Law and the Michigan Mental Health Code. The Agency was in operation beginning October 1968 when the then Wayne County Board of Supervisors approved the joining of Wayne County (County) with the City of Detroit to create the Agency. The Agency was governed by a twelve (12) member Board of Directors, with six (6) directors appointed by the Mayor of the City of Detroit, and six (6) directors appointed by the Wayne County Chief Executive Officer.

The Agency was a division of the County Department of Health and Human Services. The Executive Director is hired by the Board of Directors and is responsible for implementing all the functions of a community mental health services program as mandated by the Michigan Mental Health Code.

Public Act 258 was amended by Public Acts 375 and 376 of 2012 to require that the Detroit Wayne County Community Mental Health Agency transition to an Authority effective September 30, 2013. The name was changed to Detroit Wayne Mental Health Authority (DWMHA). The governing board of directors continues to have six members nominated by the Mayor of the City of Detroit and six members nominated by the Wayne County Commission. The 12 members must be approved by the Wayne County Commission.

DWMHA is responsible for managing specialty services for Consumers with or at risk for serious emotional disturbance (SED), severe mental illness (SMI), intellectual/developmental disabilities (I/DD), and substance use disorders. DWMHA manages a full array of specialty mental and substance use disorders services through contracts with Managers of Comprehensive Networks (MCPNs) and Direct Contractors.

Introduction

What is the DWMHA Network?

The DWMHA network is a comprehensive group of contracted organizations to provide services for the SMI, SED, SUD and I/DD eligible populations in Wayne County. The network is comprised of:

- Managers of Comprehensive Provider Networks and their subcontracted provider and
- Other DWMHA Direct Contractors which includes Substance Use Disorder providers, MI Health Link Dual Eligible providers, and Autism Spectrum Disorders Benefit providers.

What is a Manager of Comprehensive Provider Networks (MCPN)?

The Michigan Department of Health and Human Services revised their plan for procurement which required DWMHA to develop a vertically integrated network of Provider of Specialty Service Networks (PSSN) to ensure choice for Consumers receiving publicly funded mental health services. The Managers of Comprehensive Provider Networks (MCPN) are DWMHA PSSNs.

An MCPN is a business contracting entity established to develop and manage a comprehensive network of providers who can meet the needs of individuals with or at risk of developing severe mental illness, serious emotional disturbance, intellectual/developmental disabilities, and co-occurring disorder. The ultimate goal of DWMHA and each MCPN is to provide choice and access to quality care and services.

MCPNs are:

- NOT managed care plans
- NOT insurance companies

Governance

As defined by the Michigan Mental Health Code, the MCPN governing body must include individuals in the system. At least one-third of the governing body must be primary or secondary consumers. At a minimum, 50% of the one-third member representatives must be primary consumers.

MCPNs must provide consumer representatives with transportation to and from meetings of the governing body. The MCPN must publicize the availability of transportation so that primary consumer representatives can take advantage of the available transportation.

The MCPN must have a policy and program Advisory Council comprised of consumers. The Advisory Council must meet on a monthly basis to review and provide input for existing, new and revised policies, procedures, and programs.

Documentation of the Advisory Council meetings must include registration/sign-in of attendees, agenda and minutes of the meeting, and a record of the directives of the Council.

MCPNs must be able to demonstrate that they have promoted the existence of similar advisory councils within their provider networks.

Contacting DWMHA

Address	707 W Milwaukee Detroit, MI 48202
Phone	313-344-9099
Fax	313-833-2156
Customer Service	1-313-833-3232 1-888 490-9698-Toll Free
TTY Line	1-800-630-1044-Toll Free
Recipient Rights TDY Line	1-888-339-5595-Toll Free 1-888-339-5588-Toll Free
24 Hour Help Line TTY	1-800-241-4949-Toll Free 1-800-870-2599-Toll Free

DWMHA maintains office hours Monday through Friday - 8:00 AM to 5:00 PM.

For DWMHA policies, procedures, and documents, visit our website at www.dwmha.com.

Observed Holidays

DWMHA is closed the following holidays:

- New Year's Day
- Martin Luther King's Birthday
- Memorial Day
- Independence Day
- Labor Day
- Columbus Day
- Thanksgiving Day
- Day following Thanksgiving
- December 24th through January 1st
- General Election Day

myStrength™:

Detroit Wayne Mental Health Authority provides an evidence-based self-management tool, myStrength™, which is available to our provider network to help members and staff manage their health, stay healthy and reduce risk. myStrength's proven web and mobile resources can help strengthen mind, body, and spirit. This wellness self-management tool offers personalized resources to improve depressed or anxious moods and help overcome the challenges of stress, drug and alcohol abuse, pain management and insomnia. To enroll, see the "Member" tab at www.dwmha.com.

Enrollment

The Detroit-Wayne Mental Health Authority provides mental health and substance use disorder services for Consumers with or at risk for serious emotional disturbance, severe mental illness, intellectual/developmental disabilities, and substance use disorders. Our programs are designed to give individuals, within the identified populations, greater choice, and involvement in their treatment. The cornerstones of this program are: (1) providing choice, (2) Person-Center Planning principals, and (3) maximizing the use of and developing new community based services. Services are provided through the Managers of Comprehensive Provider Networks, and other DWMHA Direct Contracted Providers. The enrollment process is centralized through DWMHA's Access Center. The Access Center provides screening and eligibility determinations for all applicants seeking community mental health and substance use disorder services. However, there are currently exemptions to the Centralized Access Center process, which are the following:

- Inpatient and crisis services, which includes hospitals and screening centers
- Outpatient providers managing crisis or emergent situations with an individual that walks into their facility
- Specialized Direct Contract Providers
- All Criminal Justice programs
- Infant Mental Health
- Housing and Urban Development (HUD)
- Persons discharged from hospitals
- Children in Foster Care under the auspices of the Michigan Department of Human Services (DHS)
- The MI Health Link program (Medicare/Medicaid Enrollee)

Eligibility for Enrollment with DWMHA

Wayne County residents with or at risk for developing serious emotional disturbance, severe mental illness, intellectual/developmental disabilities, substance use disorder, and co-occurring disorder are eligible.

Based on the Michigan Mental Health Code, services are available to eligible Consumers regardless of the ability to pay. Therefore, neither the lack of funds nor the ability to directly pay through private funds or insurance can be a barrier to receiving services if the person is in the priority population. The clinically responsible service provider assists consumers that lack insurance with applying for their entitlements. DWMHA benefit package for the uninsured allows for the consumers to receive specific services for a limited time. Wayne County residents who are in the priority population and have private insurance or are able to directly pay the cost of services are eligible for community mental health services.

Registering New Members for Enrollment

Registering new members is a two-step process:

Step 1

For Consumers that are not listed in MH-WIN or not assigned to an MCPN, but are seeking mental health services, the consumer/family/guardian must contact DWMHA Access Center**,** Wellplace formerly Pioneer Behavioral Health at 1-866-690-8257 to initiate the screening and eligibility process. A face to face screening shall be provided based on choice/individual need. The Access Center shall inquire as to the existence/desire to complete an Advance Directive. As part of its triage process, Pioneer determines if the Person is requesting and is appropriate for mental health services. Once appropriateness for mental health services is determined, the Person is offered options of intake locations. The Access Center will assign an MCPN, and then enter the potential member and the assigned MCPN into MH-WIN.

Step 2

The Access Center will schedule the first intake appointment with the consumer/family/guardian based on their choice of provider locations and available appointments which have been entered in MH_WIN by providers. Non-emergent intake appointments shall be scheduled within fourteen (14) days, and persons discharged from hospitals shall receive an appointment within seven (7) days.

Confirmation of Enrollment

The Access Center will make a determination of eligibility immediately following the telephonic/face to face screening process. The Access Center will send a Welcome Packet within 24 hours of enrollment. The Welcome letter shall include the information specific to Advance Directives.

MCPN Transfers

Enrolled members may request a change of their assigned Managed Comprehensive Provider Network (MCPN) twice per fiscal year which begins October 1st and ends September 30th. The enrolled person shall be able to initiate the change process by submitting a MCPN Change Request Form to DWMHA's Access Center during open enrollment. Change applications can be submitted 30 days prior to October 1st and/or March 1st.

Enrolled persons shall have the opportunity to change MCPN assignments outside of the open enrollment periods due to extenuating circumstances. Staff in the Managed Care Operations unit will review and approve all MCPN Exception Change Requests per policy.

The MCPN and the current provider are required to cooperate with and assist the member in a smooth transition (e.g. provide clinical information, transfer personal property, etc.) to the new MCPN and subcontractor. A copy of the clinical record must be provided seven (7) business days prior to the Person's transfer. Medication(s) and other personal care items must accompany the person at the time of transfer if the person is in residential care. Personal property, (e.g., clothes, small appliances, radios, etc.) must either accompany the residential Person at the time of transfer or be delivered to the Person within two (2) business days of the transfer.

The cost of transfer is the responsibility of the MCPNs. The MCPNs must coordinate with each other and their respective subcontractors to cover the cost of transfers. MCPNS are free to establish funding means or plans to support the transfer process.

Disenrollment

Consumers may leave or dis-enroll from the network for a variety of reasons including relocation out of Wayne County, death, prison sentence (Michigan Department of Corrections), or case closure due to inactivity, e.g., clinical improvement, completion of the treatment plan, or declination of services by the Person.

Coordination of Benefits

DWMHA's contractors are responsible for identifying and coordinating covered services, benefits and determine the individuals' ability to pay. They are also responsible for identifying other potential first and third-party liabilities for payment of service.

DWMHA's contractors must have a method to ensure that payments from DWMHA are payments of last resort and that the best use of community resources and supports are explored for each person receiving services.

If the MCPN or other DWMHA contractors do not obtain this information directly from the individual, then each entity must establish a process with its subcontractors to obtain the information. The MCPN or its subcontractor or other DWMHA contractor must:

- Verify the Person's eligibility for other benefit coverage,
- Bill the other coverage as primary payer,
- Notify the MCPN of such coverage,
- Notify DWMHA of such coverage, and
- Notify DWMHA of changes in insurance or other coverage status.

The MCPN or Contracted Provider must assist Consumers in applying for and maintaining their eligibility and enrollment with entitlements as appropriate.

Membership Card

The MCPN must issue enrolled Consumers a membership card with the following important information:

- Name of the MCPN,
- MCPN's 24-hour, 7-day per week toll-free telephone number,
- DWMHA's Customer Service telephone number, and
- Detroit-Wayne Mental Health Authority identified on the card.
- Re-issuance of an Enrollee membership card is to be honored upon request at no cost to the enrollee.

Covered Services

Enrollee Covered Services and Benefits

Covered services are based on the MDHHS PIHP/CMHSP contract and the Michigan Medical Services Administration Community Mental Health Services Program Manual. From time to time, covered services may change based on Federal, State and/or County mandates and requirements.

The following is a partial list of services that are available for Consumers with, SED, SMI, I/DD and SUD within the DWMHA network. All services and supports must be medically necessary/clinically appropriate, individualized and based on Person-Centered Planning. For a detailed list, please refer to the Medicaid Policy Manual.

- Hospital-Based Services
- Residential Services
- Community Based Programs for Consumers with SED/SMI
- Community Based Programs for Consumers with I/DD
- Prevention Services for Consumers with SUD
- Treatment Services for Consumers with SUD

Family Subsidy

Michigan's Family Support Program was established with the passing of Public Act #249 of 1983, the Family Support Subsidy Act. The Program is designed to provide financial help for families who are caring for their children, 17 years of age and younger, with severe disabilities in the family home. Monthly stipends are equivalent to the monthly maximum supplemental security income payment available in Michigan for an adult recipient living in the household of another. Increases are determined annually by legislative appropriation.

DWMHA's Family Subsidy Office may be contacted at 313-833-4150.

MI Health Link

General Information:

MI Health Link is a dual eligible demonstration project that integrates Medicare and Medicaid benefits, rules and payments into one coordinated delivery system.

The five health plans – Molina, Midwest, Aetna, AmeriHealth, and Fidelis - are known as Integrated Coordinating Organizations (ICO) that manage acute, primary, pharmacy, dental and long-term supports and services.
Detroit Wayne Mental Health Authority (DWMHA), as the designated regional Pre-Paid Inpatient Health Plan (PIHP) for Wayne County, will manage the full scope of behavioral health services covered by Medicare and Medicaid. The PIHP will continue to coordinate and monitor services delivered to individuals with mental illness, intellectual/developmental disabilities and substance use disorders. These services would include:

- Outpatient visits (Medicaid and Medicare) for individuals with mild to moderate, severely mentally impaired (SMI), substance use disorders (SUD), and intellectual/developmental disabilities (I/DD)
- Outpatient treatment for alcohol and drug use
- One depression screening per year
- Individual and group therapies
- Family counseling
- Psychiatric evaluation
- Medication management
- Diagnostic tests
- Exclusive of Medicare Part D medications
- Other Medicaid behavioral health services for individuals with specialized needs related to the behavioral health and I/DD beyond covered acute care services
- Medicare Part B covers partial hospitalization – a structured program of outpatient psychiatric services which are provided as an alternative to inpatient care
- Medicare Part A (Hospital Insurance) assists in paying for inpatient mental health services. Care is delivered either in a general hospital or in a psychiatric hospital that only cares for individuals with mental health concerns Individuals eligible for MI Health Plan must:
    - Be 21 years of age or older at the time of enrollment
    - Live within the demonstration area
    - Must have full Medicaid benefits without spend-down
    - Must have full Medicare benefits including Part A and must be enrolled in Part B and D.

Those individuals who are not eligible for the dual eligible program are either living in a State Facility, are covered under a commercial HMO, have a Medicaid spend-down or are receiving Hospice Services.

Enrollment into MI Health Link:

Individuals eligible to participate in MI Health Link will be sent information materials regarding MI Health Link approximately 30-60 days of initial enrollment. The State of Michigan will access Michigan ENROLLS to enroll potential members/enrollees. Individuals' questions will be answered by the Michigan Medicare and Medicaid Assistance Program (MMAP) – 1-800-803-7174.

It is important to note that transition of care procedures have been developed and will be implemented to ensure continuity of care. Existing relationships with "out-of-network" Providers will be maintained by the health plan during the transition to MI Health Link. Enrollees may choose to continue to receive services through the "out-of-network" Providers for 180 days. Providers will be given an opportunity to join the MI Health Link network after completing the DWMHA credentialing and empaneling process. If they choose not to become a contracted provider, consumers will be transitioned to an in-network MI Health Link Provider after 180 days.

Care Coordination Following Enrollment:

Once enrolled, the consumer is assigned an ICO Care Coordinator and undergoes initial screening. Within 45 days of initial screening, the ICO completes a Health Risk Assessment. Should the enrollee identify a need for behavioral health services, he/she will be offered a referral for such services. Referrals are sent to DWMHA Access Center to determine if this person is already a consumer of services or a new referral. If the consumer is already receiving services at a MI Health Link network provider, a request is made for the current provider to send over biopsychosocial and diagnostically appropriate level of care (LOCUS/SIS/ASAM) assessment via the MH WIN system. In this program, the biopsychosocial and level of care are called the Level II assessment for behavioral health.

For consumers without a current behavioral health provider, the DWMHA Access Center will schedule the Level II assessment with a Behavioral Health Provider that is a contracted MI Health Link Provider. The Level II assessment consists of a biopsychosocial assessment, LOCUS/SIS/ASAM, as well as a consent to share information form. This documentation must be completed within 15 days of Level I completion. The completed documents are then uploaded and sent to the ICO via MHWIN. The PIHP care coordinator monitors and ensures that the assessments are completed in a timely manner and contacts responsible Providers as necessary. Additionally, the PIHP care coordinator engages enrollees and guardians, as appropriate, to ensure that he/she is linked to appropriate services. This care coordinator also maintains contact with the ICO care coordinator to provide updates that affect the enrollee's overall care plan.

Following completion of the Level II assessment, the care coordinator should schedule an Integrated Care Team (ICT) meeting with the enrollee, the ICO care coordinator, and any other providers or natural supports involved in the member's care, and always including member preference. Individuals who receive mile to moderate behavioral health services have their ICT meetings scheduled by the ICOs; those who are deemed to be SMI or I/DD will have their ICT meetings scheduled by the behavioral health Providers. When possible, ICT meetings should be mapped on to the person-centered planning processes outlined in the Michigan Mental Health Code to reduce redundancy. The ICT plan should incorporate the following:

- Assessment results
- Consumer's health needs
- Consumer's preference for care
- Supports and services needed to assist in consumer's care
- Consumer's prioritized concerns, goal list, and strengths
- Specific services with scope, frequency, duration, and amount identified
- Strategies to address identified concerns and goals
- Identified individuals who will carry out various portions of the plan
- The date of plan initiation as well as the reassessment date

Specialized Residential Services for MI Health Link Consumers:

12 Specialized residential services are authorized and offered by the Managers of Comprehensive Provider Networks (MCPN). If the individual is not assigned to an MCPN, then the consumer may choose the MCPN they prefer using the Consumer Enrollment form. A referral for residential services is made by the behavioral health Provider to the identified MCPN. The referral packet will include a biopsychosocial assessment, psychiatric evaluation, nursing assessment, and medication sheet. The MCPN will then complete a level of care assessment to determine appropriateness for specialized residential services. The level of care assessment includes individual choice with regard to residential options. If the individual is homeless, then the MCPN and behavioral health Provider can assist in identifying pre-placement/transitional housing until a more permanent option is identified. Once results of the assessment become available, the PIHP care coordinator should notify the ICO. If the individual accepts specialized residential services, then the ICT meeting should also include plans to assist him/her to transition into the new residential setting. It should be noted that if the need for specialized residential services becomes known while the individual is in an acute setting and he/she has not undergone the Level I or Level II assessment, the process for placement will continue as described above. However, the PIHP and ICO care coordinator will work together to ensure the assessments are completed as soon as possible.

MI Health Link Care Coordination in Acute Care Settings:

The following steps are to be taken by DWMHA Utilization Management (UM) and MI Health Link Care Coordinators:

- UM at DWMHA will be notified of an inpatient admission or other acute care activity.
- UM will then notify the PIHP care coordinator
- PIHP care coordinator will contact the hospital and obtain information regarding enrollee's potential needs at discharge; a clinical packet consisting of psychosocial assessment, psychiatric evaluation, nursing assessment, and medication sheet will be emailed via secure email or faxed
- PIHP care coordinator notifies the ICO of the admission and also shares the clinical packet as appropriate. If there are significant medical issues, the PIHP care coordinator works with the ICO care coordinator to ensure that the necessary supports are in place to address these prior to discharge.
- PIHP care coordinator identifies if the enrollee is engaged with a behavioral health Provider and works with the hospital discharge planner and outpatient provider to ensure a smooth transition and that the ICT and person-centered plan are updated as appropriate.

MI Health Link Enrollee Protections:

Enrollees are able to choose their ICO or change their ICO to suit their preference. Enrollees also have a choice of behavioral health Providers and care coordinators. Health plans are required to include consumers in ICO Advisory Councils and obtain input on changes made to the program.

Enrollees should be provided with information regarding the Grievance and Appeals Process during the person-centered planning/ICT meeting. Standard terms, language, and documents are developed to clearly explain membership, appeals rights and all other protections available

The MI Health Link Ombudsman's office is a free State-funded entity that provides advocacy and problem-solving services to MI Health Link beneficiaries. MI Health Link beneficiaries are able to contact the Ombudsman's office with questions, for assistance in obtaining resources, filing grievances and appeals and making a complaint.

Contact info:

MI Health Link Ombudsman

Monday- Friday 8:00am to 5:00pm

1-888-746-6456

Medicaid/ Autism Benefit

DWMHA offers Applied Behavior Analysis (ABA) Services to individuals who:

- Have an Autism Spectrum Disorder (ASD) Diagnosis
- Are younger than 21 years of age
- Are Medicaid Eligible

ABA is an intensive, behaviorally-based treatment that uses various techniques to bring about meaningful and positive changes in the communication, social interaction, and repetitive/restrictive behaviors that are typical of ASD. Each enrollee will have an individualized ABA Plan that breaks down desired skills into manageable steps to be taught. Each ABA Plan is designed for the individualized needs of the enrollee and will include an average of 5 to 25 hours of direct interventions per week depending on medical necessity. These services are intensive and can be provided either in the home or in a clinic setting. ABA interventions involve parent/guardian training and participation.

To receive ABA services in Wayne County, the child must be screened. Either the child's Primary Care Physician or the Detroit Wayne Mental Health (DWMHA) Access Center can help start this process. The DWMHA Access Center can be reached by calling (800) 241-4949. Additional information on DWMHA's Applied Behavior Analysis Autism Benefit can found at www.dwmha.com

Integrated Healthcare (IHC)

Integrated Health Care is a systematic, holistic approach to the overall care of an individual. It is the coordination of integrating health care services for physical health, mental health, substance use disorder, and developmental disabilities. By combining medical care with behavioral health services, it will fully address the spectrum of problems that an individual might bring to the health care Provider whether it is in a primary care or mental health setting. Integrated care produces the best health outcomes and more effectively cares for people with complex healthcare needs.

In Detroit-Wayne County, integrated health care will give individuals and family members comprehensive and easy access to recovery-oriented supports, and that meet the individual's needs. Medical and behavioral health professionals will work together as a team, to improve the overall health and well-being of each individual at any Provider location. Advantages of Integrating Mental Health and Physical Health Care Services Integrated health care will be central to improve the overall health of consumers of mental health and substance use disorder services. Persons with behavioral health conditions are disproportionately affected by preventable and treatable medical conditions like type II diabetes, heart disease, obesity, and hypertension. Integrated care aims to address whole person health and recognizes benefits such as:

- Improved Access to Care,
- Reduced morbidity and mortality rates,
- Better monitoring of health conditions,

- Decreased medication complications and
- Reductions in stigma related to behavioral health.

Guiding Principles and Characteristics of Integrated Health Care:

- Holistic Approach to Patient-Centered Care - Primary care and behavioral health providers assess all health care needs of consumers, including mental, physical, substance use, etc.

- Measurement-Based Treatment to Target - Each consumer's care plan clearly articulates personal goals and clinical outcomes that are routinely measured.

- Evidence-Based Care - Consumers are offered treatments that have credible research evidence to support their efficacy in treating the target issue.

- Care Management - Behavioral health case managers use their skill set to assist in addressing issues of chronic illness from a preventive, recovery-oriented approach.

- Financial Accountable Care - Providers are accountable to maximize use of resources reimbursed for quality care and outcomes.

- Prevention, Promotion, Wellness, and Recovery Programs - Self-defined balance of health habits such as exercise, productivity, nutrition, social contact, and supportive relationships.

- Population-Based Care - Care team shares a defined group of consumers, using a health information exchange, for bi-directional pertinent information sharing. Practice track and reach out to consumers who are not improving; and mental health specialists provide caseload-focused consultation, not just ad-hoc advice.

Integrated Care – Complex Case Management

Detroit Wayne Mental Health Authority (DWMHA) offers a Complex Case Management (CCM) program for eligible individuals who might benefit from more intensive care coordination services. The CCM program is designed to support individuals with complex behavioral health and medical concerns who need to be linked to services and appropriate community resources. Criteria for acceptance into the CCM program include:

- The presence of complex behavioral health and medical health concerns that require a higher level of care - i.e., specialized residential services - and intensity of services

- The use of extensive behavioral health utilization within a 12-month period

- The individual's willingness to actively participate in CCM as the program is voluntary

For more details, members, please contact 1-888-490-9698 or providers can fill out the referral form, located on the DWMHA website or attached to page 118 of this manual, and email to pihpccm@dwmha.com. There is no cost to individuals who are interested in participating in the CCM program. The CCM team is looking forward to working with individuals to improve the overall quality of life and well-being.

Behavioral Health and Substance Abuse Screening Program

Detroit Wayne Mental Health Authority (DWMHA) is committed to excellence in behavioral health service delivery. DWMHA strives not only to meet but also to surpass standards set forth by the National Council for Quality Assurance (NCQA) for Managed Behavioral Health Organizations (MBHO). NCQA is an accrediting organization intended to assist behavioral health organizations in achieving the highest level of performance possible, reducing member risk for untoward health outcomes, and creating an environment of continuous improvement.

To best serve our members with the provision of appropriate behavioral health and substance use services, and to continue to exceed quality standards, DWMHA is dedicated to advancing wellness and taking action to reduce negative effects of mental illness and substance use disorders through the promotion of early screening and assessment. Towards this effort and dedication, DWMHA has implemented two screening programs, one for coexisting mental health and substance use disorders using the Bio-psychosocial Assessment, and a second screening program, for screening for depression in adults, the Patient Health Questionnaire-9 (PHQ-9). These two screening measures are based on scientific evidence, best practice, and industry standards. DWMHA will review scientific evidence and update these programs every two years, or more often, where appropriate if new evidence becomes available in between scheduled reviews. The selection of screening measures, identification of population screened, recommended frequency of the screenings, and overall program design has been a collaborative effort between DWMHA, MCPN's and providers and practitioners within DWMHA's Provider Network.

According to SAMHSA (Substance Abuse and Mental Health Services Administration), approximately 8.9 million adults have co-occurring disorders, meaning, they have both a mental health and substance use disorder, and only 7.4% of these individuals receive treatment for both conditions (SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2008 and 2009).

The Bio-psychosocial Assessment

The Bio-psychosocial Assessment was developed by a committee of contracted providers and practitioners as well as representatives from the MCPN's in collaboration with DWMHA. It encompasses questions from the American Society of Addiction Medicine (ASAM) criteria, Addiction Severity Index (ASI), Mental Health Screening form lll, Mood Disorder Questionnaire and Patient Health Questionnaire, to screen for coexisting behavioral health and substance use disorder conditions.

The Bio-psychosocial Assessment should be completed face to face on all individuals deemed to be eligible for services with DWMHA within fourteen (14) calendar days of a non-emergent request for service or within seven (7) calendar days of a psychiatric inpatient admission as well as annually and must be completed or visible in MHWIN. MHWIN is an online application developed by Peter Chang Enterprises (PCE). MHWIN is DWMHA's primary business and clinical application. Its main functions are claims processing, consumer demographics, and a repository of consumer assessments.

Based on age and positive answers to mental health screening questions, the clinician will be prompted to complete a Mood Disorder Questionnaire (MDQ) and/or a Generalized Anxiety Disorder (GAD) assessment. For positive answers to screening questions on alcohol or drug use, the clinician will be prompted to complete the Alcohol Use Disorder Identification Test (AUDIT) and/or the Drug Abuse Screen Test (DAST-10). These assessments are linked to within MHWIN. Once completed, any assessments completed are scanned and attached to enrollee/member's case.

The MDQ was developed by a team of psychiatrists, researchers, and consumer advocates to address the timely and accurate diagnosis of bipolar disorder. It is designed for screening purposes only, and a positive screening should be followed by a comprehensive assessment. Based on answering yes to either or both of the following questions, the clinician is prompted to complete the MDQ. "Do you feel hyper or high (like on drugs) even though you haven't taken any? Or "Do you have times when your thoughts race or you have less need for sleep lasting more than a week?"

The GAD is a ten-question screening tool that identifies whether a complete assessment for anxiety is indicated. Based on answering yes to either or both questions: Do you feel you are a nervous person? Or "Is it hard for you to control your worry?" the clinician is prompted to complete the GAD.

AUDIT is a ten-item screening tool developed by the World Health Organization (WHO) to assess alcohol consumption, drinking behaviors, and alcohol related problems. A score of 8 or more is considered to indicate hazardous or harmful alcohol use. Based on answering yes to "Do you sometimes use beer, wine, or other alcohol where you or someone close to you feels there is a problem or there have been legal consequences?" the clinician will be prompted to complete the AUDIT.

The DAST-10 was designed to provide a brief instrument for population screening and clinical case finding to assess drug use and abuse. It assesses drug use (not involving alcohol or tobacco) in the past twelve months. Based on answering yes to "Do you sometimes use any drugs for recreation use (such as marijuana, cocaine, crack, heroin) or take prescription medications more often than prescribed?" the clinician will be prompted to complete the DAST-10.

The PHQ-9

Major Depression is one of the most common illnesses in the United States. The total lifetime prevalence for adults is close to 20%, and twelve-month prevalence rates just under 10%. We know that major depression adversely impacts one's general health, compromises compliance with wellness initiatives, and contributes to premature morbidity and mortality.

The majority of people with depression do not present to behavioral health providers, and the majority of treatment and referrals occur in primary care settings. The Journal of the American Medical Association in January 2016 published recommendations on the early detection, intervention, and treatment of depression for primary care and OB/GYN settings utilizing the Patient Health Questionnaire 9 (PHQ9) or similar tools.

While mood disorders are the most common diagnosis in public behavioral health settings, these settings have not been as methodical in utilizing standard tools for screening, and for monitoring the outcomes of treatment. In fact, some studies have shown that other specialties are better at treating depression to remission than is behavioral health!

To that end, DWMHA has implemented the utilization of the PHQ9 for screening, as well as monitoring treatment outcomes. DWMHA expects the goal of clinicians to treat depression to remission, and tools such as the PHQ9 help the clinician and member monitor the target symptoms and overall progress.

DWMHA requires providers/practitioners to complete a PHQ-9 on all adults aged 18 years and older at the point of intake. Members with a score of 10 or greater should have a follow up PHQ-9 administered at least quarterly to monitor the target symptoms and overall progress and must be completed or visible in MHWIN.

The PHQ-9 is the nine-item depression scale of the patient health questionnaire. It is one the most validated tools in mental health and can be a powerful tool to assist clinicians with diagnosing depression and monitoring treatment response. The nine items of the PHQ-9 are based directly on the nine diagnostic criteria for major depressive disorder in the DSM-IV. The PHQ-9 is rather unique in that it functions as a screening tool to aid in diagnosis and as a symptom tracking tool that can help track a member's overall depression severity as well as track the improvement of specific symptoms with treatment.

The selection of screening measures, identification of population screened, recommended frequency of the screenings, and overall program design has been a collaborative effort between DWMHA and providers and practitioners within DWMHA's Provider Network. Program design and implementation were discussed in collaboration with:

- DWMHA's Managers of Comprehensive Networks (MCPN) bi-monthly partnership meetings, which consist of staff from both the MCPN's and DWMHA. The purpose of these meetings is to share information on DWMHA initiatives, policies, procedures and program descriptions to get input and feedback.
- The Medical Director's meeting which is a quarterly meeting. The PIHPs of Macomb, Oakland, and Wayne Counties conduct these jointly, with rotating responsibilities for hosting. Medical Directors and Administrators, as well as Clinical Leads, from the PIHPs, provider clinics, and hospitals are invited. Also invited are pharmacy and pharmacology specialists, and MDHHS representatives. The purpose is for education, information sharing, and policy review.
- The Adult Mental *Health Learning Collaborative (*AMILC), hosted by our Clinical Practice Improvement Division, consist of a group of our Adult Mental Health Providers who come together bi-monthly to discuss any trends, issues, information and updates that pertain to evidence based practices, and system wide endeavors.
- The screening programs are found on DWMHAs website, and within the Provider Manual and will continue to be distributed to new providers and practitioners as part of the credentialing process through the distribution of the Provider Manual.

Substance Use Disorder

Substance Use Disorder services for Wayne County residents are accessed through Detroit Wayne Mental Health Authority.

The services provided by Substance Use Disorder agencies contracted with DWMHA are for Medicaid, Healthy MI, uninsured and under insured consumers only. The following services are available:

- Screening, Diagnosis, Placement, and Referral
- Outpatient Services:
    - Individual Therapy
    - Family Therapy
    - Group Therapy
- Intensive Outpatient Services:
    - With Domicile
    - Without Domicile
- Residential (sub-acute) Detoxification

- Residential Services (short and long term)
- Food and Drug Administration (FDA) approved controlled substances (e.g., Methadone, other medication assisted treatments, etc.).

In order to participate in the Detroit Wayne Mental Health Authority, substance use disorders services an individual must:

- Have recognized, appropriate identification (i.e., State of Michigan Identification, a valid driver's license, birth certificate, Social Security card, etc.).
- Be a resident of the Wayne County whose Medicaid, Healthy MI, Block Grant, or MI Child service case is currently held in the Detroit Wayne Mental Health Authority Region as identified by the recipients Medicaid/Healthy MI card or Medicaid/Healthy MI case file only. Detroit Wayne Mental Health Authority residents have priority for substance abuse treatment within the Detroit/Wayne region.

Access to care for Substance Use Disorder recipients entering the Detroit Wayne County Region can be facilitated through any of the following entry points:

- Detroit Wayne Mental Health Authority Access Center for Service-Adults and adolescents.
- Calling the region's Toll-Free *Access Center Line*-Adults and adolescents – 1-800-241-4949.

Consumerism

Each Contracted Provider and MCPN must adopt the MDHHS Consumerism Best Practice Guidelines. They must actively promote consumerism by giving Consumers, family members, and advocates decision-making roles in the service design, implementation, delivery, and evaluation process. Primary and secondary consumers must be involved in the design and selection of the provider network, operational policies, and procedures, and all other major aspects of decision-making. Examples of decision-making roles are: identifying in-service education topics, developing consumer hiring practices, reviewing utilization management policies, critiquing promotional brochures, identifying network gaps, etc. Consumer input may be obtained through board membership, advisory councils, focus groups, public forums, interviews, or any other means that provides members with opportunities for meaningful input.

MCPNs must establish a person/stakeholder advisory body composed of Consumers, family members, and advocates. The advisory body is responsible for advising the Executive Director and Board of Directors on all aspects of implementing consumerism including (1) choice, (2) consumer-run services, and (3) consumer involvement in the design, implementation, delivery, and evaluation of the network and network operations. Given the critical need the MCPNs have, it is expected that this body meets no less than

monthly. However, once the body is fully constituted and all functions are implemented, it may choose to meet less frequently, but no less often than quarterly.

MCPNs must include representation of primary and secondary consumers on their Board of Directors. Refer to the Governance section for additional details.

As part of their Quality Improvement Programs, MCPNs must design an ongoing process for assessing consumer satisfaction. Consumer satisfaction results must be aggregated annually and reported to the MCPNs Board of Directors, its Advisory Body, and DWMHA. The MCPN is also free to develop other methods of assessing satisfaction, including direct input through focus groups, and to gather ideas and responses from Consumers regarding their experiences with services.

MCPNs must establish a mechanism for active participation of consumers, family members, and advocates in the quality improvement process. This includes meaningful participation in the evaluation of mental health and substance abuse services.

MCPNs must establish consumer recognition and awards for special achievements through employment, public service, sports, education and other areas of accomplishments. MCPNs should take every opportunity to recognize consumer's contributions at board meetings, proactively seek media exposure for consumer-run services and activities, and create forums for consumers to receive public recognition for accomplishments.

MCPNs must ensure that mental health services are implemented within the context of the Person-Centered Planning process in order to provide choice, control, independence, and integration.

MCPN policies and procedures must:

- Assure "Person-First Language" is utilized in all publications, formal communications, and daily discussions. "Person-First Language" means that when individuals receiving mental health services are mentioned in the same phrase with their disorder, the person is always referred to first. For example the appropriate reference would be adults with mental illness versus mentally ill adults; children with serious emotional disturbance versus seriously emotionally disturbed children.
- Establish a mechanism to provide Consumers, including advocates or guardians, the information, and counsel needed to make informed treatment choices.
- Establish a means to help Consumers and families examine and weigh their treatment and support options, financial resources, housing options, education and employment options. This also includes assisting individuals in learning how to make their own decisions and take responsibility for themselves.

- Design mechanisms to help Consumers understand his or her social obligations and develop interactive social skills.
- Assure that Consumers are provided opportunities and choices that will enable them to reach their fullest potential.

Inclusion

Each MCPN, their sub-contractors, and the direct contracted providers must adopt the MDHHS Inclusion best practice guidelines. MCPNs and Direct Contracted Providers must assure programs and services are designed to support the principle of normalization. This includes delivery of clinical services and supports that:

- Use community-established resources before developing new or using those that serve only mental health programs.
- Address the social, age appropriate, cultural, and ethnic aspects of services and outcomes of treatment.
- Help consumers gain social integration skills and become more self-reliant
- Assist Consumers in obtaining compensated employment. Assistance may include, but is not limited to, helping Consumers develop relationships with coworkers, using assistive technology to obtain or maintain employment, or providing transportation to and from employment.
- Identify community support that can foster or promote inclusion.
- Assist Consumers to obtain/maintain permanent, individual housing integrated in residential neighborhoods.
- Help families develop and utilize both informal and community networks of supports and resources.
- Provide children with treatment services, which preserve, support, and in some instances, create a permanent, stable family (for example, adoption).

Employment of Consumers Receiving Services

MCPNs must:

- Involve Consumers in the design, delivery, monitoring, and evaluation of covered services.
- Use their best effort to ensure that at least 10% of the aggregate of the MCPN and its contracted Provider Network are Consumers who are in paid positions of at least ten (10) hours per week.
- Increase their commitment and that of their contracted Provider Network to employ Consumers including making provisions for recruitment, placement, and development of pay scales, benefits and training.
- Establish programs specifically dedicated to Persons' interests, staffed by Consumers and/or family members.

- Demonstrate improvements in performance in employment of Consumers
- Solicit and ensure Persons' input and involvement in the MCPN's Provider Network, its community and population needs assessment, and service planning activities.

Recovery

Services and programs provided to Consumers with mental illness and related disorders shall strive to accomplish the following goals:

- Provide information to the general public to reduce the stigma of mental illness.
- Create environments for all Consumers in which the process of "recovery" can occur.
- Provide basic information about mental health, recovery, and wellness to Consumers and the public.

Peer Support

Peer support services are an evidence-based model of care which consists of utilizing qualified peer support specialist in assisting individuals with their recovery from mental illness and substance use disorders. Peer Support Specialist provides individuals with support, mentoring and assistance in achieving community inclusion, participation, independence, recovery, and resiliency.
Peer Support Specialists participate as a team member in the person-centered planning process based upon consumer choice and preference.

Peer supports are a Medicaid b (3) covered service in the Michigan Medicaid Specialty Health Plan Provider Manual.

Peer Recovery Coaches

A peer recovery coach is an individual who has lived experience in receiving services and/or supports for a substance use condition. They serve as a guide to initiate, achieve and sustain long-term recovery from addiction including medication assisted, faith based, 12 step and other pathways to recovery. Recovery coaches provide connections in navigating recovery supportive systems and resources including professional and non-professional services.

Person Centered Planning Process and Approval

The MCPN and other DWMHA Direct Contracted Providers shall ensure implementation of the Person/Family-Centered Planning process for all individuals except those receiving short-term outpatient services (12 sessions or less annually) or medication reviews. Each MCPN shall ensure implementation of DWMHA's standardized PCP documents: pre-planning, psychosocial assessment for adults and children, and the individualized plan of services/person/youth/family centered plan.

Covered Services must be provided in accordance with Person/Family-Centered Planning (PCP) practices. All DWMHA contractors must promote family support approaches for Consumers living with their natural family. Contractors must also assure that there are choices available to Consumers for Covered Services, including, but not limited to, choice of case managers and offer self-determination models for adults. The PCP process must include both verbal and nonverbal translation of services when needed.

The MCPN and other DWMHA contractors must ensure that all Covered Services provided by the contractor or its subcontractors are in keeping with the Michigan Mental Health Code, DWMHA Policies, the MDHHS, and current, clinical guidelines. The MCPN must provide PCP training to its subcontractors/providers, staff, families/guardians, and other stakeholders. For additional information reference DWMHA Person-Centered Planning policy and the Performance Standards section of the Manual.

Services and supports provided to minors and their families must be:

- Delivered in a family-centered approach implementing comprehensive services that address the needs of the minor and his/her family, and
- Individualized and respectful of the minor and family's choice of services and supports.

Crisis Plan

Consumers shall be offered the opportunity to develop a Crisis Plan. MCPN and Providers shall ensure documentation of acceptance or decline of this opportunity is in the case record.

Crisis plans help staff identify and address consumers that may be experiencing a mental health crisis. Staff should be able to identify when a consumer is in the beginning stages of de-compensating to try and work with them on stabilizing the consumer to avoid a full blown crisis situation. Crisis Plans assist the crisis response programs to better provide consumers the needed services and improve communication among all service providers. Crisis plans should be developed with all consumers and documented in their files. Crisis Plans should be completed and/or uploaded into DWMHA's electronic system. The electronic system has a highlighted banner alerting that the consumer has a crisis plan in place.

Self Determination

Self-determination is the value that people served by the public mental health system must be supported so they may have a meaningful life in the community. Michigan's Self-Determination Policy & Practice Guideline (SD Guideline attached as Appendix A) requires that Prepaid Inpatient Health Plans/Community Mental Health Service Programs (PIHP/CMHSPs) offer arrangements that support self-determination, assuring methods for people to exert direct control over how, by whom, and to what ends they are served and supported.

MCPNs and other DWMHA Direct Contracted Providers must offer Self Determination arrangements to Consumers and document that services have been offered. The MCPN and other DWMHA contractors must provide training on Self Determination to its subcontractors/providers, staff, families/guardians, and other stakeholders. For additional information reference the DWMHA Self Determination Policy.

Independent Facilitation

Independent Facilitation is an ongoing process of supporting people with disabilities to take up their full citizenship and participate in their community.

An independent facilitator helps an individual create a vision for their future. It's a process rooted in relationship and can facilitate many objectives: exploring passions and interests, finding paid or volunteer work, developing new roles in community, nurturing new friendships and exploring options for home are just some of the aims that an individual may focus on through Independent Facilitation.

The MCPNs, sub-contracted provider networks, and Direct Contracted Providers must ensure consumers are provided access to the option of independent facilitation services. Advocacy organizations, such as the ARC's, National Alliance for the Mentally Ill (NAMI), and peer specialist or consumers/individuals receiving services, may be included in the pool of individuals/ organizations to provide this service.

MCPNs, sub-contractors, and Direct Contracted Providers must ensure that Individuals providing the independent facilitation services meet the following criteria:

- Free of any conflict of interest (i.e., not employed at the organization he/she is providing the service),
- Have had criminal background checks that demonstrate no history of criminal activity,
- Have received training in the Independent facilitation process,
- Are knowledgeable of the person-centered planning process, and
- Are skilled facilitators.

DWMHA recommends that independent facilitators be reimbursed per plan, per year, for independent facilitation services.

All DWMHA contractors must ensure that consumers and family members are given the opportunity to evaluate independent facilitation services through consumer satisfaction surveys immediately following the person-centered planning meeting. Quality Improvement measures should be initiated, as necessary, based upon the results of the feedback from the survey process.

Implementation of Core Values

The core values of the Detroit-Wayne County CMH system are:

- Consumerism
- Employment
- Inclusion
- Recovery
- Person-Centered Planning
- Self Determination
- Independent Facilitation
- Compliance with Advance Directives
- Cultural Competence/Limited English Proficiency (LEP)
- Meaningful Access/Accommodations
- Family-Driven and Youth-Guided Principles
- Adult Jail Diversion
- Housing Practice Guideline

All MCPNs, Subcontractors, and Direct Contract Providers must adopt all MDHHS, and DWMHA established Best Practice Guidelines that apply to the population they serve.

Compliance with Advance Directives

Each MCPN, Centralized Access Center subcontractors, and direct contractors must ensure compliance with Federal and State regulations and contractual responsibilities to inform consumers, and their families of the consumer's right to understand and to develop Advance Directives for Medical and Mental Health Treatment within the context of the PCP process.

DWMHA Access Center and Providers must inform consumers that the decision to complete an Advance Directive is completely voluntary and is not a condition of care.

Staff training and education, based upon written policies and procedures, concerning Medical and Psychiatric Advance Directives shall occur at least annually and follow any substantive changes in State Law as soon as possible, but no later than 90 days after the effective date of the change in State Law.

Consumers who choose to develop an Advance Directive must be able to give informed consent. The determination of the consumer's ability to provide informed consent shall include an assessment of their ability to:

- Understand the need for treatment,
- Understand the treatment options (including no treatment and the potential implications) for the illness/ condition,
- Consider the possible benefits and drawbacks (such as side effects from medication) from each treatment, and
- Make a reasonable choice among the treatments available.

MCPNs, sub-contractors, and direct contractors must ensure completion of an examination by a physician and a mental health professional (who can be a physician, psychologist, registered nurse, or masters-level social worker) for determination of the consumer's ability to provide informed consent. The consumer may choose the physician and mental health professional they wish to make this determination. Findings must be documented in the medical record.

There is no required form for completion of an Advance Directive. DWMHA has developed a pamphlet and handbook respectively entitled "Advanced Directives for Medical and Mental Health Care Choices" and "Advance Directives-Medical and Mental Healthcare Advance Directive Handbook and Forms." *Advance Directives shall be included in the Welcome packet and during New Enrollee Orientation process.* Copies are available through the DWMHA Access Center and the provider networks.

Advance Directives must be signed by two competent adults, who are not an immediate family member(s), treating provider(s), patient advocate, employees) of a hospital or behavioral health program of the consumer. Advance Directives do not require a notary signature. Particular issues that may arise as part of an Advance Directive include:

- **Do Not Resuscitate:** It is important to train all involved staff regarding "Do Not Resuscitate" (DNR) Orders. A DNR order can be a part of the Advance Directive. If there is no Advance Directive, an adult consumer may consent to a DNR order verbally or in writing, if two adult witnesses are present. When consent is given verbally, one of the witnesses must be a primary physician or a physician affiliated with the hospital where the consumer is receiving care.

- **Durable Power of Attorney:** Staff must also be aware of "Durable Power of Attorney (DPOA) for health care. A DOPA is a legal Advance Directive that names a person (Patient Advocate) to act on the signer's behalf in enacting decisions about the signer's medical care if the signer becomes unable to make medical decisions for him or herself.

Consumers must be made aware of where to file complaints concerning Advance Directives. Complaints may be filed with the MDHHS State Survey and Certification Agency.

Consumers must be aware that he/she may change or cancel the Advance Directive and the decision to do so for medical care goes into effect immediately. However, the consumer can stipulate that advance directives regarding mental health can be cancelled with 30 days notification. Consumer's awareness must also include the fact that a MCPN/MCPN contractor or Medicaid care professional can refuse to honor their wishes concerning a specific mental or medical treatment, location, or professional if:

- There is a mental health/medical emergency endangering the life of the consumer or the life of another person.
- The treatment requested is unavailable.
- There is a conflict between the Advance Directive and the provisions set forth in a petition or court-ordered treatment.

Cultural Competence/Limited English Proficiency

MCPNs must subcontract with and make referrals to providers from different ethnic groups so that each person requiring culturally appropriate services may receive services from a provider who shares his or her cultural background, values, and perspective.

To effectively demonstrate the MCPNs' commitment to cultural and linguistic service competency, MCPNs must have these components in place:

- Method of assessment that reflects community demographics,
- Method to ensure organizational cultural competency is achieved and maintained (includes MCPNs and their sub-contractors),
- Plan to identify, remedy, and otherwise improve cultural competency,
- Policies and procedures for ensuring cultural needs are comprehensive and available to all staff, and
- Training is provided to all staff that effectively instills cultural competency.

All providers of behavioral health services must ensure that they can access language services that comply with federal guidelines when a consumer requires/requests them.

Meaningful Access

Accommodations:

Each MCPN, and direct contract provider and other DWMHA contractors must comply with all Americans with Disability Act (ADA) requirements including Title VI of the Civil Rights Act of 1964, and Title II and III of the Americans with

Disability Act of 1990(PL 101336). The contractors must establish and implement policies and procedures that include:

- Individuals with visual, mobility or communication limitations/impairments shall be assured full participation and maximum benefit from services offered and involvement in governance functions
- Services, programs, board meetings, and other governance functions must be accessible to and usable by individuals with disabilities. This includes, but is not limited to:
    - Provision of language assistance services.
    - Accommodations for service animals
    - Ensure that elevators are available in multi-story buildings.
    - Ensure that parking lots have sufficient designated parking for vehicles with handicap permits.
    - Provision of alternate methods to facilitate communication.

Communication aids and alternative communication methods, including a qualified sign language interpreter or augmentative communication specialist, must be provided for Consumers, family members, and others who are involved in the provision of services and treatment.

Accommodation shall be made at expense of the MCPN or the other DWMHA contractor. Accommodations must afford accessibility to the building, work site, and any areas used by consumers to enable individuals to perform all essential program functions. Arrangements for the provision of accommodations shall not depend on a request by the consumer or others involved in treatment.

Staff shall receive annual training on resources and technology available for individuals with visual, mobility, or communications limitations/impairments. Documentation of these training sessions must be made available to DWMHA upon request.

Family-Driven and Youth-Guided Principles

Family-driven and youth-guided principles should be measured at several different levels: the child and family level, the system level and the peer-to-peer level. These principles incorporate all levels and will be detailed under section D: Essential Elements.

- Families and youth, providers, and administrators share decision-making and responsibility for outcomes.

- Parents, caregivers, and youth are given accurate, understandable, and complete information necessary to set goals and to make informed

decisions and choices about the right services and supports for individual children and their family as a whole.

- All children, youth and families (parents) have a biological, adoptive, foster, or surrogate family voice advocating on their behalf.

- Families and family-run organizations engage in peer support activities to reduce isolation, gather and disseminate accurate information, and strengthen the family voice.

- Families and family-run organizations provide direction for decisions that impact funding for services, treatments, and supports and advocate for families and youth to have choices.

- Providers take the initiative to change policy and practice from provider-driven to family-driven and youth-guided.

- Administrators allocate staff, training, support, and resources to make family driven and youth-guided practice work at the point where services and supports are delivered to children, youth and families.

- Community attitude change efforts focus on removing barriers and discrimination created by stigma.

- Communities and public and private agencies embrace, value and celebrate the diverse cultures of their children, youth, and families and work to eliminate mental health disparities.

- Everyone who connects with children, youth, and families continually advances their own cultural and linguistic responsiveness as the population served changes so that the needs of diverse populations are appropriately addressed.

Adult Jail Diversion

There is a general consensus with the principle that the needs of the community and society at large are better served if persons with serious mental illness, serious emotional disturbance or developmental disability who commit crimes are provided effective and humane treatment in the mental health system rather than be incarcerated by the criminal justice system. It is recognized that many people with serious mental illness have a co-occurring substance disorder.

This practice guideline reflects a commitment to this principle and conveys Michigan Department of Health and Human Services (MDHHS) jail diversion policy and resources for Community Mental Health Services Programs (CMHSPs). The guideline is provided as required under DWMHA of the

Michigan Mental Health Code, PA 258 of 1974, Sec. 330.1207-Diversion from jail incarceration (Add. 1995, Act 290, Effective March 28, 1996).

Section 207 of the Code states:
"Each community mental health service program shall provide services designed to divert persons with serious mental illness, serious emotional disturbance, or developmental disability from possible jail incarceration when appropriate. These services shall be consistent with policy established by the department."

The guideline outlines CMHSP responsibilities for providing jail diversion programs to prevent incarceration of individuals with serious mental illness or developmental disability who come in contact with the criminal justice system. A separate practice guideline will address Juvenile Diversion of children with serious emotional disturbance.

Jail diversion programs are intended for individuals alleged to have committed misdemeanors or certain, usually non-violent, felonies and who voluntarily agree to participate in the diversion program.

Housing Practice Guideline

The Michigan Department Health and Human Services recognizes housing to be a basic need and affirms the right of all consumers of public mental health services to pursue housing options of their choice. Just as consumers living in licensed dependent settings may require many different types of services and supports, persons living in their own homes or sharing their household with another may have similar service needs. The Clinically Responsible Service Provider (CRSP) shall foster the provision of services and supports independent of where the consumer resides.

The CRSP, shall educate consumers about housing options and supports available, and assist consumers in locating habitable, safe, and affordable housing. The process of locating suitable housing shall be directed by the consumer's interests, involvement, and informed choice, Independent housing arrangements in which the cost of housing is subsidized by the CRSP are to be secured with a lease or deed in the consumer's name

This policy is not intended to subvert or prohibit occupancy in the participation with community based treatment settings such as an adult foster care home when needed by an individual recipient.

Managers of Comprehensive Provider Networks and Direct Contracted Providers

Management of Services

DWMHA has delegated the management of the comprehensive service array for Consumers to the Access Center, MCPNs, and DCPs. The management of comprehensive service array for Medicare/Medicaid Enrollees (MME) is the responsibility of DWMHA. The MCPNs and DCPs have the responsibility to ensure that services are accessible, are appropriate to meet the consumer's needs, and are provided in the least restrictive environment. Each MCPN must submit a current list of its subcontractors to DWMHA on a monthly basis. DWMHA maintains a list of providers credentialed to participate in the MI Health Link program for MMEs. That list must include at a minimum:

Complete contact information:

Sub-contractor's name
Address
Telephone number
Contact person
NPI number
Type of service
A column indicating that the provider is/is not accepting referrals

Any delegated services or responsibilities including:

- Utilization management
- Level of care assessment and service support
- Service authorization
- Utilization Review
- Customer service
- Information services
- Complaint, Grievance, Appeals processes
- Community Benefit
- Provider network management
- Network development
- Network policy development
- Quality management
- Credentialing and Privileging
- Standards setting
- Performance measurement
- Regulatory management or Corporate compliance
- Managing Review processes
- Provider education and training
- Financial management
- Financial operations and risk management
- Claims management

- Information systems management

Access Standards

The following are the access standards that must be adopted and demonstrated in the Quality Management Program:

- **30 Minutes or 30 Miles:** Consumers must have reasonable access to all types of covered services. Consumers receiving services must not be required to travel greater than 30 minutes or 30 miles to receive services.
- **Emergent:** Must be seen immediately by a provider for a face-to-face evaluation by a mental health professional.
- **Urgent:** Must be seen by a mental health professional for a face-to-face evaluation within 24 hours of the request for services (including transfer between levels of care during a chemical dependency episode).
- **Routine:** Must be seen by a mental health professional for a face-to-face intake/evaluation within 14 calendar days of the request for service.
- **Ongoing Services:** Must be established within 14 calendar days from the intake/evaluation.
- **Acute Inpatient:** Assessment, determination, and disposition must be made following medical clearance and within 3 hours of the request.
- **Discharge from Hospital:** A psychiatrist must see Consumers within seven (7) calendar days of discharge from a state, community, or partial hospital program.

Emergency After-Hours Crisis Services

The MCPN and DWMHA must provide after-hours telephone and face-to-face coverage for its Consumers. After-hours coverage includes the availability of locations throughout the County where Consumers can obtain screening for hospitalization 24/7, intensive crisis stabilization including mobile crisis outreach for face-to-face after-hours services by nurses, physicians, social workers, and psychologists. Additionally, the MCPN must provide after-hours telephonic coverage for Consumers in care by knowledgeable mental health professionals familiar with the Consumer's care. It is expected that the MCPN and DWMHA hold its subcontractors responsible and accountable for crisis intervention including after-hours prescription coverage and arrangement for next day's appointment. The DCPs must provide information to Consumers at intake regarding how to access emergency after-hours crisis services and access to 911 emergency services line.

The MCPN must provide the emergency access and after-hours contract procedures to the Access Center and DWMHA. Additionally, DWMHA

maintains a contract with a Crisis Line Vendor for emergency telephone services and crisis intervention for the general public.

Equitable Residential Placement

MCPNs must ensure that residential placement is provided to eligible Consumers fairly and equitably. MCPNs cannot establish waiting lists that disadvantage or prevent eligible Consumers from timely residential placement. MCPNs must establish policies and procedures to guide residential placement decisions.

DWMHA recognizes there are varying levels of care provided in the residential environment. In those instances where the needs of two or more individuals can similarly be met in a residence, the individual first requesting placement must have priority. MCPNs and subcontractors must track the date of request for placement along with the requesting individual's name and the name of the person to be placed in the residence

Discharge Planning

Discharge planning begins at the time of admission and is an ongoing process throughout the course of treatment for all levels of hospital-based care. Appropriate discharge and aftercare planning are important to the successful management of behavioral health care services. The MCPNs and its subcontractors are expected to actively plan for discharge of Consumers in inpatient settings. The Plan should include:

- Involvement of the Consumer and the family in plan development,
- Brief summary of the diagnosis and course of treatment,
- Identification and confirmation of natural supports and available, appropriate community resources,
- Recommendations for the next level of care as Consumer move to a less restrictive environment,
- Initial aftercare appointment, and
- Description of course of treatment, restrictions, if any and planned final disposition.

Note: a psychiatrist must see a consumer within seven (7) days following an inpatient stay or partial hospitalization.

Out-of-Network Services

In an emergency (using "reasonable-person" standards), consumers may access services at any provider or facility, in- or out-of-network. When the consumer's condition is stabilized, the MCPN works with the consumer and the out-of-network provider to transition the consumer to a network subcontractor.

Additionally, when services cannot be provided within the 30 minutes or 30 miles access standard, (e.g., a child in foster care outside Wayne County), the MCPN must make arrangements for services in the local area in which the person is residing.

The MCPNs must ensure that costs to the beneficiary shall be no greater than they would be if the services were furnished within the network. The MCPNs are responsible for communicating this protocol in writing to all out of network providers.

Out of Network providers for the MI Health Link program are providers that do not have contracts with DWMHA but provide behavioral health services to the Medicare/Medicaid enrollee. They have an option to contract with DWMHA within 90 days of determining that a consumer is a MME. They should contact the Integrated Care unit or Provider Network unit at 313-833-2500.

Intensive Care Management Program

As part of DWMHA's Utilization Management Program, the MCPN is conducting an intensive telephonic outreach and monitoring individuals who have high utilization of authorized services. The MCPN will contact the consumers, providers, and MCPNs to ensure and support, continuity of care, and full implementation of Person-Centered Planning.

Managing Co-Occurring Substance Use Disorders (SUDs)

The MCPN and other network providers are responsible for providing and ensuring that needed substance abuse treatment services are available to Consumers. MCPNs must have providers within their networks who are capable of treating individuals with SED, SMI, and I/DD who also have co-occurring substance use disorders (SUDs). The DCPs must also have the capability to treat consumers with co-occurring SUDs. Traditionally, these individuals are not best served in programs whose sole focus is the treatment of substance use disorders. It is expected that the MCPNs and DCPs develop integrated programs where mental health and substance abuse treatment occur in the same treatment setting.

From time to time individuals may appear for screening or in treatment that are more appropriate for traditional substance use disorders services, e.g., an individual who is an injection drug user and requires methadone treatment. In such cases, when the psychiatric condition will not interfere with the psycho-educational model, such individuals should be referred to DWMHA.

Managing Consumers with Co-Occurring SED, SMI, and/or DD

DWMHA expects that MCPNs and other network contractors are responsible for the provision of services to Consumers with co-occurring mental illness and developmental disabilities. MCPNs and subcontractors must have an integrated approach and model to treat and manage Consumers with these disorders. Services include ambulatory, residential and hospital-based services

Coordination with Other Human Service Organizations

DWMHA network providers are required to coordinate with other health and human services and criminal justice systems in the community. Coordination of care ensures effective service planning, can improve member outcomes,

and conserve resources. These systems include education, public health, child and adult protective services, the courts, juvenile and adult probation as well as appropriate providers such as shelters.

The MCPNs, subcontractors, and DCPs are required to maintain coordinating agreements with public partners. The purpose of these agreements is to develop procedures and protocols for mutual referrals, continued coordination of services, and follow-up to ensure services are being provided as expected.

Medicaid Health Plans

In addition to general medical services provided as a part of the Medical Services Administration Comprehensive Health Care Program, the Medicaid-contracted Health Plans (MHPs) are responsible for the following non-specialized mental health services:

- Screening for behavioral health disorders during wellness checks for adults.
- Early Periodic Screening Diagnosis and Treatment (EPSDT) exams for children that include age-appropriate medical, developmental, and mental health evaluations.
- All other medical transportation including:
    - Behavioral health services provided by primary care physicians, or other applicable
    - Medicaid physicians within the scope of their licenses.
    - Behavioral health services provided by federally qualified health centers and rural health clinics.
    - Ambulatory, laboratory, pharmacy, diagnostic testing services for Medicaid eligible individuals.
    - Medical/surgical services for Medicaid beneficiaries in acute community psychiatric hospitals, other than the physical examination which is the responsibility of the MCPN.
    - Physician or facility services in a medical/surgical emergency room prior to stabilization of the psychiatric crisis.
    - Pharmacy for Medicaid recipients.
    - Medicaid Health Plan 20 visits (limited non-specialized mental health benefits).
    - Occupational Therapy, Physical Therapy Services for General Medical Conditions (e.g., stroke, heart attack).

MCPNs must have agreements with the MHPs. Those agreements must describe in detail the operational policies, procedures, and protocols for referrals and treatment coordination for the Consumers.

MCPNs may obtain the name of the Consumer's MHP by contacting Medifax, the MSA's Medicaid eligibility verification system. Note: not all Consumers are enrolled in Medicaid. To confirm Medicaid eligibility, the MCPN or its subcontractors may check MHWIN or access the State's Medicaid eligibility roster through State directed sources.

Other Primary Care Providers

MCPNs and subcontractors must identify the Consumer's primary health care provider. If the Consumer does not have a general medical primary care provider, the MCPN should assist the Consumer in obtaining a primary care provider and age appropriate general medical services. The MCPN is expected to be familiar with the medical services offered in Wayne County and identify a primary care provider by doing the following:

- Contact the consumer's insurance company (MHP, Medicaid, BCBS, HMO) for a selection of primary care providers,
- Arrange appointment with physician,
- Arrange transportation to physician's office, if needed,
- Contact local public health department or other organizations that provide no cost or low-cost care, and
- Have available local medical professional resources and telephone numbers that offer low cost or no cost care.

The MCPNs' subcontractors and the DCPs must document coordination of care with the Consumer's Primary Care Provider in the member record.

Early Periodic Screening, Diagnosis Treatment

Early Periodic Screening, Diagnosis, and Treatment (EPSDT) and Comprehensive Care Services (EPSDT-CCS) is a Medicaid program administered by the MHPs and certain fee-for-service (FFS) primary care providers. This preventive health program provides initial and periodic examinations and screening and medically necessary follow-up care for the correction of physical, mental health, and substance abuse conditions. The MHPs and Medicaid FFS primary care providers are responsible for EPSDT services.

MCPNs subcontractors and the DCPs must ensure that all Medicaid-eligible individuals under age 21 receive the EPSDT services. MCPNs, subcontractors, and DCPs are required to accept referrals from the MHPs and primary care providers for the provision of specialty mental health, development disability and substance abuse services for Consumers identified as needing such services during the screening process.

Children's Special Health Care Services Program

Children's Special Health Care Services (CSHCS) Program (formerly Crippled Children's Program) is a federally (Department of Health and Human Services Maternal Child Health Block Grant, Social Security Act, Title V) and state-funded program. The program is designed to provide general medical care and limited mental health benefits for minors up to age 21 with diagnoses including diabetes, muscular dystrophy, cerebral palsy, spina bifida, and HIV/aids.

The MCPN, network contractors and DCPs are required to refer and/or coordinate services with this program. For more information contact:

- CSHCS Family Center Phone Line: 800-359-3722

Medical documentation from a specialist regarding the chronicity and severity of the illness and treatment plan may be mailed to:

- MDHHS Review and Evaluation Division
  Customer Support Section
  P.O. Box 30734
  Lansing, MI 48909-8234

- Wayne County Health Dept. – Excluding City of Detroit:
  734-727-7088

- Detroit Health Department
  313-366-9439

To select or request a different MHP contact:

- Michigan Enrolls
  877-274-2737 or TTY 888-263-5897

DWMHA System Delegated Functions

Medicaid Managed Care Functions	**Managers of Comprehensive Provider Networks (MCPNs); Access Center; Mobile Crisis Stabilization Team**
UTILIZATION MANAGEMENT	
Access & Eligibility Determination	Wellplace (formerly Pioneer Behavioral Health)
Level of care assessment & service/support selection	MCPNs: Care Link; Consumer Link; Community Living Services (CLS); Integrated Care Alliance, acquired by Molina, Access Center Pioneer – Wellplace; Providers and Direct Contract Providers; Mobile Crisis Stabilization Team
Service authorization	DWMHA, MCPNs: CareLink; ConsumerLink; Community Living Services (CLS); Integrated Care Alliance (ICA); Access Center Pioneer -Wellplace; Mobile Crisis Intervention
Utilization Review	DWMHA, MCPNs: CareLink; ConsumerLink; Community Living Services (CLS); Integrated Care Alliance (ICA)
CUSTOMER SERVICE	
Information services	MCPNs: Care Link; Consumer Link; CLS; and ICA; Access Center
Complaints, Grievances, Appeals and Processes	MCPNs: Care Link; Consumer Link; CLS; and ICA
Community Benefit	MCPNs: Care Link; Consumer Link; CLS; and ICA
PROVIDER NETWORK MANAGEMENT	
Network development	MCPNs: Care Link; Consumer Link; CLS; and ICA
Network policy development	MCPNs: Care Link; Consumer Link; CLS; and ICA
Credentialing and Privileging	MCPNs: Care Link; Consumer Link; CLS; and ICA; Wellplace
QUALITY MANAGEMENT	
Standards setting	MCPNs: Care Link; Consumer Link; CLS; and ICA
Performance measurement	MCPNs: Care Link; Consumer Link; CLS; and ICA

Regulatory management or corporate compliance	MCPNs: Care Link; Consumer Link; CLS; and ICA
Medicaid Managed Care Function s	**MCPNs/ASO**
QUALITY ASSURANCE	
Managing Review processes	MCPNs: Care Link; Consumer Link; CLS; ICA
Provider education and training	MCPNs: Care Link; Consumer Link; CLS; and ICA
FINANCIAL MANAGEMENT	
Financial operations and risk management	MCPNs: Care Link; Consumer Link; CLS; and ICA
Claims management	MCPNs: Care Link; Consumer Link; CLS; and ICA
INFORMATION SYSTEMS MANAGEMENT	
Encounter and performance review reporting	MCPNs: Care Link; Consumer Link; CLS; and ICA

Credentialing

For DWMHA policies, procedures, and documents, visit our website at www.dwmha.com**.**

DWMHA Credentialing

The DWMHA credentialing process is applicable to MCPNs, Sub-Contractors, and Direct Contractors. The credentialing process must include primary source verification of the following:

- Licensure or certification
- Board certification, if applicable, or the highest level of credential attained; and
- Medicare /Medicaid sanction.

DWMHA and its Credentialing Verification Organization (CVO) is responsible for the oversight of standards and processes which guide the credentialing/re-credentialing process for employment of individual practitioners and pre-admission reviewers.

DWMHA/CVO requires that organizations and individuals directly or contractually employed meet all applicable licensing scopes of practice, contractual, Medicaid Medicare requirements for appropriate credentialing and re-credentialing. The Credentialing/Re-Credentialing process is required to verify that qualifications of practitioners are consistent with national credentialing standards and applicable laws.

DWMHA's Credentialing Committee shall provide oversight of the Credentialing and Re-Credentialing Process which includes the following activities:

- Development and update of credentialing criteria as needed, consistent with DWMHA, federal, and other State requirements and relevant professional standards,
- Review and final decision making for appeals of adverse credentialing decisions made by contracted providers with the network,
- Ensuring adherence to timely appeal standards for adverse credentialing decisions which include reconsideration of appeal decisions in writing within 30 calendar days of receipt of an appeal request, and referral to DWMHA's Credentialing Committee for final appeal decisions,
- Developing and monitoring adherence to established time lines for the credentialing process,
- Determining, as needed, the utilization of participating providers to ensure all relevant information is incorporated in credentialing/re-credentialing decisions,

- Maintaining oversight of the CVO, and the contracted provider network's implementation of the credentialing, and re-credentialing process, which includes the right to approve, suspend, or terminate contracted providers selected by the MCPN's, their sub-contractors, or Direct Contractors and
- Granting temporary or provisional credentials, based upon a specific community/consumer need.

Individual Practitioners

MCPNs, Sub-contractors, and DWMHA's Direct Contractors (including SUD treatment and prevention providers) must develop policies and procedures for credentialing and re-credentialing individual practitioners which shall include at least the following;

- Physicians (MDs and D.O.'s)
- Physicians Assistants
- Psychologist (licensed, Limited License, and Temporary License)
- Licensed Master's Social Workers, Licensed Bachelor's Social Workers, Limited License Social Workers and Registered Social Service technicians
- Nurse Practitioners, Registered Nurses and Licensed Practical Nurses
- Occupational Therapists and Occupational Therapist Assistants
- Physical Therapists and Physical Therapist Assistants
- Speech Pathologists
- Licensed Professional Counselors

Primary Source Verification

- Primary Source Verification is comprised of:
  - Licensure or certification
  - Board Certification, or highest level of credentials attained if applicable, or completion of any required internships/residency programs, or other postgraduate training.
  - Documentation or graduation from an accredited school
  - National Practitioner Databank (NPDB)/Healthcare Integrity and Protection Databank (HIPDB) query or, in lieu of the NPDB/HIPDB query, all of the following must be verified:
  - Minimum five-year history of professional liability claims resulting in a judgment or settlement;
  - Disciplinary status with regulatory board or agency;
  - Medicare/Medicaid sanctions.

- If the individual practitioner undergoing credentialing is a physician, then physician profile information obtained from the American Medical Association or American Osteopathic Association may be used to satisfy the primary source requirements.

Credentialing and Re-Credentialing Process

Compliance with Federal requirements prohibits employment or contracts with providers excluded from participation under either Medicare or Medicaid. Systems for Award Management https://www.sam.gov/portal must be check for government sanctions during this process. A complete list of Centers for Medicare and Medicaid Services (CMS) sanctioned providers is available on their website at http://exclusions.oig.hhs.gov. A complete list of sanctioned providers is available on the Michigan Department of Health and Human Services website at www.michigan.gov/mdhhs. (Click on Providers, click on Information for Medicaid Information for Medicaid Providers, click on List of Sanctioned Providers). This review of provider status shall be performed at least every two years.

- Health Care Professionals shall not be the subject of discrimination solely on the basis of license, registration or certification; or as a result of serving a high-risk population who specialize in the treatment of conditions that require costly treatment.
- All findings from the Quality Assessment Performance Improvement Program are submitted to the chair of DWMHA's Credentialing Committee (DWMHA Chief Medical Officer CMO) and incorporated in all re-credentialing decisions.
- Maintenance of complete individual credentialing/re-credentialing files for all credentialed providers which include: the initial credentialing and all subsequent re-credentialing applications; information gained through primary source verification; and all other pertinent information used in determining whether or not the provider met the PIHP's credentialing and re-credentialing standards.
- Inform the applicant in writing of the reasons for any adverse credentialing/re-credentialing decision to deny, suspend, terminate the contract for any reason other than lack of need, and their right to appeal the process (consistent with state and federal regulations).
    - Upon notification of substantially varied information obtained from other sources, the practitioner has the right to correct any erroneous information. The following procedures must be followed:
        i. The practitioner must complete a request in writing within 7 days of notification that information is incorrect.
        ii. Practitioners have 30 days to correct any erroneous information.
        iii. Written documentation of corrections must be submitted to the Credentialing Committee Chair

within 10 days of receipt of corrected information, DWMHA will verify corrections and notify practitioner of the status of their application.

Delegated Credentialing

DWMHA's credentialing and re-credentialing process requires the following provisions:

- The MCPN, Sub-Contractor, or Direct Contractor can delegate credentialing of professionals to the organization/facility that is accredited by a national accrediting organization where the individuals work. The MCPN is responsible for ensuring that the organization/facility meets credentialing standards.
- If the PIHP delegates to another entity any of the responsibilities of credentialing/re-credentialing or selection of providers that are required by the Credentialing/Re-Credentialing policy, it must retain the right to approve, suspend, or terminate from participation in the provision of Medicaid funded services a provider selected by that entity and meet all requirements associated with the delegation of PIHP functions. The PIHP is responsible for oversight regarding delegated credentialing or re-credentialing decisions.

CVO Credentialing Responsibilities

DWMHA's CVO is responsible for ensuring compliance with credentialing and re credentialing policy and standards identified in DWMHA and MDHHS policy and process which includes:

- Requiring that professionals' ongoing in-service training and/or continuing education related to the provision of services to the specific population group which clinicians serve delineated in the Credentialing/Re-Credentialing policy.
- Ensuring that clinicians provide care within the scope allowed by the professional's license, and determined by their training and supervisory experience.
- Maintain a common, centralized credentialing process that includes:
    - Credentialing and re-credentialing clinicians per policy,
    - Utilizes DWMHA staff directly involved in clinical review/utilization review as needed.
    - Includes appropriate professionals throughout initial and on-going credentialing activities such as child mental health professionals and preadmission reviewers.
    - Has provisions to review and oversee services provided by non-accredited direct contractors.

Initial Credentialing Process

Policies and procedures for the initial credentialing of individual practitioners require a written application that is completed, signed, and dated by the provider and attests to the following elements:

- Lack of present illegal drug use.
- Any history of loss of license and/or felony convictions.
- Any history of loss or limitation of privileges or disciplinary action.
- Attestation by the applicant of the correctness and completeness of the application.
- An evaluation of the provider's work history for the prior five years.

Temporary/Provisional Credentialing of Individual Practitioners

The Credentialing and Re-Credentialing process ensures provisions for granting temporary or provisional credentials. Temporary or provisional credentialing shall not exceed 150 days.

A decision regarding rendering temporary or provisional credentials shall be made within 31 days of receipt of a complete application. The following minimum documents shall accompany a signed application for temporary or provisional credentialing:

- Lack of present illegal drug use.
- History of loss of license, registration, or certification and/or felony convictions.
- History of loss or limitation of privileges or disciplinary action.
- A summary of the provider's work history for the prior five years.
- Attestation by the applicant of the correctness and completeness of the application.

Deemed Status

Individual practitioners or organizational providers may deliver health care services to more than one PIHP. A PIHP may recognize and accept credentialing activities conducted by any other PIHP in lieu of completing their own credentialing activities. In those instances where a PIHP chooses to accept the credentialing decision of another PIHP, copies of the credentialing PIHP's decision shall be maintained in administrative records of DWMHA's Credentialing Committee.

Re-Credentialing Individual Practitioners

The re-credentialing process for physicians and other licensed, registered, or certified health care providers shall include, at a minimum, the following requirements:

- Re-Credentialing at least every two years,
- An update of information obtained during the initial credentialing,
- A process for ongoing monitoring, and intervention if appropriate, of provider sanctions, complaints and quality issues pertaining to the provider, which must include, at minimum, review of:
    - Medicare/Medicaid sanctions o State sanctions or limitations on licensure, registration or certification,
    - Member concerns which include grievances (complaints) and appeals information and
    - PIHP Quality issues.

Criminal Background Checks

Ensure all required staff remains in good standing with the Law. All employees, contractors, and consultants hired to provide professional or direct care services to consumers receiving mental health services must:

- Be in good standing with the law (i.e., not a fugitive from justice, a convicted felon, or an illegal alien).
- Pass successfully the required criminal background checks, completed in accordance with Federal, State of Michigan or contractual requirements.
- Criminal background checks must be conducted prior to hire and annually thereafter
- All long-term care providers who subcontract with MCPNs are required to comply with the State of Michigan's Long-Term Background Check program called the Michigan Workforce Background Check Program, which includes the 'Rap Back' process.

Reporting Improper Conduct

DWMHA is committed to ensuring that all required staff and contractors remain in good standing with the legal and professional standards of conduct. All employees, contractors, and consultants hired to provide professional or direct care services to consumers are obligated to follow prevailing regulations and all standards as outlined in this Provider Manual and the DWMHA provider contract.

DWMHA Credentialing Committee

There are numerous resources available to assist the DWMHA network in meeting the challenge of performing expected duties and responsibilities. Readers of this document should refer to the Customer Service, Network Management, and the Compliance sections of this Manual for specific details. DWMHA maintains a
Credentialing Committee which meets on a monthly basis. The Credentialing Committee can be accessed for questions and concerns during regular DWMHA business hours by calling the Managed Care Operations Unit.

Required Training

The goal of Detroit Wayne Mental Health Authority (DWMHA) is to work toward advancing the development and maintenance of a highly skilled and competent workforce. In 2007, DWMHA launched the Virtual Center for Excellence (VCE) website, which is now named Detroit Wayne Connect (DWC). This multimedia website provides 24/7 training opportunities for the CMH workforce. One of the key objectives of this website is to provide convenient and easily accessible event listings, online registration and archive of video recorded lectures and distance learning opportunities. Members have the benefit of a virtual transcript which tracks registration and attendance. Using proven evidence-based practices; DWC offers the most current training and curricula in the field to advance the knowledge and skill of the workforce. In addition to online training, live training is offered monthly.

DWMHA authored a “Community Mental Health Workforce Required Training” manual and a grid which lists all trainings required for members of the CMH workforce, a description of the training, the target source of the training, the target audience, and how often the training must be taken. The core trainings are mandated not only for clinicians but the entire CMH workforce and available through DWC.

Please access www.dwctraining.com to get a complete list of the core trainings.

Network Management / Contract Management

Impaneling Providers

Impaneling is the process utilized by DWMHA to ensure that there is an adequate network of providers that can meet the behavioral health needs and SUD needs of individuals residing in Wayne County.

Behavioral health and SUD providers must be impaneled with DWMHA so that they can contract with the MCPN or become a Direct Contracted Provider with DWMHA. They must:

- Request application from DWMHA's Managed Care Operations unit
- Upon completion of application and upload of supportive documents the MCO unit will be notified
- Applications will be reviewed per the Network Monitoring Policy and the Credentialing/Re-Credentialing Policy
- Applicants will be notified of their status as the application progresses through the process
- The list of impaneled providers will be shared with the MCPNs
- Depending on the line of business requested by the provider they may also go through the provider credentialing process delineated in the Credentialing/Re-credentialing Policy
- MCPNs and DWMHA will not contract with providers that have not been impaneled

Network Management / Contract Management

DWMHA has assigned a full time masters prepared staff person (Provider Network Manager/contract manager), to support each MCPN and Direct Contract provider organization (DCP). The Provider Network Manager /Contract Manager is responsible for:

- Receiving and responding to operational requests and inquiries of the MCPN and DCP;
- Assisting the MCPN and DCP in resolving inter-network programmatic issues;
- Providing and/or arranging for technical assistance, training, resource materials and other supports to assist the MCPN and DCP in complying with the terms and conditions of the Contract;

- Advising the MCPN and DCP of changes, revisions, and/or corrections to instructions, policies, procedures, guidelines, and protocols applicable to the Contract; and
- Assuring that the MCPN and direct contract providers comply with DWMHA's contract performance expectations.
- DWMHA expects the key leaders and staff of the MCPN and DCP to meet with its Provider Network Manager(s/Contract Manager on a periodically scheduled basis (monthly for MCPNs, Access Center and Mobile Crisis Stabilization Team, the DCPs will meet no less than quarterly).

Additionally, the MCPN and DCP may designate individual(s) as point(s) of contact for the Provider Network Manager. The MCPN and DCP staff/contact person is responsible for:

- Responding to all inquiries from DWMHA in a timely manner,
- Assisting the Provider Network Manager/Contract Manager in resolving inter and intra network issues,
- Coordinating participation in DWMHA offered or sponsored trainings,
- Advising the appropriate parties within the MCPN or DCP network of changes, revisions, and/or corrections to DWMHA instructions, policies, procedures, guidelines, and protocols applicable to the Contract and
- Assisting/implementing the required policies, procedures and/or DWMHA instructions.

MCPN Subcontractor(s)

MCPN's legal agreements with their subcontractors must, at a minimum, require 90 days' notice of termination without cause for either party. If a subcontractor terminates from the MCPN network or is terminated by the MCPN from its network, the MCPN must notify DWMHA immediately upon receipt of or issuing a termination notice. Termination notice should be forwarded to DWMHA's Legal Division and a copy sent to the Provider Network Manager/Contract Manager.

The MCPN's contracts must provide a means for immediate termination of a provider for cause. MCPNs must notify DWMHA immediately upon issuing a termination notice for cause. Additionally, the MCPN must have a process of appeal and review for subcontractors terminated.

Disagreements between the MCPN and its subcontractors should be resolved between the two parties. DWMHA expects that the MCPN will utilize all available resources to resolve disputes, including mediation and requesting technical assistance from DWMHA, in such a manner that it does not disrupt services. If DWMHA becomes aware of a pattern of disputes that will impact the delivery network, DWMHA reserves the right to intervene to ensure a resolution of issues and no disruption of service for consumers.

Any costs incurred with regard to any dispute resolution are the responsibility of the MCPN and its subcontractor.

MCPN Conflicts

Disagreements between the MCPNs should be resolved between the two parties. If the MCPNs are unable to resolve a dispute, DWMHA will review written documentation of the issue from both parties, including the documentation of attempts to resolve the issue and determine an equitable solution. In the most complex situations, DWMHA or its designee, (e.g., a mediator) may request that the parties present the issue in person. DWMHA will communicate its determination to both parties within ten (10) business days. If the situation demands an urgent resolution, the decision will be communicated as soon as possible, but in no case will the determination be greater than 24 hours following receipt of the information.

MCPN and Other Publicly Funded Human Service Organizations

Should an MCPN or its subcontractors have difficulty coordinating services with other publicly funded human services organizations that cannot be resolved, the MCPN should seek technical assistance from DWMHA. The MCPNs may contact their respective Provider Network Manager/Contract Manager to request technical assistance. DWMHA will review written documentation or related materials and intervene as appropriate with the funding source to facilitate a resolution.

Staffing Standards

MCPNs and their subcontractors must have staffing standards, policies and procedures, and hiring practices that ensure appropriate; qualified staff are providing services to consumers. The MCPN must ensure that its subcontractors conduct criminal background checks on all professional and nonprofessional individuals hired by the MCPN or its subcontractor in accordance to DWMHA policies and the State's guidelines for health care workers. MCPNs and DCPs must ensure that no Consumers with criminal histories are hired at any direct care level within the organization or network. MCPNs and DCPs must review evidence of criminal background check on all employees responsible for delivery of direct care services to consumers. For additional information, refer to the Credentialing section of this manual.

Directory

The MCPN must produce, maintain and distribute a current directory of its subcontractors to consumers. The directory must include: provider name, address, phone number, picture or logo, type of practice, emergency contact numbers, 24-hour screening centers numbers and locations, and other professional services offered and applicable practice restrictions.

Directories must be updated periodically as significant network changes occur, but in any case, no less than annually. Current directories must be provided to each MCPN network administrator.

The MCPN directory must clearly identify the Detroit-Wayne Mental Health Authority and its relationship to the MCPN. The MCPN shall not, and shall ensure that its subcontractors do not, reference DWMHA in any publicity, advertisements, notices, or promotional material or any announcement to Consumers, including the Provider Directory, without prior review and written approval of DWMHA.

Quality Management/Improvement Program

Information about DWMHA's Quality Improvement Program, goals, and annual results are available on DWMHA's website at www.dwmha.com.

Quality Improvement Program Requirements

Each Direct Contracted Provider/MCPN must have a written Quality Assurance Performance Improvement Program (QAPIP) which reflects the requirements of the Balanced Budget Act (BBA) and the service provider standards for internal quality assurance mechanisms. They must have the infrastructure necessary to improve the quality and safety of supports and services it provides to persons served. These standards are based on Quality Assessment and Performance Improvement Program Technical Requirement Attachment P 7.9.1 of the MDHHS Contract FY 16/17. These requirements reflect the standards as identified by the Center for Medicare and Medicaid Services (CMS, formerly known as the Health Care Financing Administration) draft "Standards and Guidelines for Review of Medicare and Medicaid Managed Care Organizations." (December 22. 1997) The QAPIP must specify the minimum following elements:

Element I: Quality Improvement Program

The Contracted Provider/MCPN shall have a Quality Assurance Performance Improvement Program (QAPIP) that achieves, through ongoing measurement and intervention, improvement in aspects of clinical care and non-clinical services that can be expected to affect consumer health status, quality of life, and satisfaction.

- **The Contracted Provider/MCPN has a written description of its QAPIP:**
  The written description contains a detailed explanation of the structure of the QAPIP system and a set of QAPIP objectives that align with DWMHA's Strategic Plan. They are developed annually and include a timetable for implementation and accomplishment. The plan must evaluate the QAPIP program at least annually.
  - Scope**:** The written QAPIP includes a description for how the organization will assure that all population groups, care settings, and types of services are included in the scope of the QAPIP.
  - The QAPIP must document specific improvement activities**:** The QAPIP must contain the following elements:
  - The process for the identification and selection of aspects of clinical care and non-clinical services to be monitored and considered for process improvement projects;
  - The methods used to gather, analyze, report, and utilize customer satisfaction information; complies with DWMHA's Contracted Provider/MCPN Monitoring Plan

- A written Critical Event/Sentinel Events and Death Review process according to DWMHA guidelines.
- A process of verification of whether services reimbursed by Medicaid were actually furnished to recipients by affiliates (as applicable), providers, and subcontractors.
- The mechanisms that will be used to evaluate and annually revise the QAPIP written plan.
- The responsibilities of the governing body, executive director, medical director, managers, direct staff and subcontracting agencies in the QAPIP process.
- The structure is responsible for performing QAPIP functions and assuring that program improvements are occurring within the Contracted Provider/MCPN. This committee or other structure must:
    - Demonstrate that it meets with a frequency that is sufficient to show that the structure/committee is following up on all findings and required actions.
    - Establish parameters for the role, structure, and function of the quality management committee.
    - Maintain records documenting the committees, activities, findings, and recommendations.
    - Include a chart of the Quality Management organizational structure, which allows for clear and appropriate administration and evaluation of the QAPIP. The chart must show a relationship to the Detroit-Wayne Mental Health Authority.

- Continuous Activity -The QIP provides for continuous performance of quality improvement activities, including tracking of issues over time and review of data for patterns and trends.
- Follow Through -The QIP must delineate the mechanisms or procedures to be used for adopting and communicating processes and outcome improvements.
- Focus on HEDIS Measures with objectives for serving persons with multiple and complex health needs. The plan must address the role for mental health outcomes to the extent possible within existing technology.

D. Stakeholder Involvement in Decision-Making:

The Contracted Provider/MCPN ensures the incorporation of stakeholder in the QAPIP activity; this includes persons with lived experience, contractors, sub-contractors, families and advocates. At a minimum, this should include consumers receiving long-term supports or services (e.g., consumers receiving

case management or supports coordination) into the review and analysis of the information obtained from quantitative and qualitative methods and in providing input and recommendations for opportunities for improvement.

E. Transparency:

The organization makes information about its Quality Program available to the stakeholders on an annual basis. The results of the Quality Improvement activity should be available to the public. The Contracted Provider/MCPN informs persons receiving services, practitioners, providers, and their governing body of the performance and assessment results. As a result of the periodic assessments, the contracted Provider/MCPN will:

- take specific action on individual cases as appropriate,
- identifies and investigates sources of dissatisfaction,
- outlines systemic action steps to follow-up on the findings and
- evaluates and reports outcomes.

Element II: Systematic Process of Quality Assessment and Improvement

The QAPIP objectively and systematically monitors and evaluates the quality and appropriateness of care and service to members through quality assessment and performance improvement projects, related activities, and pursues opportunities for improvement on an ongoing basis.

The QAPIP has written guidelines for its quality-related activities, which includes specification of clinical or health services delivery areas to be monitored. The monitoring and evaluation of care reflect the populations served by the Contracted Provider/MCPN in terms of age groups, disease categories, and special risk status.

At its discretion and/or as required by DWMHA, the Contracted Provider/MCPN also monitors and evaluates other important aspects of care and service.

Use of Quality Indicators:

- The Contracted Provider/MCPN identifies, monitors and work to improve clinical issues relevant to persons served; and will use the measurement of quality in clinical care and drives continuing improvement that positively affects persons served.
- The Contracted Provider/MCPN identifies and uses quality indicators that are objective, measurable, and based on current knowledge and clinical experience.

- Indicators shall include, but not be limited to those selected by the Detroit Wayne Mental Health Authority.
- Data collection is used to detect the need for and implement program change.
- Monitoring monthly for adverse actions**.**

Use of Clinical Care Standards/Practice Guidelines:

- The Contracted Provider/MCPN is accountable for adopting and disseminating clinical practice guidelines relevant to the persons served for acute and chronic behavioral healthcare services. The organization used clinical guidelines approved by DWMHA to help practitioners and persons served to make decisions about appropriate health care for specific clinical circumstances.
- When there are nationally accepted or mutually agreed upon clinical standards/practice guidelines, QAPIP activities monitor the quality of care against those standards/guidelines.; i.e., ACT Fidelity Field Guide, the Dual Diagnosis Capability in Addiction Treatment (DDCAT) and/or Dual Diagnosis Capability (DCC) or Dual Diagnosis Capability in Mental Health Treatment (DDCMHT)
- When guidelines exist, a mechanism is in place for continually updating the standards/guidelines.

Ensures Continuity and Coordination of Behavioral Healthcare:

- The Contracted Provider/MCPN monitors the continuity and coordination of care that is received by persons served and take action, as necessary, to improve continuity and coordination of care across the behavioral healthcare and human service network
- The organization used information at its disposal to coordinate transitions in behavioral healthcare across the delivery system and assures continuity of care upon termination of service.
- Transitions in care include changes in the management of care between practitioners, changes in settings or where practitioners become active (or inactive) in providing ongoing care for a consumer.

Ensures Continuity and Coordination between Behavioral Healthcare and Medical Care

- The contracted Provider/MCPN collaborates with relevant medical delivery systems to monitor and improve coordination.
- The organization collaborates with relevant medical delivery systems and uses information at its disposal to coordinate behavioral healthcare and medical care.
- Areas of collaboration can include but not limited to the following: exchange of information, diagnosis, treatment and referral, psychopharmacological medication use, managing coexisting conditions, primary and secondary prevention programs.

Implementation of remedial action plans:

- The QIP requires that appropriate remedial actions be taken whenever inappropriate or substandard services are furnished as determined by monitoring activities, substantiated recipient rights complaints, customer service reviews, clinical indicators, or clinical care standards or practice guidelines where they exist.
- Follow-up remedial actions are documented.

Assessment of Effectiveness of Corrective Actions:

- As actions are taken to improve care, there is monitoring and evaluation of corrective actions to assure that appropriate changes have been made. In addition, changes in practice patterns are tracked.
- The Contracted Provider/MCPN assures follow-up on identified issues to ensure that actions for improvement have been effective.

Element III: Accountability to the Governing Body

Responsibilities of the Governing Body for monitoring, evaluating, and making improvements to care include:

- Oversight of the QAPIP

  There is documentation that the Governing Body has approved the overall QAPIP and an annual QAPIP report.

- QAPIP Progress Reports

  The Governing Body routinely receives written reports from the QAPIP describing actions taken, progress in meeting QAPIP objectives, and improvements made.

- Annual QAPIP Review

The Governing Body formally reviews on a periodic basis (at least annually) a written report on the QAPIP that includes:

- Studies undertaken
- Results,
- Subsequent actions,
- Aggregate data on utilization and quality of services, and
- Effectiveness of these activities.

Program Modification
Upon receipt of regular written reports from QAPIP the delineating actions taken and improvements made, the Governing Body assures that the Chief Executive Officer takes action when appropriate and directs that the operational QAPIP be modified on an ongoing basis to accommodate review findings and issues of concern within the Contracted/Provider MCPN.

Element IV: QAPIP Supervision

There is a designated senior executive responsible for the QAPIP program implementation. The organization's Medical Director has an identifiable role in the QAPIP program.

Element V: Provider Qualification and Selection

The QAPIP contains written procedures to determine whether physicians and other health care professionals, who are licensed by the State and who are employees of the Contracted Provider/MCPN or under contract to the MCPN, are qualified to perform their services. The QAPIP also has written procedures to ensure that non-licensed providers of care or support are qualified to perform their jobs and operates under the supervision of a qualified professional.

The Contracted Provider/MCPN must have written policies and procedures for the credentialing process that includes the organization's initial credentialing of practitioners, as well as its subsequent re-credentialing, recertifying and/or reappointment of practitioners. These procedures must describe how findings of the QAPIP are incorporated into this re-credentialing process.

The Contracted Provider/MCPN must also ensure:

- Staff possess the appropriate qualifications as outlined in their job descriptions, including the qualifications for all the following:
    - Educational background;
    - Relevant work experience;
    - Cultural competence;
    - Certification, registration, and licensure as required by law
    - Criminal Background Check. ;
- A program to train new personnel with regard to their-responsibilities, program policies and operating procedures.
- A program to identify staff training needs and provide in-service training, continuing education, and staff development activities.
- A description of the active role of providers in the review and analysis of the information obtained from quantitative and qualitative methods.

Element VI: Member Satisfaction, Rights and Responsibilities

The MCPN**,** their sub-contractors, and Direct Contracted Providers demonstrates a commitment to treating members in a manner that acknowledges their rights and responsibilities.

The MCPN, their sub-contractors, and DCPs monitor and assures that each individual has all of the rights established in Federal and State law, such as:

- A written process for informing consumers of the person-centered process;
- A written process for informing consumers of their rights to a Grievance and an Appeals process and Medicaid Fair hearing;
- A written process for informing consumers of their right to a second opinion
- An “Advance Directives” policy that includes a description of applicable state law and provides for supplying adult beneficiaries with written information on advance directives.
- Information accommodations for consumers with Limited English proficiency.

In conjunction with DWMHA, the MCPN may conduct periodic quantitative (e.g. surveys) and qualitative (e.g. focus groups) assessments of member experiences with its services and report the results to DWMHA.

- Assessments must be representative of the Consumers served and the services and supports offered.
- The assessments must address the issues of quality, availability, and accessibility of care.
- All results must be provided to DWMHA for assessment and determination as to whether an improvement project is needed.

The MCPN ensures the incorporation of consumers receiving long-term supports or services (e.g., Consumers receiving case management or supports coordination) into the review and analysis of the information obtained from quantitative and qualitative methods.

The MCPN informs recipients of service, practitioners, providers and the governing body and DWMHA of assessment results. As a result of the periodic assessments, the MCPN:

- Takes specific action on individual cases as appropriate;
- Identifies and investigates sources of dissatisfaction;
- Outlines systemic action steps to follow-up on the findings and
- Evaluates and reports outcomes.

Element VII: Utilization Management

The Utilization Management Services and Supports section of the Provider Manual discusses basic UM requirements. The Detroit Wayne Mental Health

DWMHA (DWMHA) is under contract with the Michigan Department of Health and Human Services (MDHHS) as a Pre-Paid Inpatient Health Plan (PIHP) and Community Mental Health Service Program (CMHSP). DWMHA is required to have a written Utilization Management Program that describes all core utilization management functions including delegated functions.

XIII. Utilization Management Services and Supports

Utilization Management (UM) functions are driven by the Detroit Wayne Mental Health Authority (DWMHA) Board's commitment to the provision of effective, consistent and equitable high quality behavioral health care services that produce functional outcomes. DWMHA's UM Program Description reflects the expectations and standards of the Michigan Department of Health and Human Services (MDHHS) and the Center for Medicare and Medicaid Services (CMS). The Chief Medical Officer has substantial involvement in the development, implementation, supervision, and evaluation of the UM Program. The Board of Directors (BOD) has the ultimate responsibility for ensuring the overall quality of the behavioral healthcare services delivered to Wayne County residents, and oversight of UM functions.

The DWMHA UM Program Description focuses on fulfilling our mission to be a safety net organization that provides access to a full array of services and supports to empower persons within the Detroit Wayne County behavioral health system to meet their potential. DWMHA approach to utilization management is based on the following five pillars of DWMHA Strategic Plan.

- Customer Oriented: Services should be designed to meet the needs and expectations of the individual.
- Access: Services are easily accessible, available and affordable with no undue barriers of cost, language, culture, or geography.
- Workforce: Services are delivered by competent staff who have appropriate education, training, and licensure.
- Finance: Services are sufficient in scope, frequency, and duration to achieve effective outcomes.
- Quality*:* Services are of high quality. They are person centered and given in a timely fashion.

The DWMHA UM Program Description details activities designed to actively evaluate and manage appropriate access to and allocation of behavioral health resources for individuals. UM is a continuous process that evolves and changes with the availability of new information, new research findings and/or changes in regulatory mandates. Through the application of standardized policies and procedures based on current, relevant medical necessity review criteria and expert clinical opinion when needed, the overall goal of DWMHA's UM Program is to provide oversight and monitor treatment patterns of the delivery systems to ensure maximum efficiency.

DWMHA delegates certain UM functions to the Access Center, the Crisis Service Vendor, and the MCPNs. Delegation occurs when DWMHA gives to another organization the decision making DWMHA to perform a function that we would otherwise do ourselves. It is a formal process, contractual, and consistent with state and federal regulations. DWMHA conducts pre-delegation reviews to ensure compliance and monitors delegated operations through mutually defined reporting and formal goal-based evaluations.

Access, Triage and Referral Process for Behavioral Health Services:
Serving as the central front door and screening agent for DWMHA, the Access Center is operated twenty-four (24) hours a day, seven (7) days a week. Members and/or Providers can contact the Access Center at 1-800-241-4949 or the TYY/TDD number 1-866-870-2599 for the hearing impaired.

Members contacting the Access Center who are in crisis are immediately warm transferred to DWMHA's Behavioral Health Emergency Response Call Center Vendor to provide telephonic crisis intervention and stabilization services.

Members requesting entry into the public health system and who are not in crisis go through a screening process to determine initial coverage eligibility and the likelihood of mental illness, substance use disorder, or intellectual developmental disability that qualifies his/her for supports and services. Eligible persons are then referred to a MCPN and linked with a Service Provider for a face-to-face comprehensive intake assessment. Ineligible persons are given community resource referrals.

UM Staff and Program Structure:
DWMHA requires all staff performing pre-admission reviews and/or utilization management functions including initial/continuous reviews, appeals, and denials to credentialed and re-credentialed. The UM staff are expected to be highly skilled, experienced professionals as DWMHA is committed to increasing competency and the quality of services through continuous staff development activities. Individuals who do not maintain appropriate licensing, training and scope of practice shall be immediately removed from the role of a preadmission review screener and/or utilization management decision makers.

Prior Authorization Review (PAR) Screening:
DWMHA uses a prior authorization review screening process which is a systematic assessment of clinical information about an individual referred or recommended for services and should be based on meeting the needs of the eligible person. The purpose of a PAR is to determine eligibility, benefit coverage and/or establish the

presence or absence of medical necessity so that a decision can be made regarding the request for services. Prior authorization is designed to promote the appropriate utilization of medically necessary services, to prevent unanticipated denials of coverage and to ensure that all services are provided at the appropriate level of care for the member's needs in a timely manner.

Prior Authorization is required for all acute inpatient treatment, partial hospitalization, crisis residential services, withdrawal maintenance (sub-acute detox) and state hospitalization. A PAR screening is conducted telephonically by the DWMHA Crisis Service Vendor. The source of information for the UR activity comes from the requesting facility or Provider. The request for authorization may come from the psychiatrist, physician, treatment team member or other utilization management staff member. It is expected that the caller is familiar with each case as a result of a face-to-face meeting with the member or as a result of an informed review of the clinical/medical record.

The DWMHA Crisis Service Vendor operates twenty-four (24) hours a day, seven (7) days a week. Providers can contact the Crisis Service Vendor at 1-844-296-2673 or TYY 248-424-4800 from 8am-5pm Monday-Friday and 248-995-5055 after business hours for the hearing impaired.

Continued Stay Review:
DWMHA (for the MI Health Link population) and the MCPNs (for the SMI, IDD and SUD populations) are responsible for continued stay reviews for all acute inpatient treatment, partial hospitalization, crisis residential services, withdrawal maintenance (sub-acute detox) and state hospitalization. These care reviews are completed at an interval dictated by the clinical severity of the case and are conducted prior to the end of the authorized period.

The UM staff including physician reviewers make timely and consistent determinations for all UM activities requiring review to assess the medical necessity and/or appropriateness of care or services. These determinations apply to both urgent and non-urgent requests, and extensions of time may be requested if a determination cannot be made in a timely manner due to the lack of necessary information. In whole or in part decisions and notifications are communicated to appropriate members, practitioners, and providers in a timely manner to accommodate the clinical urgency of the situation to minimize any disruption in the provision of health care.

Emergency Care Resulting in Admissions:
DWMHA and the MCPNs provide coverage to members if they require emergency or urgently needed services. Prior authorization is not needed for emergency room services or any emergent services needed to stabilize the emergent or urgent condition. Emergent and/or urgent care should be rendered as needed with notification of any admission to the DWMHA Crisis Service Vendor within forty-eight (48) hours of the admission. The Crisis Service Vendor will review emergent and/or urgent admissions within one (1) calendar day of request for services.

Medical Necessity:
DWMHA has adopted nationally developed and published Behavior Health guidelines from MCG Health, which is part of the Hearst Health Network. The MCG Behavioral

Health Medical Necessity Guidelines describe best practice care for the majority of mental health and substance related disorder diagnosis, covering fifteen (15) diagnostic groups with graded evidence from published resources. There are seventy-one (71) diagnosis-based guidelines plus twenty-seven (27) level of care guidelines with content covering adult, child and adolescent populations, members with unknown diagnosis and members with substance abuse disorders. These criteria then serve as a decision support tool to help define the most appropriate treatment setting and help assure consistency of care for each individual. The MCG Behavioral Health Medical Necessity Guidelines are available to contracted providers/practitioners, annually or whenever updates are made by calling the DWMHA UM Department for log in information for online version and on a removable device such as a jump drive. . Members and providers can request a copy of the medical necessity criteria in relation to a specific requested service free of charge by contacting DWMHA's UM Department.

DWMHA is currently utilizing Edition 21. DWMHA and their UM delegated entities utilize this criteria for behavioral health inpatient, residential, partial hospitalization, intensive outpatient and outpatient services for all Medicaid members. For the MI Health Link member, the National Coverage Determination (NCD) Criteria developed by the Centers for Medicare & Medicaid Services (CMS) is utilized. If no NCD has been issued, or an NCD requires further clarification, a Local Coverage Determination (LCD) will be utilized. LCD's are developed by the Medicare Administrative Contractor for the geographic service area and either supplement or explain when an item or service will be covered if there is no NCD. Michigan is in jurisdiction 8. In addition, the CMS Coverage Manual or other CMS-based resources such as the Medicare Program Integrity and Medicare Benefit manuals are used to determine coverage provisions for this population. In coverage situations where there is no NCD or LCD or guidance on coverage in original Medicare manuals, DWMHA may make its' own coverage determination utilizing the MCG criteria or send out to an Independent Review entity. The NCD and LCD criteria are available to contracted providers/practitioners through a shared google drive or by mail, email or fax. Members and contracted non-contracted providers can obtain a copy of specific criteria related to their case by contacting the DWMHA UM Department by phone or in-person.

DWMHA has adopted nationally developed and published criteria from the American Society of Addiction Medicine (ASAM) to determine medical necessity and level of care decisions for substance use disorders (SUD). These criteria have become the most widely used and comprehensive of guidelines for placement, continued stay, and transfer/discharge of enrollee/members with addiction and co-occurring conditions. The ASAM Criteria, Third Edition, is copyrighted but can be purchased by contacting:

American Society of Addiction Medicine 4601 North Park Ave
Upper Arcade Suite 101
Chevy Chase, MD 20815
Telephone: 301-656-3920 Fax: 301-656-3815
Email: email@asam.org

Members and contracted non-contracted providers can obtain a copy of specific criteria related to their case by contacting the DWMHA UM Department by phone or in-person.

Inter-Rater Reliability:

Review of consistency of Behavioral Health UM decision making Inter-Rater reliability testing is administered annually for UM reviewers and psychiatrists involved in UM reviews. DWMHA utilizes the MCG web-based Inter-Rater Reliability module which tests the proper use of MCG guidelines with clinician-developed case studies. It evaluates an individual's ability to find and apply the appropriate guideline based on a specific scenario. DWMHA has a benchmark standard of scoring 90% or greater. Any UM reviewer or physician reviewer with an Inter-Rater reliability score less than 90% will be placed on a corrective action plan (CAP) with the expectation that the person passes a re-test administered within thirty (30) days. CAPS can involve such activities as face to face supervision and coaching and/or education and re-training. During the time period of the CAP, random samples of the staff member's current cases will be audited. If upon re-testing, the staff person does not achieve 90% or greater, he/she will be subject to a transfer to a role outside the UM Department or termination. Note that annual education and training on the criteria is provided for all staff performing UM activities that involve the application of the medical necessity criteria. MCG also has web-based on-demand training modules that are available 24/7. The results of the Inter-Rater reliability case reviews will be used to identify areas of variation among decision makers and/or types of decisions. The results will also help to identify opportunities for improvement as well as further training needs. MCG also provides reports outlining all of the training modules completed by each UM reviewer including physicians to ensure that all required training modules are completed.

Denial of Authorization for Care:
DWMHA only allows physicians (MD or DO) to render behavioral health care and pharmaceutical medical necessity denials. Certified addiction medicine physicians are available to review Substance Use Disorder (SUD) medical necessity cases. DWMHA ensures that practitioners have the opportunity to discuss any Utilization Management (UM) denial decision with a physician reviewer. The physician reviewer must discuss the clinical merits of the request with the physician/Provider prior to issuing a denial. All pertinent clinical information must be obtained and reviewed as part of this process. When a denial is issued, the Provider is notified verbally and in writing, and the member is notified in writing. The notification must inform the Provider and member of clear information regarding the reasons for the denial and the availability of the UM appeal and dispute resolution processes. At the time that the provider/practitioner is notified of the denial, the opportunity to discuss the medical necessity denial is also discussed. Services may not be denied solely based on preset limits of the cost, amount, scope and/or duration. Instead, determination of the need for services shall be conducted on an individualized basis. Physicians nor any other UM staff are rewarded for issuing denials of coverage or service or reducing the provision of care which is deemed medically necessary.

Affirmative Statement:

All DWMHA, MCPN, Crisis Service Vendors, and Access Center practitioners and employees who make Utilization Management decisions understand the importance of ensuring that all consumers receive clinically appropriate, humane and compassionate services of the same quality that one would expect for their child, parent or spouse by affirming the following:

- Utilization Management decision making is based only on appropriateness of care, service, and existence of coverage.
- DWMHA, Access Center, Crisis Service Vendors, and MCPNs do not reward practitioners or other individuals for issuing denials of coverage or service care.
- No Physicians nor any other staff making UM decisions are rewarded for issuing denials of coverage or service or reducing the provision of care which is deemed medically necessary.
- Practitioners may freely communicate with members about their treatment, regardless of benefit coverage limitations.

Utilization Management (UM)/Provider Appeals and Alternative Dispute Resolution:
DWMHA has established appeals and dispute resolution policies and processes that afford fair, efficient, consistent and timely review of a UM decision for providers. An appeal or dispute can be initiated by telephone or in writing and

must be done within prescribed time frames depending on the funding stream of the service(s).

The types of appeal and alternative dispute resolution reviews are as follows:

- **Administrative-** an appeal or dispute review involving a benefit determination decision that was not based on medical necessity. Administrative appeals involve utilization management issues such as denials resulting from not obtaining a prior authorization and/or continued authorization for some or all types of services and/or for all dates of services. _
- **Medical Necessity-** an appeal or dispute review involving a decision that a service does not meet MCG, NCD, or LCD medical necessity criteria or is considered to be experimental or investigational. The medical necessity appeal is reviewed by a DWMHA, COPE or MCPN physician with the same or similar credentials as would usually treat the condition which is being appealed. The physician reviewing the appeal has no involvement in the initial denial.
- **Expedited/Urgent**-a request to review a decision concerning eligibility, screening, admission, continued/concurrent stay, or other behavioral healthcare services for an enrollee/member who has received urgent services but has not been discharged from a facility, or when a delay in decision-making might seriously jeopardize an enrollee/member's life, health, or ability to attain, maintain, or regain maximum function.
- **Standard**-is a request to review a decision concerning eligibility, screening, admission, continued/concurrent stay, or other behavioral healthcare services for an enrollee/member who has received services or is currently receiving services but a delay in decision-making does not jeopardize an enrollee/member's life, health, or ability to attain, maintain, or regain maximum function.

Annual UM Program Evaluation:

Quarterly, DWMHA collects and analyzes utilization tracking and trending data in order to identify opportunities to improve the quality of UM processes and the efficiency of clinical operations. In addition, the UM Program Description is formally reviewed and evaluated annually for overall program effectiveness, and its impact is documented within the annual Quality Improvement Program evaluation.

The annual evaluation of the DWMHA UM Program includes but is not limited to:

- Monitoring trends and patterns of key utilization management indicators for under and over utilization and appropriateness of care;
- Member and Provider satisfaction with the UM process;
- Compliance with UM decision-making timeframes;
- Compliance with certification, non-certification and appeal resolution timeframes;
- Consistency of UM decisions and application of medical necessity criteria by UM decision-makers;
- Evaluation of UM process complaints and assessment of complaint trends;
- Quality improvement activities;
- Denial and Appeal category analysis;
- Selection and application of Medical Necessity Criteria used for UM decisions;
- New Technology Recommendations.

Customer Service

For DWMHA policies procedures, and documents, visit our website at www.dwmha.com

Customer Service Office

The Detroit Wayne Mental Health Authority's Customer Service Office (CSO) is committed to being the front door to DWMHA. It is responsible for conveying an atmosphere that is welcoming, helpful and informative. It provides oversight and monitoring of mandated Customer Service standards at DWMHA, Access Center, MCPNs, and those service providers that have the delegated function of Customer Service.

Overview

DWMHA's Customer Service office is available Monday -Friday, 8:00 AM-4:30 PM EST and is staffed by highly trained Customer Service Representatives. Staff routinely handles calls and or walk-in service requests that address referrals, complaints, grievances, appeals, State Fair Hearings, and Family Subsidy. Inquiries that are related to enrollment or of a crisis in nature are warmly transferred to DWMHA's Access Center. The Access Center, which is available 24-hrs per day 365 days per year, including holidays, has clinically-trained staff that can immediately assess and make the appropriate referrals for service and/or crisis intervention. After normal business hours, calls are forwarded to the Access Center for processing.

DWMHA's Customer Service mission is to exceed its customer's expectation. Through its courteous staff, the emphasis is placed on providing prompt and efficient service, while ensuring that everyone is treated with dignity and respect.

Customer Service staff is sensitive to those customers that are in need of special accommodations i.e., hearing and /or language assistance. It is their responsibility to accommodate each individual's specific need with the specific need of the individual so that appropriate service is always provided.

DWMHA Customer Service Office's commitment to continuous quality improvement is carried out in their daily monitoring of the Customer Service function throughout DWMHA's service network. Monitoring, tracking, trending and reporting on Customer Service standards of performance are key in promoting process improvement initiatives. DWMHA conducts Member and Provider experience surveys annually. The findings are an integral part of DWMHA's continuous quality improvement plan to ensure we are serving our members and effectively collaborating with our Provider Network.

Customer Service Standards

DWMHA's Customer Service Office is responsible for ensuring:

- Prompt response to enrollee/member inquiries;
- Systems navigation services;
- Prompt handling and resolution of enrollee/member complaints, grievances and appeals processes, local dispute resolution, Medicaid Fair Hearing, Alternative Dispute Resolution. Information, referrals, linkage, and follow-through;
- Coordinate the maintenance of current listings of all Service Providers, with whom the Authority has contracts. The list is to include: services, languages, independent facilitators and any specialties. Enrollees/members are to be given this list initially and be informed annually of its availability;
- Maintenance of access to information about DWMHA including the annual report, current organizational chart, DWMHA's board member list, meeting schedule and minutes provided in a timely manner;
- Upon request, the Customer Service Office will assist enrollees/members with grievances, appeals, local dispute resolution, Fair Hearings, alternative dispute resolutions and coordinate records as appropriate with the Office of Recipient Rights;
- Development and distribution of resource materials (i.e., Member Handbook and educational brochures);
- Participation with enrollee/members, community and advocacy groups in collaborative efforts and events for advancing the rights of people with disabilities;
- Development and implementation of structured customer service-related outreach, training and learning opportunities for staff, enrollees, and Service Providers;
- Continuous monitoring of the customer service function at the Access Center**,** MCPNs, and Service Provider locations to meet compliance

standards for customer service, member grievances, appeals and enrollee rights;

- Technical assistance to the Access Center, MCPNs**,** and Service Providers to promote customer service quality assurance, improvement, and management. Trending, tracking and reporting on:
    - Call Center activities (i.e., total call volume, abandonment rates, the average speed of answer, hold time, call types, etc.).
- Coordinate monitoring activities and the development of tools to evaluate system-wide customer satisfaction.

DWMHA's Access Center, MCPNs, and Service Providers are expected to adhere to the following mandated customer service standards:

- Maintain an identifiable Customer Service unit staffed with qualified individuals knowledgeable in customer service protocols.
- Ensure that all customer service staff is trained on customer service standards, policies and procedures within 30 days of hire and as required thereafter. Training shall be provided by Authority approved trainers utilizing Authority training modules.
- Complete staff training as indicated by the Authority and should be proficient in conflict resolution, consumer advocacy, enrollee rights, grievance and appeals processes and cultural competency.
- Identify a customer service staff person as the contact person to serve as a liaison to DWMHA's CSO. The contractor shall provide immediate notification of any changes.
- Customer Service unit shall be staffed with a minimum of one (1) full-time staff dedicated to customer services. If any customer service function is delegated to contracted providers, appropriate full-time equivalents (FTEs) shall be assigned to sufficiently meet the needs of the people in the service area.
- Comply with to all DWMHA Customer Service Office policies, procedures and standards.

DWMHA's Access Center, MCPNs and Service Providers Customer Service Units are to:

- Provide systems navigation including services that are peer delivered;
- Provide problem identification, clarification and resolution assistance;
- Provide direction for the prompt handling and resolution of grievance and appeals processes, information, referrals, and follow-through;
- Ensure prompt responses to all inquiries;
- Distribute DWMHA's resource materials as indicated by DWMHA (i.e., DWMHA Member Handbooks, brochures, directories, etc.).

- Promote learning opportunities for enrollees/members and participation for individuals to enhance system design and delivery;
- Participate with consumer, community and advocacy groups in collaborative efforts and events for advancing the rights of people with disabilities;
- Track and report on staff training and structured learning opportunities;
- Develop and promote participation with the Authority's efforts and opportunities for meaningful enrollee/member involvement with organizations in the community system in the following areas:
    - Governance
    - Policy development
    - System assessment, planning, and evaluation
    - Contracting and procurement
    - Quality assurance, improvement, and management.
- Provide organizational oversight, performance measurement and monitoring of customer service functions at all applicable delegated levels;
- Provide monthly performance monitoring, tracking and reporting to DWMHA's CSO;
- Ensure enrollees/members are provided with a DWMHA approved orientation that addresses services, benefits, and rights of the enrollee at time of enrollment and is informed of their rights annually, thereafter;
- Provide documentation, monitoring and reporting on enrollees to DWMHA's CSO;
- Ensure that enrollees/members participate in DWMHA's efforts to assess consumer satisfaction with the system and services provided**,** and to protect individuals from any harassment and /or retaliation that may result from participation;
- Provide information and assistance to enrollee/member filing grievances, appeals and/or rights violations.

Customer Service Staff Training

All customer service staff hired at DWMHA, Access Center and contractors, shall be trained on customer service standards within thirty (30) days of hiring and annually thereafter. Training is to be conducted by DWMHA approved trainers utilizing DWMHA approved training materials. In addition, customer service staff shall be expected to attend continuous staff training and education workshops and or seminars as directed by DWMHA. Training shall be inclusive of topics that have been outlined in the customer service standards.

Customer Service Compliance Monitoring

To ensure that customer service functions are being carried out in accordance with DWMHA, Federal and State requirements, DWMHA's Customer Service Office (CSO)

is responsible for monitoring the Access Center, MCPN's compliance on an ongoing basis. This compliance monitoring includes reviewing monthly performance reports and conducting periodic meetings with contractors to address compliance issues. An annual site assessment is also conducted by DWMHA's Customer Service Office to address compliance standards as indicated by the following:

- DWMHA, MDHHS and Medicare contracts,
- The Mental Health Code,
- Balanced Budget Act (BBA),
- Americans with Disability Act (ADA),
- The Affordable Care Act, Section 1557
- MDHHS Customer Service Standards
- NCQA Standards
- DWMHA Customer Service policies:
    - Customer Service
    - Member Grievance
    - Customer Service Enrollee/Member Appeals
    - New Member Orientation
    - Accommodations for Individuals with Visual & Mobility Impairments
    - Communication Using Teletype Device & Michigan Relay Service or Other

      Communication Devices
    - Limited English Proficiency (LEP)*See Section for further details
    - Cultural Competence
    - Member Experience

When conducting the site assessment, a monitoring tool is used that clearly identifies the specific standard that is being reviewed including the elements and criteria evidence that will be requested to meet the standard.

The following are examples of key standards that are applicable to the customer service function and the specific elements that require evidence of compliance:

Customer Service Standard
Evidence of:

- Customer Service Identifiable functions
- Customer Service Policy
- Access to Services
- Call Center Standards
- Performance Standards of Excellence and Efficiency

- Cultural Sensitivity and Accommodations
- Delegation of Customer Service Function
- Welcoming Environment

Grievances & Appeals Standard
Evidence of:
- Method for Filing
- Process for Handling Grievances & Appeals
- Recordkeeping
- Delegation

Enrollee Rights Standard
Evidence of:
- New Member Policy
- Right to Request and Obtain Information
- Right to be Treated with Dignity and Respect
- Right to Receive Information on Treatment Options

Customer Service Performance Measurement

DWMHA's Customer Service Office is committed to providing leadership and support for the development of effective performance measures that support the mission, goals, and values of DWMHA as it pertains to customer service functions. DWMHA Access Center, MCPNs, and Service Providers are to monitor, track and report customer service related performance measurements that are required by DWMHA.

Examples of performance measurements are as follows:

- Percentage of grievances resolved within sixty (60) calendar days
- Percentage of enrollees/members who receive an orientation within fourteen (14) business days after enrollment
- Percentage of newly hired Customer Service staff receiving a Customer Service orientation within thirty (30) days of hire
- Percentage of Customer Service inquiries processed within twenty-four (24) hours

Dictated performance measurements are to be accurately tracked, recorded and reported to DWMHA on the Monthly Performance Measurement and Tracking Report. If the Customer Service function is delegated to its Provider network, it is the responsibility of the MCPN to obtain this information and report to DWMHA's CSO.

It is expected that the following process will be implemented to accomplish the aforementioned:

- Assignment of a unit or department who will be responsible for the timely submission of customer service performance measurements
- Utilization of an internal monitoring tool and system to address customer service activities, training, grievances, appeals, enrollment and orientation processes within its organization/ network
- A system that will tabulate, document, and provide timelines to report information

The areas that are to be tracked monthly and monitored are:

- Number of Customer Service calls handled
- Number of Customer Service calls resolved within 24 hours
- Number of Customer Service Walk-ins
- Number of Grievances handled
- Number of Advance and Adequate notices generated
- The tracking of continued education training of Customer Service staff
- Any Customer Service Satisfaction Surveys that may be conducted in coordination with DWMHA.
- Consumer education and training attendance
- Other activities as dictated by DWMHA

It is the responsibility of DWMHA, Access Center, and contractors to record, monitor, track and report on all customer service activities, trainings and staff attendance using the DWMHA Customer Service MCPN Monthly Activity Performance Tracking Report. The report must be submitted by the 5th day of each month.

Sanctions

- In the event of a violation of any prevailing laws, regulations, and/or breach of contractual provisions regarding Customer Services by the Access Center or any contracted entity, DWMHA shall take immediate corrective action and will continue to monitor. Such violations of Customer Service may include, but not be limited to, the following:

    - Any impediment to an enrollee/member's access to the grievance and appeals procedures;
    - Any impediment to monitoring by staff employed by DWMHA or
    - Any harassment or retaliation against any individual seeking to report, pursue a grievance or appeal or failure to cooperate with the resolution of a grievance or an appeal.

- Appropriate prompt action against the Access Center and /or contracted entity in the event of any violation of the aforementioned provisions may be imposed based on

the severity of the findings. Such actions may include, but are not limited to, the following:

- Removal of a staff from a service site or stop further referrals to the Contracted Provider;
- Removal of the offending Contracted Provider from its network;
- Withholding all or a portion of contractual payments to offending Contracted Provider;
- Assessing monetary sanctions reflecting the severity of the violation; and/or terminating the Agreement.

Limited English Proficiency (LEP)

DWMHA, Access Center, MCPNs, and contractors must take reasonable steps to provide enrollees/members with Limited English Proficiency with meaningful access and opportunity to participate in DWMHA funded programs by doing the following:

- Develop policies and procedures that will assure language assistance to Consumers with limited English proficiency
- Ensure all services, programs, or activities shall be available to enrollees/members with LEP.
- Provide adequate information to enable enrollee/members with LEP to understand the types of services and benefits available.
- Ensure meaningful access by enrollee/members with LEP to critical services while not imposing undue burdens on the entity. Applying the four-factor analysis might lead to the conclusion that different language assistance measures are sufficient for different programs or activities. An individualized assessment that balances the following four factors should be conducted:
    - The number or proportion of LEP enrollees/members eligible to be served or likely to be encountered. (This may be obtained through an examination of the latest census data for the area served, data from school systems and community organizations.) The greater number or proportion, the more likely language services will be required.
    - The frequency with which LEP individuals come in contact with the program. The more frequent the contact with a particular language group, the more likely that enhanced language services will be needed (e.g., a program that encounters LEP Consumers on a daily basis may have a greater obligation than a program that encounters LEP Consumers sporadically.)
    - The nature, importance, and urgency of the program. The more essential and crucial the activity, the more likely that language services will be needed (e.g., the communication of rights to a person whose benefits are being terminated).

    - The resources are available to provide effective language assistance. Reasonable steps may cease to be “reasonable” where costs substantially exceed benefits.

- Provide a range of language assistance which may include:
    - Using sign language interpreters for individuals with hearing impairments/limitations.
    - Disseminating alternative formats such as large print or Braille for individuals with visual impairments/limitations.
    - Providing bilingual employees that are trained and competent in interpreting.
    - Testing identified bilingual staff to assure language proficiency.
- Contract with outside interpreter(s) to meet the language needs of enrollees/members served.
- Arrange for the services of trained and skilled voluntary community interpreter(s), which includes testing for an adequate level of fluency.
- Provide telephonic language interpreter service as needed. This may be used as a supplemental system or when other resources cannot accommodate the encountered language.
- Ensure that interpreters are familiar with the terminology used in to the provision of mental health and substance abuse services.
- Ensure that vital documents are available in language(s) other than English for each regularly encountered LEP group eligible to be served or likely to be affected by the program.
- Ensure access to, at a minimum, provide notices in writing, in the LEP individual’s primary language, of the right to receive free language assistance in a language other than English, including the right to competent oral translation of written materials free of cost. Notice can be provided by, but not limited to:
    - Use of language identification cards, which allow LEP *enrollees/member* to identify their language needs. A message on the card must invite the LEP person to identify the language he/she speaks. Identification must be included in the individual’s record.
    - Posting signs in regularly encountered languages (in accordance with Federal safe harbor guidelines) other than English in waiting rooms, reception areas, and other initial points of entry. These signs must inform applicants and beneficiaries of their right to free language assistance services and invite them to identify themselves as enrollees/members needing services.

- Translation of applications, and instructional information, and other written materials into appropriate non-English languages by competent translators.
- Uniform procedures for timely and effective communication between staff and LEP individuals. This includes instructions for English speaking employees to obtain assistance from interpreters or bilingual staff when receiving calls from, or initiating calls, to LEP individuals.
- The inclusion of statements about services available and the right to free language assistance services, in applicable non-English languages in brochures, booklets, outreach, and recruitment information and other materials routinely disseminated to the public.

- Disseminate Limited English Proficiency policy to staff (i.e., through staff training, initial orientation, memoranda, etc.).

- Provide training to new employees and annually thereafter (or as new or existing regulations modify standards of business/clinical practice to ensure all professionals:
  - Are knowledgeable and aware of LEP policy and procedures,
  - Are trained to work effectively with interpreters and
  - Understand the dynamics of interpretation between consumers and the interpreter.
- Monitor the language assistance program periodically to assess:
  - The current LEP makeup of its service area,
  - The current communication needs of LEP applicants and consumers,
  - Whether existing assistance is meeting the needs of such enrollees/members,
  - Whether staff is knowledgeable about policies and methods of implementation,
  - Whether sources of arrangements for assistance are still current and viable,
  - If modifications are needed.

Intended Beneficiary/New Enrollee Orientations

State and Federal requirements dictate that new enrollees/members are to be provided a timely orientation to the benefits and services available, including how to access them within DWMHA, MCPNs, and contractors.

The MCPN and Service Providers are responsible for orientating Consumers via the New Member/Enrollee Orientation Process as required by the State of Michigan.

These services must be provided within the Michigan Department of Health and Human Services Contract, Section 4.7.1, Customer Services, and Section 3.12, Compliance with Civil Rights and Title VI of the Civil Rights Act of 1964, 42 U.S.C. 2000d ET. Seq.

DWMHA's Customer Service unit is responsible for ensuring that Customer Service divisions of the Access Center, MCPNs and contracted Service Providers and their entities, comply with the following orientation procedure:

- Shortly after initial enrollment and or at the time of initial intake, all intended beneficiaries are to be made aware of their need for an orientation to behavioral health service, benefits and how to access them within 3 – 7 business days.

- The enrollee shall receive an orientation packet which includes information on the following:

    - DWMHA Welcome Letter
    - MCPN Welcome Letter
    - Recipient Rights Handbook
    - Member Handbook (supplied by DWMHA)
    - Grievance and Appeals Pamphlet
    - Customer Service Related Brochures
    - Information from MCPN and Service Providers (i.e., information specific to their organization)
    - Advance Directive Brochure

  The enrollee must be provided detailed information specific to each MCPN regarding:

  - Benefits covered;
  - Cost sharing, if any;
  - Service area (i.e., Wayne County);
  - Names, locations, telephone numbers of current affiliated Providers with ability to communicate with non-English language enrollees/members;
  - Information about where and how to obtain counseling or referral services that are not covered because of moral or religious objections;
  - The notification to all enrollee/members and potential beneficiaries of the availability of information in alternative formats, taking into consideration their special needs (e.g., visual, limited reading proficiency), and how to access those formats;

- A mechanism to help enrollees/members and potential beneficiaries understand the managed care program, and the requirements and benefits of the plan;
- The availability of written information in the prevalent non-English languages in Wayne County in accordance with the Federal Limited English Proficiency Guidelines and/or DWMHA's contract with the Michigan Department of Health and Human Services (MDHHS); and
- The availability, free of charge, of oral interpretation services to non-English languages (not just those identified as prevalent) in accordance with State and Federal guidelines.

General information must be furnished to the beneficiary/person as follows:

- Notification that enrolled members may request a change of their assigned Managed Comprehensive Provider Network (MCPN) twice per fiscal year which begins October 1st and ends September 30th. The enrolled person shall be able to initiate the change process by submitting an MCPN Change Request Form to DWMHA Access Center during open enrollment. Change applications can be submitted 30 days prior to October 1st and/or March 1st.
- Notification that enrolled persons shall have the opportunity to change MCPN assignments outside of the open enrollment periods due to extenuating circumstances. DWMHA will review and approve all MCPN Exception Change Requests per policy (hyperlink to MCPN Member Enrollee Change Process).
- Notification of any restrictions on the freedom of choice among network
- Notification of rights and protections (as noted in subsection E, below);
- The enrollee/member is free to exercise his or her rights, and that

  the excision of those rights will not adversely affect the way DWMHA, MCPN, or its Providers, or the Michigan Department of Health and Human Services (MDHHS) treat the beneficiary/person.
- Notifications of their right to "Psychiatric Advance Directives."
- Information on the structure of DWMHA or the MCPN, and the scope and process of accessing emergency services and post-emergency care including:

    - Prior authorization not being required for emergency services,
    - The process and procedures for obtaining emergency services including the proper use of the local 911-telephone system,
    - The locations of any emergency services at which Providers and hospitals furnish emergency services and post-stabilization services covered by DWMHA,
    - The amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that enrollee/member

beneficiaries/Consumers understand the benefits to which they are entitled,

- The estimated cost to DWMHA of each covered service and support that he/she is receiving,
- Procedures for obtaining benefits, including authorization requirements.

Identified Customer Service staff shall conduct the orientation by reviewing each document in the orientation packet and highlighting the entitled benefits, services, and process on how to access them. The Intended Beneficiary is to be provided an opportunity to ask questions. Upon completion of this process, the Intended Beneficiary is to be given the applicable customer service phone numbers and advised where to call for questions. The New Enrollee shall be informed of DWMHA and MCPN/Provider service structure**.**

Enrollees/members must be informed of their Enrollee Rights: These Enrollee Rights shall include but are not limited to the following:

- To be provided with information about enrollee rights and protections;
- To be treated with respect and recognition of your dignity and right to privacy;
- To be provided with information on the structure and operation of Detroit Wayne Mental Health Authority (DWMHA);
- To receive information about DWMHA, its services, its practitioners and providers and rights and responsibilities;
- To be provided freedom of choice among network providers;
- To a candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage and to freely communicate with your providers and without restriction on any information regarding care;
- To receive information on available treatment options;
- To participate in decisions regarding health care, the refusal of treatment and preferences for future treatment decisions;
- To be made aware of those services that are not covered and may involve cost sharing, if any;
- To request and receive an itemized statement for each covered service and support you received;
- To track the status of a claim in the claims process and obtain information over the telephone in one attempt or contact;
- To receive information on how to obtain benefits from out-of-network providers;
- To receive information on advance directives;
- To receive benefits, services and instructional materials in a manner that may be easily understood;

- To receive information that describes the availability of supports and services and how to access them;
- To receive information and help in alternate language or format, if requested;
- To receive interpreter services free-of-charge for non-English languages as needed;
- To be provided with written materials in alternative formats and information on how to obtain them for individuals who are visual and/or hearing impaired or have limited reading proficiency;
- To receive information within a reasonable time after enrollment;
- To be provided with information on services that are not covered on moral /religious basis;
- To receive information on how to access 911, emergency, and post-stabilization services as needed;
- To receive information on how to obtain referrals for specialty care and other benefits not provided by the primary care provider;
- To receive information on how and where to access benefits not covered under Detroit Wayne Mental Health Authority (DWMHA) Medicaid contract but may be available under the state health plan, including transportation;
- To receive information on the grievance, appeal, and fair hearing processes;
- To voice complaints and request appeals regarding care and services provided;
- To be provided with timely written notice of any significant State and provider network-related changes;
- To make recommendations regarding DWMHA member rights and responsibilities;
- To supply information (to the extent possible) that DWMHA and assigned providers and practitioners need in order to provide care;
- To follow plans and instructions for care that enrollee have agreed to with your practitioners and
- To understand an enrollee's health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.

Note: All DWMHA, the Access Center, Manager of Comprehensive Provider Networks (MCPNs), and Service Provider employees shall acknowledge, uphold and demonstrate knowledge of the above enrollee rights and responsibilities.

The enrollee is expected to sign the New Member Orientation Log Sheet and the (DWMHA) New Member Orientation Receipt Form.

Upon completion of the orientation, the member is provided an Orientation Evaluation form to complete.

Copies of the New Member Orientation Log Sheets are to be tallied monthly and reported to the MCPN Customer Service Unit. They will then be expected to prepare

a final orientation tally report and forward monthly to the Authority's Customer Service Unit.

Note: Upon request, original Orientation log sheets are to be made available for DWMHA site reviews.

Copies of the signed DWMHA New Intended Member Orientation Receipt Form are to be immediately filed in the medical record file and made available upon request, for DWMHA site review purposes.

Orientation presentations and materials when applicable must be modified to accommodate the special needs of the enrollee/member with physical disabilities, hearing and/or visual impairments, limited English proficiency, and alternate forms of communication.

Member Grievance and Appeals

For DWMHA policies, procedures, and documents, visit our website at www.dwmha.com.

When a request for a level of care requiring prior authorization is denied, an appeal of that decision is offered to the enrollee and Provider. Both the enrollee and Provider may request an appeal. The MCPNs are responsible for distributing and assuring compliance with DWMHA's policies for accessing the clinical appeal process.

Appeal: A review of an adverse benefit determination.

Adverse Benefit Determination: A decision that adversely impacts a Medicaid beneficiary's claim for services due to:

- 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;
- Reduction, suspension, or termination of a previously authorized service;
- Denial, in whole or in part, of payment for a service;
- Failure to make a standard authorization decision and provide notice about the decision within **14 calendar days** from the date of receipt of a standard request for service;
- Failure to make an expedited authorization decision within **72 hours** from the date of receipt of a request for expedited service authorization;
- Failure to provide services within **14 calendar days** of the start date agreed upon during the person-centered planning and as authorized by DWMHA;
- Failure of DWMHA to act within **30 calendar days** from the date of a request for a standard appeal;
- Failure of DWMHA to act within **72 hours** from the date of a request for an expedited appeal and/or

- Failure of DWMHA to provide disposition and notice of a local grievance/complaint within **90 calendar days** of the date of the request.

Advance Notice

- Whenever services are denied, suspended, reduced or terminated (e.g., services will not be provided as specified in the IPOS), the individual, parent, authorized representative, or his or her guardian shall receive the Advance Notice Form, A Local Request Form, and a prepaid envelope will be provided for the beneficiary. A copy of the signed Request for Hearing form shall be placed in the case record.
- The written notice is required regardless of the reason of reduction, termination, suspension or denial of services (e.g., the person moves out of state or the country, or the person indicates they no longer want services). The advance notice must be mailed 30 calendar days before the intended action takes effect. The only exception is where there is credible evidence of death.

Adequate Notice

- Whenever services are denied or immediately terminated or reduced, the individual and his or her guardian shall receive the Adequate Action Notice form, and a prepaid envelope addressed to the MDHHS/AT. A copy of the signed form shall be placed in the enrollee's case record.
- Adequate Action Notice shall be provided to each Medicaid beneficiary whose services are denied or if services will be terminated in less than ten **(10)** days. These individuals will also be provided with a request and instructions on how to process a Local Appeal. The Adequate Action Notice should always be a part of developing an Individualized Plan of Service or a Master Treatment Plan.

Local Appeal Process

Federal regulations provide a Medicaid beneficiary the right to a local level appeal of an action (adverse benefit determination). PIHP appeals, like those for fair hearings, are initiated by an "action" (adverse benefit determination). The beneficiary may request a local appeal under the following circumstances:

- The beneficiary has sixty calendar days from the date of the notice of action to request a local appeal.
- An oral request for a local appeal of an adverse benefit determination is treated as an appeal to establish the earliest possible filing date for appeal.
- The beneficiary may file an appeal with the PIHP organizational unit approved and administratively responsible for facilitating local appeals.
- If the beneficiary or representative requests a local appeal, not more than 12 calendar days from the date of the notice of action, the PIHP must reinstate the Medicaid services until the disposition of the hearing.
- The PIHP, MCPN or Service Provider is responsible for providing reasonable assistance to the beneficiary to complete the forms and to take other

procedural steps. This includes but not limited to providing interpreter services, toll free numbers that have adequate TTY and interpreter capability.

- The PIHP is to acknowledge the receipt of each appeal. Once the local appeal has been reviewed by the appropriate staff, the PIHP is to provide a letter of disposition to the beneficiary, representative, guardian or authorized representative of the deceased's estate within 30 calendar days. The letter will also include a self-addressed envelope for the beneficiary to file a State/Medicaid Fair Hearing should they choose.

Expedited Appeals

An expedited appeal is available when it is determined that following the standard timeframe could seriously jeopardize the beneficiary's life, health or ability to attain, maintain or regain maximum function. Medicaid beneficiaries must be given instructions for accessing the expedited local appeal process, which can be filed in writing or orally. The following information can be utilized for written or faxed appeal requests:

DWMHA Customer Service
707 West Milwaukee St.
Detroit, Michigan 48202
Voice: 1-888-490-9698
Local: 313-833-3232
TTY: 1-800-630-1044
Fax: 313-833-2217

Medicaid Fair Hearing Appeal Process (State Fair Hearing Appeal Process)

The following section outlines the required steps in the Medicaid Fair Hearing Process:

- A Medicaid beneficiary has the right to request a Medicaid Fair Hearing when the PIHP or its contractor takes an "adverse benefit determination," or a grievance request is not acted upon within 60 calendar days. The beneficiary must exhaust the local appeals process before he/she can request a Medicaid Fair Hearing/State Fair Hearing.
- The authority may not limit or interfere with the beneficiary's freedom to make a request for a Medicaid Fair Hearing after the conclusion of a Local Appeal.
- The parties to the State/Medicaid Fair Hearing include the PIHP, the beneficiary, his or her representative, guardian or the representative of a deceased beneficiary's estate.
- The beneficiaries are given 120 calendar days from the date of the notice to request a State/Medicaid Fair Hearing.
- If the beneficiary or representative requests a fair hearing not more than 12 calendar days from the date of the notice, the PIHP must reinstate Medicaid services until disposition by the Administrative Law Judge.

- The option for an expedited state/Medicaid fair hearing is available to the beneficiary and or his/her representative (guardian or representative of a deceased beneficiary's estate) when it is determined that following the standard timeframe could seriously jeopardize the beneficiary's life, health or ability to maintain or regain maximum function. This course of action would be reviewed by an Administrative Law Judge through the Michigan Administrative Hearing System, and a determination is made whether or not the request is granted. The Michigan Administrative Hearing System will provide the appellant with written notice within two days regarding the acceptance or denial of the request to grant an expedited hearing.

MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF HEALTH AND HUMAN SERVICES
ADMINISTRATIVE TRIBUNAL
P.O. BOX 30763
LANSING, MI 48909-9951

Grievances:

A member has the right to say that he/she is unhappy with the services or supports or the staff who provide them, by filing a "grievance." A member can file a grievance *any time* by calling, visiting, or writing to DWMHA, MCPN or Service Provider's Customer Service unit. Assistance is available in the filing process by contacting the Grievance Coordinator or a Customer Service Representative. The member will be given detailed information about grievance and appeal processes when he/she first starts services and then again annually. You may ask for this information at any time by contacting DWMHA, MCPN, or Service Provider Customer Service unit.

DWMHA, the Access Center, MCPN's and Service Providers will:

- Assure that all employees are trained on the grievance and appeal process within 30 days of hire and annually thereafter.
- Assure that the enrollee is provided information on the grievance and appeal process upon enrollment, at the time the IPOS is developed, annually thereafter, and as requested by the enrollee/member.
- Prominently display grievance and appeal forms, posters, and brochures in public areas of the service Provider locations.
- Not substitute the grievance or appeal process for filing a recipient rights complaint.
- Ensure persons who file a grievance or appeal shall not be subject to discrimination or retaliation.
- Ensure staff that participates in the review or resolution of a grievance or an appeal shall not be subject to discrimination or retaliation.
- Ensure that the grievance and appeal process is timely, objective, and fair to all parties.

- Ensure that a grievance or appeal will be expedited when it is determined that following the standard timeframe could seriously jeopardize the enrollee/member's life or health or ability to attain, maintain, or regain maximum function.
- Ensure that the grievance and appeal process is accessible and understandable to the member/enrollee/legal representative and service Provider.
- Ensure that documentation of grievance and appeal records and logs are maintained in MHWIN.

The enrollee/member or legal representative shall be:

- Informed orally and in writing of the appeal and grievance process available and methods to file a grievance.
- Informed that filing an appeal or grievance will not affect the eligibility of service.
- Offered reasonable assistance in completing appeal and grievance forms and in taking other procedural steps.
- Provided interpreter services and toll-free numbers that have adequate TTY and interpreter capability.
- Provided reasonable accommodations via ADA requirements.
- Provided information regarding their appeal and grievance rights in a format provided or approved by the Authority at the time of initial enrollment and at least annually thereafter.

A member may file a grievance or an appeal by contacting his/her Service Provider, MCPN or DWMHA at:

DWMHA Customer Service
707 West Milwaukee St.
Detroit, Michigan 48202
Voice: 1-888.490.9698
Local: 313-833-3232
TTY: 1(800) 630-1044

Fax: 313-833-2217 or 313-833-4280

A **MI Health Link** enrollee/member may file an external grievance or appeal by calling **1-800-MEDICARE** or **1-800-633-4227** seven (7) days a week. TTY users can call **1-877-486-2048**.

Note: Please refer to the referenced documents below for additional information:

- The Member Handbook
- Member Grievance Policy
    - Customer Services Local Appeal Policy for Medicaid, Healthy Michigan, MI Child and MI Health Link

- Customer Services Local Appeal Policy for Medicare

Recipient Rights

For DWMHA policies, procedures, and documents, visit our website at www.dwmha.com.

Mission Statement of the Office of Recipient Rights

To ensure that recipients of mental health services through the Detroit-Wayne Mental Health Authority system of care receive individualized treatment services suited to his/her condition as identified in their individualized plan of service, that is developed in the Person-Centered Planning process, and receives services in a safe, sanitary, and humane environment where they are treated with dignity and respect, free from abuse and neglect.

Overview of the Office of Recipient Rights

The Office of Recipient Rights (ORR) is a unit of the Detroit Wayne Mental Health Authority (DWMHA). ORR takes actions that are appropriate and necessary to safeguard and protect the rights guaranteed to recipients receiving services through DWMHA and contracted service provider network as mandated by Federal statutes, Michigan Mental Health Code (MHC), Administrative Rules, MDHHS contract, and DWMHA policies.

The ORR protects the rights of recipients receiving services by:

- Complaint resolution through the investigation of allegations of Recipient Rights violations occurring within the jurisdiction of DWMHA;
- Providing Recipient Rights training for all employees, volunteers and agents within the DWMHA system of care;
- Monitoring of each service site under contract within the DWMHA service delivery network at least annually for compliance with the Recipient Rights mandates of the MHC, DWMHA policies, and other established laws and standards of care;
- Providing advocacy and support to the recipients of services.

Contractor and Subcontractor Responsibilities

The Executive Director of each Contractor and Contracted Provider is responsible for the performance of functions related to Recipient Rights, and that staff is adequately trained and qualified to perform these functions.

- Ensure ORR unimpeded access to all programs and services operated by Contractor and Contracted Provider; all staff, volunteers, and agents

employed Contractor and Contracted Provider; and all evidence necessary to conduct a thorough investigation

- Staff receive New Hire Recipient Rights training within 30 days of being newly hired into the public mental health system. If an individual receives New Hire training from an MDHHS-ORR certified trainer who uses an MDHHS-ORR-compliant curriculum, within 30 days of being initially hired into the public mental health system, they are considered compliant. If this individual continues to work in the public mental health system with no significant break in their employment, they remain compliant regardless of the number of Contracted Providers they subsequently work at. When the individual moves to another Contracted Provider, they must present documentation (i.e., training certificate) evidencing they successfully completed New Hire training from an MDHHS-ORR certified trainer who used an MDHHS-ORR compliant curriculum. If the individual can do that, they remain compliant with the law and do not have to go through New Hire training again.
- Applicants for, and recipients of, mental health services or their guardians, and in the case of minors, the applicant's or recipient's parent or guardian, shall be notified by the providers of those mental health services of the rights guaranteed by MHC.
- Directly providing or ensuring that recipients are informed of their rights, including being provided a copy of the Recipient Rights Handbook.
- Provide notification of Recipient Rights, Confidentiality, and Person-Centered Planning at the initiation of services and at least annually thereafter.
- Ensure current and approved ORR contract language is included in all contracts for services.
- Be available to respond to recipients and staff who have questions regarding Recipient Rights. This includes referring recipients (or making the contact on behalf of the recipients) to the ORR and conducting the necessary follow-through to ensure recipients access to the rights protection system.
- Remedial action: Ensure a timely response and appropriate remedial actions if it has been determined through investigation that a right has been violated. The remedial actions must meet all of the following requirements:
    - Corrects or provides a remedy for the rights violations;
    - Is implemented in a timely manner;
    - Attempts to prevent a recurrence of the rights violation;
    - Substantiated reports of abuse, neglect, retaliation, or harassment, REQUIRE disciplinary action for the employee, volunteer, or agent of a provider. Appropriate disciplinary actions are:
        - Written Counseling

- Written Reprimand
- Demotion
- Suspension
- Reassignment
- Termination

The remedial action shall be documented and made part of the record maintained by the ORR.

- No Retaliation or Harassment: The Contractor and Contracted Provider shall not retaliate in any manner against its employees, agents, volunteers, DWMHA ORR staff, or recipient(s) for any actions pertaining to the notification, reporting, filing of required written reports, the investigation of, or the cooperation in an investigation of alleged or suspected Recipient Rights violations. The Contractor and Contracted Provider shall ensure Recipient Rights staff are protected from pressures that could interfere with the impartial, even-handed, and thorough performance of their duties, and shall take appropriate disciplinary action if there is evidence of retaliation or harassment.

Sanctions

Where Contracted Provider has failed to take appropriate corrective or remedial action, the Contractor shall take or require prompt action against its Contracted Provider in the event of breach of the MHC or of the contractual provisions regarding Recipient Rights, including but not limited to, the following: (i) any impediment to a recipient's access to the complaint or appeal process; (ii) any impediment to monitoring or investigation by ORR staff; (iii) any harassment of, or retaliation against, any individual seeking to report, pursue or investigate a rights violation or failure to cooperate with an investigation of a rights violation. The Contractor shall impose sanctions for substantiated Recipient Rights violations appropriate to the severity of the findings. Such actions may include, but are not limited to:

- Require removal of recipient(s) from a service site;
- Stop further referrals to the Contracted Provider;
- Remove the offending Contracted Provider from its network;
- Withhold all or a portion of payments to the Contracted Provider;
- Assess monetary sanctions reflecting the severity of the violation;
- Terminate the Agreement.

Monitoring

- ORR and certified volunteer monitors of the ORR shall have unimpeded access to all programs and services operated by Contractor and Contracted Provider, all staff employed by

Contractor and Contracted Provider, and all evidence necessary to fulfill its monitoring function.

- Contractor and Contracted Provider are expected to ensure timely and appropriate responses to all corrective actions required by DWMHA as a result of announced or unannounced site review visits.
- Contractor and Contracted Provider are expected to monitor all sites of service within the scope of its contract to ensure a uniformly high standard of Recipient Rights protection throughout its service delivery system in accordance with Federal, State and local laws, and DWMHA policies. Contractor and Contracted Provider shall monitor each site of service to ensure:
- Recipients, parents of minor recipients, and guardians or other legal representatives are notified of those rights in an understandable manner, both at the time services are requested and periodically during the time services are provided to the recipient
- Telephone number and address of the ORR are conspicuously posted
- "YOUR RIGHTS" booklets (also known as Blue Book) are available
- Recipient Rights complaint forms are available
- Other postings as required (i.e., Abuse and Neglect poster)

Employee Training

- Ensure that all staff, volunteers and agents of the Contractor and Contracted Provider, complete Recipient Rights New Hire training within 30 days of hire into the public mental health system, and complete Recipient Rights update training annually thereafter.
- Participate in training events and meetings sponsored by the ORR to become better informed regarding Recipient Rights-related issues and developments as well as efforts of continued learning.

Behavior Treatment Committees

Ensure inclusion of Recipient Rights staff as ex-officio members in all Behavior Treatment Committees

Quality Improvement

A written protocol to address the use of Recipient Rights data and information as part of the planned quality improvement efforts.

Communication

Sharing Information with Consumers

MCPN and Direct Contracted Providers (DCP) Board of Trustees (or comparable governing body) and Board Committee meetings related to its performance of the contractual agreement with DWMHA must be open to the public. The MCPN and the DCP must provide reasonable advance notice for such meetings and allow for input from consumers, advocates and citizens. Additionally, the MCPN and DCP must ensure, through its contracts with providers and provider monitoring, that the subcontractors adhere to similar requirements.

The only exceptions to open meeting requirements recognized by DWMHA are those meetings that are solely dedicated to attorney-client privileged information and/or confidential patient information.

Sharing Information with Subcontractors and Line Staff

The MCPNs and DCPs are expected to communicate and train individuals as necessary on applicable policies, procedures, Medicaid regulations, **DWMHA** requirements/standards, and other relevant information that will assist the subcontractor and its staff in providing care and services to consumers. It is particularly important that line staff have all the information available to assist them in providing care.

Marketing Standards

Definition

Material that is intended primarily to attract or appeal to eligible Consumers and to promote membership retention by providing general information about the Managers of Comprehensive Provider Networks (MCPN) and Direct Contracted Providers and the services offered. Materials include written information, letters developed for mass mailing, and any other communication that is directed to more than 25 individuals.

Requirements

All materials that may be distributed or used in advertising or promotion to individuals or guardians/family members of individuals who are Intellectually/Developmentally Disabled, Seriously Emotionally Disturbed, and/or Seriously Mentally Ill must be reviewed and approved by DWMHA.

- All printed materials and marketing merchandise distributed must contain the DWMHA logo.
- DWMHA must be properly acknowledged on MCPN and provider websites with the DWMHA logo.
- All submitted materials must be “camera ready”, i.e. ready for print or in final format before being submitted to DWMHA for review

- MCPNs are required to adhere to a specific format when developing communication materials and all must include DWMHA logo on provided materials.
- Material readability must be at the 4_{th} grade level
- Materials must be translated to a language alternative when an alternative language-related population comprises 5% of the eligible population including, at a minimum, Spanish, Chinese, Arabic, French, Italian, and Polish
- Materials in non-English languages or Braille must be submitted in the non-English or Braille format, "camera ready" version accompanied by an English translation of the communication along with a letter of attestation from the CEO that both documents convey the same information
- A professional translator must translate materials. The name and the translator's credentials must accompany any translated materials submitted to DWMHA
- Materials must be printed in 12-point or larger font size, preferably in the New Times Roman type
- All marketing conveyances (e.g., newspaper, radio, TV, brochures, etc.) are applicable to the marketing requirements
    - Marketing material must clearly explain the concept of networks and subnetworks and the concept of choice.
    - Annual letters of notification for re-selection must disclose the names and telephone contact numbers for other MCPNs offered in the service area.
    - The person's ability to choose a new MCPN or transfer MCPNs must be clearly explained in all the marketing materials.
    - Descriptions of the Quality of the MCPNs network and DCPs must not be "embellished". For example:

      MCPNs and DCPs cannot use:

      - Superlatives (e.g., highest, best)
      - Unsubstantiated comparisons with other MCPN networks or DCPs
      - Direct negative statements about other MCPNs or DCPs including individual statements from members MCPNs and DCPs can use:
      - Qualified superlatives (e.g., among the best, some of the highest)
      - Superlatives (e.g., ranked number 1) if they can be substantiated by ratings, studies or statistics; the source must be identified in the advertisement
      - Survey data regarding own organization (but may not use it to make specific comparison to others)
- Testimonials must comply with marketing material review guidelines and cannot use negative testimonials about other MCPNs, or DCPs.

- If the MCPN uses the name and/or picture of providers and/or facilities to market itself, the provider information may only be used within the context of informing potential Consumers with choice or current Consumers that the provider is associated with the MCPN's network.
- The MCPN cannot imply that the provider is exclusively available through his/her network unless such a statement is true.
- Marketing materials or efforts cannot discriminate
- Marketing staff cannot be solely compensated on commission
- It must be clear to the Consumer with choice who is selecting a MCPN that the MCPN holds a contract with DWMHA.

Should you have any questions at any point in time, please contact the DWMHA Director of Communications at 313-833-2500.

Reporting Requirements

MCPNs and Direct Contract Providers are required to report:

- Quality Performance standards as outlined in the Contract and the Performance section of this manual.
- Recipients Rights data as outlined in the Contract and the Recipient Rights section of this manual.
- Financial performance as outlined in the Contract and the Finance section of this manual
- Recipient services via encounters in electronic or direct data entry format as indicated per contract. This includes **BH-TEDS** data and the Peer Support codes.
- Utilization Data as outlined in the Management of Services section of the manual and the Contract
- Monthly Financial Statement including a narrative outlining explanations for significant variances and % of paid claims outstanding
- Quarterly Narrative Report from the Direct Contractors
- Monthly Provider Network List – this list must include a column indicating that the provider is/is not accepting referrals
- E-form data- electronic or direct data entry submission of E-form data as indicated per contract.
- DWMHA, MCPNs and Direct Contractors will work collaboratively to determine the remainder of DWMHA's reporting needs, timing and format. DWMHA expects that periodically reporting needs will be examined, refined, and revised as data is collected and available. Additionally, DWMHA anticipates that the States requirements will change. It is incumbent upon the MCPNs, Direct Contractors and their subcontractors to be capable of responding to new reporting requirements as they are presented.
- **MCPN sub-contractors and DCPs shall report within 24 hours any and all critical events involving individuals receiving mental health services. All critical incidents shall be reviewed by Quality Improvement to ensure that the standard of care of all parties involved are followed.**

Report all incidents of abuse and neglect (and safeguarding) in accordance with Federal, State, local laws, MDHHS requirements and DWMHA policies, guidelines and contractual agreements. Additionally, any staff, volunteer or agent of the Contractor or Contracted Provider who has reasonable cause to suspect the criminal abuse of a recipient shall immediately make or cause to be made, by telephone or otherwise, an oral report of the suspected criminal abuse to the law enforcement agency for the county or city in which the criminal abuse is suspected to have occurred or to the state police, Adult/Child Protective Services and if applicable, Bureau of Children and Adult Licensing.

Death reporting

The Contractor shall report the death of a consumer to the ORR **to obtain a Death Log number from ORR** within 24 hours of the provider being notified of the death**. Also submit the Report of Recipient Death to Quality Improvement within 10 business days of the consumer's death.**

Incident Reporting
Contractor and Contracted Provider shall report within 24 hours any and all unusual occurrences involving individuals receiving mental health services. All incidents shall be reviewed by ORR to ensure that the rights of all parties involved are protected.

Information Systems - MCPN

Overview

The network manager's Managed Care Information System (MCIS) should be designed for use in a Managed Care setting. It must accommodate, maintain and report data for Consumers receiving services, providers rendering behavioral health services, and payers managing and reimbursing providers for the delivery of medical services. It is critical that the MCIS accommodate a large number of the administrative tasks that take place between these three parties.

The information system for the MCPN must include the following qualifications:

- Ability to import and manage enrollment information;
- Ability to store and report member specific socio-economic information;
- Ability to store and report other sources of benefit coverage (COB) information;
- Ability to store and accurately reflect the subcontractor's structure for the MCPNs or CAs;
- Ability to capture, store, and report utilization data for all levels or care/services;
- Capability of adjudicating claims and encounters;
- Ability to store, manage and report member rights issues;
- Ability to support clinical and business analysis;
- Compliance with HIPAA standards as required by federal and state laws; and
- Ability to transfer and receive data between DWMHA and the MCPN using ANSI Standard, HIPAA compliant transaction formats.

The MCPN shall have and maintain a Management Information System and related practices that reflect sufficient capacity to fulfill the obligations as a contractor. Management information systems capabilities are necessary for at least the following areas:

- Monthly downloads of Medicaid eligible information;

- Person registration and demographic information;
- Provider enrollment;
- Third party liability activity;
- Claims payment system and tracking;
- Grievance tracking;
- Tracking and analyzing services and costs by population group, and special needs categories as specified by the MDHHS;
- Encounter and demographic data reporting;
- Performance indicator reporting;
- HIPAA compliance;
- 837 submission;
- UBP (Uniform Billing Project) compliance; and • User access and satisfaction.

MH-WIN

MH-WIN is **DWMHA's** web-based MCIS application. Each MCPN must ensure that its subcontractors have access to MH-WIN so that eligibility lookup capability is always available. DWMHA will ensure that the subcontractor obtains access to MH-WIN in a reasonable time frame (no greater than seven (7) business days) after receiving all necessary information from the MCPN.

The MCPN subcontractor must have Internet access in order to use MH-WIN. This cost of internet access will not be incurred by DWMHA.

Mi-Care Connect

Access will be given access to the Mi-Care Connect System to support the broader care coordination strategies of the Provider, MCPNs, and DWMHA. Access to Mi-Care Connect will be closely monitored to ensure that its use is specific for care coordination. The Providers and MCPNs have the responsibility to educate and monitor staff for this purpose.

Encounters

MCPNs must submit encounters directly to the **DWMHA** MH-WIN system weekly.

Funding

Funding will be delivered monthly to the network managers in the ANSI X12 820 format.

Membership Lookups

All MCPNs and subcontractors may review membership eligibility in MH-WIN. The MCPNs may request access to MH-WIN by completing DWMHA's MCPN Provider Data Sheet. See the Provider Data Sheet in the Forms section of the Manual.

Information Systems - Providers

Overview

The Provider's Management Information System must have full EMR capability. This includes the ability to track Consumer, clinical and administrative, transactions performed within the Provider organization. The system should be designed specifically to support Community Mental Health functions as determined by the Detroit Wayne Mental Health Authority. It must be able to support managed care capabilities including the management of service authorizations where-ever appropriate.

Administrative capabilities include:

- The detailed tracking of costs and reimbursement for services performed by the organization.
- The ability to track the eligibility and benefits of individuals served within the provider organization and accurately apply this information to the processing of claims and reporting from the Provider systems.
- The tracking across time of demographic, socio-economic, and Quality Improvement (QI) data attributable to the Consumers served by the Provider.
- The ability to receive and send clinical and administrative data to the various trading partners within the PIHP. This includes the movement of data between the funding MCPNs and DWMHA. The Provider systems must be able to support standard methods for movement of data between these trading partner systems.
- The data maintained in the Providers EMR must follow all recognized industry standards for documenting clinical and support services.
- The system must be able to track various funding methods in support of services to the Consumers.
- The Provider and their system must provide the appropriate safeguards for "protected health information" – (PHI) in accordance with HIPAA, the Michigan Mental Health Code, 42-CFR – Part-2 as well as other regulatory requirements that apply to the Provider and our network.
- The Provider's system and administration must be able to support various audits as prescribed by DWMHA, the MCPNS, and the State of Michigan.

- The Provider system must be at a level that supports any accreditation and certification requirements.
- The Provider's system must be scale-able to accommodate the current and potential size of the population served within its organization.

- The Provider's system must be configured and managed in such a way so that it isolates the business of DWMHA and not comingle data with other business endeavors.

- The system must support a fully functional claims and encounter management system that includes the functionality identified in the Claims Section of this manual.

- The Provider's system must be able to support DWMHA administrative requirements to support Consumer rights and outreach range down into the providers organization including but not limited to Grievances and appeals, fair hearing, incident reporting, Critical Events, etc.

- The Provider systems must be able to support the administrative tracking and reporting of the State of Michigan Performance Indicators.

MH-WIN

MH-WIN is DWMHA web-based MCIS application. DWMHA will ensure that the Providers obtain access to MH-WIN in a reasonable time frame. The Providers must have Internet access in order to use MH-WIN.

Mi-Care Connect

Access will be given access to the Mi-Care Connect System to support the broader care coordination strategies of the Provider, MCPNs, and DWMHA. Access to Mi-Care Connect will be closely monitored to ensure that its use is specific for care coordination. The Providers and MCPNs have the responsibility to educate and monitor staff for this purpose.

Encounters

Where appropriate the Provider must submit encounters, and claims directly to DWMHA MH-WIN system weekly.

Membership Lookups

All MCPNs and Providers may review membership eligibility in MH-WIN. The Providers may request access to MH-WIN by completing DWMHA's Provider Data Sheet. See the Provider Data Sheet in the Forms section of the Manual

Claim and Encounter Submission

DWMHA will receive, process and pay clean claims as described in its Claims Processes Policy for covered services as described per DWMHA Utilization

Guidelines and per contract. Please also see the "Information Systems" section of this manual. **Information to Include on a Claim/Encounter Form**

For a claim to be considered a clean claim, it must:

- Include a valid member identification number
- Indicate patient's name, address, birth date
- Indicate the day, month, and year the service was provided
- Be submitted within 90 days of the date of service (or discharge date for a facility); for resubmission or secondary claims, claims must be submitted within 180 days of service date.
- Include all relevant provider information including:
    - Provider name,
    - National Provider Identifier (NPI),
    - Location of service and
    - Provider identification number (if different from NPI).
- Include a description of the covered service using **DWMHA** accepted codes stated in the contract, CPT codes, or other codes required by the State of Michigan
- Include a valid diagnosis code
- Only be submitted for services covered
- Have all fields necessary for accurate payment completed

DWMHA, MCPN, or any organization paying Medicaid claims must pay 90% of clean claims within 30 days and 99% within 90 days of receipt of the clean claim.

Web-Based Encounter Submission

Only direct contract providers (non-MCPN contractors) may submit encounter data to DWMHA through the web-based application, MH-WIN. Electronic submission of data is still available to the direct contract providers using the 837 format. It is critical that all data be submitted accurately.

Compliance

Overview

The Michigan Department of Health and Human Services (MDHHS) has changed its relationship to the Community Mental Health Service Programs (CMHSPs) in the state. MDHHS no longer identifies as a provider of services but is now rather a purchaser of Behavioral Health Services and as a result, is placing greater emphasis at the local level to understand and meet not only State requirements but also Federal regulations.

- The Compliance Division of the **DWMHA** was created to provide regulatory oversight, conduct trainings, and investigate complaints relating to fraud, waste, and abuse occurring in Medicaid/ Medicare funded services;
- This means the Compliance Division has a general review and oversight function regarding the investigations of violations of the major laws, regulations, rules, protocols, standards and contractual terms that govern DWMHA's activities directly and through its established mechanisms for providing mental health services;
- DWMHA's Compliance Plan was reviewed by its Board of Directors and establishes regulatory management activities that will be coordinated across the network;
- DWMHA's Compliance Program includes the Compliance Plan, Standard of Conduct Policy, and the Conflict of Interest Policy and Fraud Waste and Abuse Policy, which call all be found at http://www.dwmha.com/Documents.asps .

Each MCPN will be expected to develop its own Compliance Plan, Standard of Conduct, and Conflict of Interest policies. In addition, all Providers that contract directly with DWMHA shall develop their own Compliance Plan, Standard of Conduct, and Conflict of Interest policies similar to DWMHA's. At a minimum, each Compliance Plan should incorporate the seven standards given in the federal Sentencing Guidelines as evidence of a health care provider's due diligence. (United States Sentencing Commission Guidelines 1991. The Compliance Division may request the compliance documentation from the MCPN or providers at any time for review. Moreover, each MCPN and/or Provider staff will be responsible for receiving web-based training developed by DWMHA (i.e., VCE) pursuant to DWMHA's "Required Trainings Chart (as amended).

DWMHA's Compliance Division, with assistance and coordination with the Quality Division, will monitor implementation of each MCPN/Provider Compliance Plan.

Fraud and Abuse

In addition to the Compliance Plan, DWMHA has adopted a Fraud Waste and Abuse Policy which advocates to advance the prevention of fraud, abuse, and waste in providing health care and to detect misconduct or wrongdoing as soon as it occurs so that the problem can be quickly remedied, and adverse consequences can be minimized. The Compliance Division of DWMHA has oversight

responsibility for the audits conducted to verify the provision of Medicare and Medicaid services.

Each MCPN and/or Provider should have a methodology for the verification of the provision of Medicare and Medicaid services.

Key regulations that MCPNs, Providers and their subcontractors are required to be compliant with include:

- The False Claims Act 31 U.S.C. 3799,
- The Anti-Kickback statute 42 U.S.C. 1320a-7b(b),
- The Anti-Self-Referral Statute 42 U.S.C. Section 1395nn (Stark I),
- The Omnibus Budget Reconciliation Act of 1993 (Stark II),
- The Deficit Reduction Act (PL 109.171),
- The Examination and Treatment for Emergency Medical Conditions and Women in Labor statute 42 U.S.C. 1395dd, and
- The Health Insurance Portability and Accountability Act of 1996.

Health Insurance Portability and Accountability Act (HIPAA)

In addition to the key provisions of HIPPA relating to fraud and abuse including mandatory exclusion from Medicare and Medicaid of providers who violate fraud and abuse provisions, there are HIPAA standards regarding transactions, privacy, and security.

DWMHA Policies

- **Compliance Plan:** establishes the requirement of a Compliance Plan and a (Compliance) Program within DWMHA and its network.
- **Compliance Reporting Policy:** provides a procedure to report compliance issues to the Compliance Division.
- **Fraud Waste and Abuse Policy** establishes the standards to prevent the abuse and misuse of Medicare and Medicaid funds.
- **Investigation Policy** establishes the process of how each compliance complaint will be investigated.
- **Standard of Conduct:** establishes the standards for the how business will be conducted by DWMHA staff and its provider network.
- **Conflict of Interest:** establishes the definition for the various conflicts and the reporting requirement for all DWMHA employees, including board members.

NOTE: The above references are not meant to be all-inclusive. All polices can be found at http://www.dwmha.com/Documents.aspx

Health Care Compliance Resources:

- U.S. Department of Health and Human Services, Office of the Inspector General website: www.hhs.gov/oig.
- Health Care Compliance Association website: www.hcca-info.org.
- The Health Care Corporate Compliance website: www.complianceinfo.com.
- Center for Medicare and Medicaid Services website: www.cms.gov.

Integrated Health Care Initiatives
Complex Case Management
Referral Form

Complex Case Management is designed to assess, plan, implement, coordinate, monitor and evaluate options and services needed to meet an enrollee's chronic complex health (behavioral and physical) and human service needs. Enrollees are chosen for Complex Case Management because of frequent inpatient admissions, frequent visits to the Emergency Department, and because they have complex medical and behavioral needs that are not being resolved using traditional means/resources. Along with this referral form, please include the psychosocial assessment, current LOCUS, medication sheet, and any other clinicals that would be useful in managing this enrollee's care.

Referral Source	
	Behavioral Health Provider
	Medical Health Provider/Primary Care Provider
	DWMHA
	Self-Referral
	Other (Please Specify):
Facility/Agency/Referral Source	
Name:	
Telephone #:	
Fax #:	
Enrollee Name:	
Date of Birth:	
Enrollee Telephone #:	
Reason for Referral:	

Please fax completed form to: 313-989-9529
Please send via secure email to: pihpccm@dwmha.com

For DWMHA USE:

Date Referral Received: _____

Case Assigned To: _____ Date Referral Assigned: _____

Definitions Detroit-Wayne Mental Health Authority

For DWMHA policies, procedures, and documents, visit our website at www.dwmha.com.

KEY TERMS/PHRASES	
TERM	DEFINITION
Access Center	Centralized calling center for DWMHA's public mental health services. The Access Center provides information on a wide variety of services, recommends where help can be obtained and assists in scheduling appointments, The Access Center is available to all Wayne County residents, 24 hours a day, 7 days a week.
Acknowledgement Letter	A letter acknowledging receipt of the consumer's grievance.
Acute Crisis, Intervention Home	Short-term services provided in a protected residential setting under the supervision of a Qualified Mental Health Professional for developmentally disabled adults who also have mental illness and are experiencing an acute exacerbation of the illness.
Administrative Efficiencies	The ability to produce a desired effect in with a minimum of effort, expense, or waste as applied to management functions of the organizations.
Administrative Fair, Hearing or Medicaid Fair Hearing	An impartial review process maintained by the MDHHS to ensure that Medicaid beneficiaries or their legal, representatives involved in a community Mental Health Services Program have the opportunity to appeal decisions of DWMHA or its representatives which result in the denial, suspension, reduction or termination of Medicaid covered services. A Medicaid beneficiary or any person entitled to services may request a hearing within 90 days of notice of the denial, suspension, reduction or termination of Medicaid-covered benefits.
Adult Foster Care Home (Adults ages 18 and over)	Adult Foster Care is a general licensed living arrangement that may accommodate one or more residents. Residents in this setting have mild to no maladaptive behaviors and may or may not require assistance with community living and self-care tasks. Specialized services can be arranged and provided in this setting if indicated.
Advance Directives	A legal document, signed by a competent adult that gives direction to healthcare providers about the consumer's treatment choices in specific circumstances, including but not limited, to medical or psychiatric conditions, should the consumer become unable to make or communicate healthcare decisions.
Adverse Action	A denial, suspension, reduction or termination of mental health services, except as ordered by a physician's determination of absence of medical necessity.

Authority	Detroit-Wayne Mental Health Authority (DWMHA), is the community mental health services program established and administered pursuant to provision of the State Mental Health Code, for the purpose of providing a comprehensive array of mental health services appropriate to the condition of individuals who are Wayne County residents, regardless of ability to pay.
AFP	MDHHS's required Application for Participation.
Appeal	A process established by MDHHS to provide a mechanism for prompt reporting, review, investigation, and resolution of apparent or suspected violations of the rights guaranteed by the Mental Health Code.
Assertive Community Treatment (ACT)	From the Consumer Handbook as approved by the State Jan 2008 ACT provides basic services and supports essential for people with serious mental illness to maintain independence in the community. An ACT team will provide mental health therapy and help with medications. The team may also help access community resources and supports needed to maintain wellness and participate in social, educational and vocational activities. Assertive Community Treatment (ACT) is a comprehensive and integrated set of medical and psychosocial services provided on a one-to-one basis primarily in the client's residence or other community locations (non-office setting) by a mobile multidisciplinary mental health treatment team. The team provides an array of essential treatment and psychosocial interventions for individuals who would otherwise require more intensive and restrictive services. The team provides additional services essential to maintaining an individual's ability to function in community settings. This would include assistance with addressing basic needs, such as food, housing, and medical care and supports to allow individuals to function in social, educational, and vocational settings
Authorization	A decision rendered by a Qualified Professional to approve a request for clinical services. **IMPORTANT NOTE: A MEDICARE BENEFICIARY DOES NOT REQUIRE PRIOR AUTHORIZATION FOR ANY SERVICES.** As a result, a beneficiary having both Medicaid and Medicare coverage does not require authorization for services, even if they are necessary under the Medicaid plan.

Beneficiary	Consumers who are Medicare and/or Medicaid-eligible.
Best Value	A process used in competitive negotiated contracting to select the most advantageous offer by evaluating and comparing factors in addition to cost or price.
CAFAS	Child and Adolescent Functional Assessment Scale
Capitation	Fixed amount paid per month per Person to the MCPN for Covered Services.
Carrier	Any entity that has responsibility for the financial coverage of health care for a beneficiary. This includes commercial as well as governmental entities.
Categorical Funds	Funds that are designated for a specific service, program and/or special population.
CCH	Contracted Community Hospital that provides acute inpatient and/or partial hospitalization services by contract with DWMHA.
Certification	Certification is a process of evaluating/screening clients to determine and approve appropriate and clinically necessary services for inpatient psychiatric admission, and other prior authorized services, which includes certifying appropriateness of all inpatient hospital and physician services related to the admitting mental health diagnosis, including laboratory and x-ray services, medications, etc. Any inpatient psychiatric admission not certified by the CMH is not a benefit of the Medicaid program.
Certified Peer Support Specialist (CPSS)	Individuals who have a mental illness, substance use or co-occurring disorder, have been through the recovery process, have been trained and certified to assist others who are in need of recovery services and supports. CPSS are trained to connect consumers to numerous supports and services needed in recovery.
Child Mental Health Professional	One of the following: a) A person who is trained and has one year of experience in the examination, evaluation, and treatment of minors and their families and who is one of the following: i. A physician ii. A psychologist iii. A certified social worker or social worker; iv. A registered nurse; OR b) A person with at least a bachelor's degree in a mental health related field from an accredited school who is trained, and has three (3) years of supervised experience, in the examination, evaluation, and treatment of minors and their families. OR c) A person with at least a master's degree in a mental health-related field from an accredited school who is trained and has one year of experience, in the examination, evaluation, and treatment of minors and their families.
Children's Diagnostic and Treatment Service	A program operated by or under contract with a Community Mental Health Services Program, which provides examination, evaluation and referrals for minors, including emergency referrals, that

	provides or facilitates treatment for minors, and that has been certified by MDHHS.

Clean Claim	A clean claim is one that can be processed without obtaining additional information from the provider of the service or a third party. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity. As stated in the FY 02 State Appropriation Act (P.A. 60), a clean claim that is not paid within 45 days after receipt shall bear simple interest at a rate of 12% per annum.
CM	Case Manager/qualified primary case manager
CMH	Community Mental Health
CMHP	Child Mental Health Professional
CMS	Centers for Medicare and Medicaid Services
Coordination of Benefits (COB)	The process by which multiple carriers are involved in the payment for services provided to a beneficiary.
Co-Insurance	A type of patient responsibility for a covered service involving a percentage of a claim. For example, at 20% coinsurance on a $100 claim, requires the beneficiary to pay $20 for the covered service. The beneficiary is not responsible for any co-pays, deductibles or co-insurance fees.
Commercial Carrier	A private insurance or Managed Care Organization providing healthcare coverage to a beneficiary.
Community Mental Health Services Program (CMHSP)	A program operated under Chapter 2 of the Michigan Mental Health Code – Act 258 of 1974 as amended.
Community Behavioral Health Management Initiative	DWMHA contracted administrative service organization having responsibilities for information, referral, utilization review, and other identified services operated by Behavioral Health as the Detroit Regional Service Center.
Complaint	An oral or written statement made to the Office of Recipient Rights (ORR) alleging violation of a Mental Health Code protected right.
Consumer Satisfaction Contact Letter	A letter forwarded to the beneficiary prior to the 60_{th} calendar day requesting a satisfaction response to the resolution of his/her grievance after all other contact attempts have been unsuccessful.
Consumers	Recipients of services designated by two types: Primary and Secondary. Primary refers to the recipient of services. Secondary refers to family members of the primary recipient.
Contracted Provider	An individual or entity participating in the Provider Network pursuant to a contract with the MCPN to provide
Co-occurring Disorders	When used in the context of Consumers, this term refers to co-

	occurring psychiatric and/or substance use disorders.
Co-pay	A type of patient responsibility that involves a flat rate that is the responsibility of the beneficiary. For example, a $25 copay on prescription drugs means that the beneficiary is responsible for $25 for each prescription drug acquired. The beneficiary is not responsible for any COPA, Deductible or Co-Insurance costs.
Covered Services	Covered Services Specialty supports and services.
Cultural Competency	A set of academic and interpersonal skills that allow individuals to increase their understanding and appreciation of cultural differences and similarities within, among, and between cultural groups. This requires a willingness, and ability to draw on community-based values, traditions, and customs, and to work with knowledgeable individuals of, and from, the community in developing targeted interventions, communications and other supports to address the unique needs of specific population groups. An acceptance and respect for difference, a continuing self-assessment regarding culture, a regard for and attention to the dynamics of difference, engagement in ongoing development of cultural knowledge, and resources and flexibility within service models to work toward better meeting the needs of the minority populations. The cultural competency of an organization is demonstrated by its policies and practices.
Customers	In this Agreement, a potential recipient of Covered Services, which includes all people located in the defined service area.
Deductible	A type of patient responsibility where the patient is responsible for the very first component of care in a period of time such as a year. For example, a beneficiary who has a $500 deductible for inpatient care is responsible for the first $500 dollars in inpatient costs incurred in the benefit year. Deductible can have a complicated nature in that they may be applied to any time frame and sometimes are reset in gaps between occurrences. Medicare beneficiaries have complex structures for inpatient care and need to be specifically reviewed by beneficiary *It is important to note that in a COB situation, secondary and other coverages are constructed to cover deductible and other beneficiary out-of-pocket costs. In the case of a Medicaid beneficiary, the patient is held harmless for out of pocket costs. I.E. If at the end of all payments by carriers there remains a patient responsibility, this is to be paid by Medicaid.
DEG Download	The process involving the download of Medicaid Enrollment data from the State of Michigan's "Data Exchange Gateway"

Denial	An adverse decision made by a psychiatrist regarding a request to authorize services, after appropriate evaluation of relevant clinical information.
Dependent Living Setting	a) An Adult Foster Care facility b) A nursing home c) A Home for the Aged d) Child Caring Institution
Intellectual/ Developmental Disability (I/DD)	Means either of the following: 1. If applied to an individual older than five years, a severe, chronic condition that meets all of the following requirements: a. Is attributable to a mental or physical impairment or a combination of mental and physical impairments, b. Is manifested before the individual is 22 years old, c. Is likely to continue indefinitely, d. Results in substantial functional limitations in three or more of the following areas of major life activities: (1) self-care, (2) receptive and expressive language, (3) learning, mobility, (4) self-direction, (5) capacity for independent living, (6) economic self-sufficiency, e. Reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services that are of lifelong or extended duration and are individually planned and coordinated. 2. If applied to a minor from birth to age five, a substantial developmental delay or a specific congenital or acquired condition with a high probability of resulting in developmental disability as defined in item 1 if services are not provided.
Direct Contractor	A legal entity or entities contracted with DWMHA to provide community mental health services/supports (often known as program services) as defined by DWMHA and is not a MCPN.
Dual Diagnosis	A person with a two or more of the following diagnoses: mental illness, developmental disability, Serious emotional disability and/or substance abuse disorder.
Early On Program	Early On services are delivered to children ages 0 to 3 identified either with a developmental delay or developmental disability. Early On services provide infant mental health services to families with children between the ages of 0 to 3, who have been identified as "at risk" for an

	out of home placement due to parenting problems such as substance abuse, mental illness, physical abuse, or neglect. Additional services include clinic-based and home-based services for children between the ages of 3 to 5. These services shall be designed and delivered in such a manner as a) to provide an aftercare option for children who were discharged from Early On services or infant mental health services due to reaching the age limitation; b) to provide a transitional option for children who were discharged from Early On services or infant mental health services due to achieving their treatment goals; c) to provide services to families with children ages 3 to 5, who have been identified as "at risk" for an out-of-home placement due to parenting problems such as substance abuse, mental illness, physical abuse or neglect.
Effective Freedom	The realization of social citizenship and full community membership. Citizens are able to build upon basic freedoms – to effectively unlock the potential of liberty – by making choices, pursing personal goals, engaging in productive activity, establishing a wide range of associations and relationships, participating in community events, and living in real homes.
Emergency Situation	A situation in which an individual is experiencing a severe mental illness or a developmental disability, or a child is experiencing a serious emotional disturbance, and one of the following apply: 1. The individual can reasonably be expected within the near future to physically injure himself, herself, or another individual, either intentionally or unintentionally. 2. The individual is unable to provide himself or herself food, clothing, or shelter, or to attend to basic physical activities such as eating, toileting, bathing, grooming, dressing, or ambulating, and this inability may lead in the near future to harm to the individual or to another individual. 3. The individual's judgment is so impaired that he or she is unable to understand the need for treatment and, in the opinion of the mental health professional, his or her continued behavior as a result of the mental illness, developmental disability, or emotional disturbance can reasonably be expected in the near future to result in physical harm to the individual or to another individual.
Encounter	A document submitted in a claim format specified by DWMHA that documents the services and costs of services provided to a consumer.
Enhanced Health Services	Those services beyond the responsibility of the Person's health plan, that are provided for rehabilitative purposes to improve the

	Person's overall health and ability to care for health-related needs. This includes nursing services, dietary/ nutrition services, maintenance of health and hygiene, teaching self-administration of medication, care of minor injuries or first aid, and teaching the Person to seek assistance in case of emergencies. Services must be provided according to the professional's scope of practice and under appropriate supervision. Enhanced health services must be carefully coordinated with the Person's health care plan.
EOB	Explanation of Benefit - A term often used interchangeably with EOP. However, an EOB is a document sent to a beneficiary to document a claim payment on their behalf. An EOB is sent by the paying carrier
EOP	Explanation of Payment – A term often used interchangeably with EOB. However, an EOP is a document sent to the provider detailing the payment from a carrier. An EOP is sent by the paying carrier. A carrier (including Medicaid) will require that EOPs are received from all other, higher carriers, prior to considering their payment responsibility.
Early and Periodic Screening, Diagnosis and Treatment (EPSDT)	Federal regulations require state Medicaid programs to offer early and periodic screening, diagnosis, and treatment (EPSDT) to eligible Medicaid beneficiaries less than 21 years of age. The intent is to find and treat problems early, so they do not become more serious and costly.
Expedited Appeal	The expeditious review of an action, requested by a beneficiary or the beneficiary's provider, when the time necessary for normal appeal review process could seriously jeopardize the beneficiary's life, health or ability to attain, maintain, or regain maximum function. It the beneficiary requests the expedited review, the service provider determines if the request is warranted. If the beneficiary's provider makes the request, or supports the beneficiary's request, the service provider must grant the request.
Facility	A residential building for the care or treatment of individuals with severe mental illness, serious emotional disturbance, or developmental disability that is either a state facility or a licensed facility.
FIA	Family Independence Agency is the Agency that determines eligibility for Michigan's Medicaid Program
Formal Grievance	A grievance initiated at DWMHA Customer Service Unit for follow-up and resolution.
Grievance	A process for expressing dissatisfaction with an actual or supposed circumstance regarded by the complainant as just cause for protest about mental health treatment/services/supports, managed and/or delivered by DWMHA network, made in accordance with the Mental Health Code, with available assistance of an ORR

	representative, as needed.

Grievance Process	An impartial local level review of a Medicaid beneficiary's grievance (expression of dissatisfaction) about PIHP/CMHSP service issues other than an action.
HCFA	Health Care Financing Administration, now known as the Centers for Medicare and Medicaid Services.
Health Insurance Portability and Accountability Act of 1996 (HIPAA)	Public Law 104-191, 1996 to improve the Medicare program under the title XVIII of the Social Security Act, the Medicaid program under the title XIX of the Social Security Act, and the efficiency and effectiveness of the health care system, by encouraging the development of a health information system through the establishment of standards and requirements for the electronic transmission of certain health information. The Act provides for improved portability of health benefits and enables better defense against abuse and fraud, reduces administrative costs by standardizing format of specific healthcare information to facilitate electronic claims directly addresses confidentiality and security of patient information – electronic and paper-based, and mandates "best effort" compliance. HIPAA mandates, among others, that the following requirements must be implemented: 1. Data integrity, confidentiality, and availability guards 2. Access control (user-based, role-based, and availability) 3. Audit controls (user-based, role-based) 4. Data authentication (automatic log-off, unique user ID, password, PIN, biometrics, token, or telephone callback) 5. Unauthorized access guards 6. Communications/network controls (access controls, encryption, integrity controls or message authentication) 7. Network controls (alarm, audit trail, entity authentication, event reporting, user-based, role-based, or context-based access)
Individual	Consumers with mental illness, developmental disabilities, or substance use disorders (or a combination of disabilities). For the purpose of this application, includes Consumers who are Medicaid-eligible, as well as other mental health and substance abuse specialty services recipients who may be indigent, are self-pay, or have private insurance coverage.
Informal Grievance	A grievance initiated at the MCPN/CA, Direct Contractor, and Subcontractor's level for follow-up and resolution.

Initial Assessment	Term used in substance abuse service. It is a process that collects

	sufficient information to determine a level of care based on at least the six dimensions of the American Society of Addiction Medicine Patient Placement Criteria. This initial assessment process also gathers enough information to determine an initial diagnostic impression using the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition.
Intensive Crisis Residential (ICR)	Short term intensive treatment services provided in a protected residential setting as an alternative to inpatient hospital admission when clinically appropriate for people experiencing acute psychiatric crisis diagnosed by a Qualified Mental Health Professional, as meeting criteria for an acute inpatient hospital admission. The mentally ill adult must have symptoms that can be stabilized in an alternative community setting.
Intensive Crisis Stabilization	The process of stabilizing an individual in acute crisis to avert a psychiatric admission or to shorten the length of an inpatient stay.
Intensive Crisis Stabilization Services	Structured treatment and support activities provided by a mental health crisis team, under psychiatric supervision and designed to provide a short-term treatment alternative to inpatient psychiatric services. Services should be used to avert a psychiatric admission or to shorten the length of an inpatient stay.
IPOS	Individual Plan of Service
ITT	Interdisciplinary Treatment Team
I-Team	DWMHA Inter-Divisional Team
Jail Diversion	A collaborative, integrated program utilizing a community's resources to divert a person with severe mental illness serious emotional disturbance or developmental disability from possible jail incarceration when appropriate.
Legal Representative	The representative, parent of a minor or other person authorized by law to represent an applicant or consumer.
Level of Care (LOC) Severity of Illness/Intensity of Service	Protocols provided by the Michigan Department of Health and Human Services (MDHHS) and the Authority, each as amended from time to time, as part of a utilization management system, which is intended to monitor the appropriateness of mental health care. Severity of Illness refers to the nature and severity of the signs, symptoms, functional impairments, and risk potential related to the person's complaint. Intensity of Service pertains to the setting of care, to the types and frequency of needed services and supports, and to the degree of restriction necessary to safely and effectively treat the individual.
Limited English Proficiency (LEP)	Consumers who cannot speak, write, read or understand the English language in a manner that permits them to

	Interact effectively with health care providers and social services agencies.
Linguistically Appropriate Services	Provided in the language best understood by the consumer through bilingual staff and the use of qualified interpreters, including American Sign Language, to individuals with limited-English proficiency. These services are a core element of cultural competency and reflect an understanding, acceptance, and respect for the cultural values, beliefs, and practices of the community of individuals with limited-English proficiency. Linguistically appropriate services must be available at the point of entry into the system and throughout the course of treatment and must be available at no cost to the consumer.
MACMHB	Michigan Association of Community Mental Health Boards
MCO	Managed Care Organization
MCPN	Manager of a comprehensive provider network contracting with the Authority. For each Manager of Comprehensive Provider Network Contract, MCPN shall include all parties to such agreement other than the Authority.
MCPN Manual	The manual developed and implemented by the Authority, and adopted by the MCPN that includes all policies, procedures, forms, instructional materials, and other information used to support and supervise/manage the Provider Network, in accordance with DWMHA guidelines.
MDHHS	Michigan Department of Health and Human Services, State of Michigan. The State division is responsible for funding a comprehensive array of specialty mental health services for Consumers with severe mental illness and children with serious emotional disturbances and specialty services for Consumers with developmental disabilities and to priority populations as defined in the Michigan Mental Health Code.
Means Testing for Priority Population Beneficiaries	A financial test that is applied to an individual that does not qualify for Medicaid to determine what portion of benefits will be covered under the Priority Population segment. There are individuals who have the means to pay all or a portion of their coverage. This test is used to determine this amount.
Medicaid Eligible	Using established criteria to recommend or evaluate the medical necessity of services, effective use of resources, and cost-effectiveness. Individual who has been determined to be eligible for Medicaid by the State of Michigan.
Medicaid Fair Hearing (MFH)	An impartial state level review of a Medicaid beneficiary's appeal of an action presided over by a MDHHS Administrative Law Judge. It is also referred to as an "Administrative Hearing."

Medicare Crossover/MME	A term used to identify a Medicaid beneficiary that also has Medicare Coverage.
Medicare Crossover Claims (or coverage)	This is a commonly used term for a Medicaid beneficiary whose has a claim also covered by Medicare
Medicare Part-A	The Hospitalization component of Medicare Coverage. All Medicare beneficiaries have Medicare Part-A coverage.
Medicare Part-B	The outpatient clinical component of Medicare Coverage. This coverage is optional to the Medicare beneficiary and must be purchased for a nominal premium. According to the state of Michigan Technical Advisory dated March 18, 1999. A Medicaid plan may purchase this coverage on behalf of the beneficiary.
Mental Health Professional	A person who is trained and experienced in the areas of mental illness or mental retardation and who is any one of the following: 1. A physician who is licensed to practice medicine or osteopathic medicine in Michigan and who has substantial experience with mentally ill or developmentally disabled recipients for one year immediately preceding his/her involvement with a recipient under these rules 2. A psychologist 3. A certified social worker 4. A registered nurse 5. A professional person, other than those defined in this rule, which is designated by the director in written policies and procedures. This mental health professional shall have a degree in his or her profession and shall be recognized by his or her respective professional association as being trained and experienced in the field of mental health
MI Path	A workshop organized by trained leaders that help participants improve their health and feel better about themselves, physically and mentally. Participation in MI Path workshops by consumers must be documented in their Person-Centered Plan.
MORC	Macomb Oakland Regional Center
MRS	Michigan Rehabilitation Services, now known as the Michigan Department of Career Development—Rehabilitation Services.
Multicultural Services	Specialized mental health services for multicultural populations such as African-Americans, Hispanics, Native Americans, Asian and Pacific Islanders, and Arab/Chaldean Americans.

No Grievance Involved	The complaint presented does not meet the mandate or definition of a grievance as outlined by the State.

Non-Categorical Funds	Funds that are not designated for any specific programs, services or special populations.
OBRA	Omnibus Budget Reconciliation Act of 1987; 1990 is Federally mandated legislation establishing programs and a funding program that was developed in 1989.
Office of Recipient Rights (ORR)	Division of DWMHA established in accordance with the Michigan Mental Health Code to ensure a uniformly high standard of protection of the rights of the recipients throughout the State.
OPL	“Other Party Liability” – For this document’s purpose, this is another name for COB
Out-of-Area Services	These are services provided to Wayne County consumers by out-of-area service providers who are not part of the Detroit-Wayne County Community Mental Health Network. Typically, special "purchase of service" arrangements are negotiated with the out-of-area provider or responsible CMHSP for that area, to provide the service(s). While the Authority's MCPNs are expected to have a countywide network, there may be occasions when the MCPN may need to secure such service provisions as out-of-area on a temporary time targeted basis. There are times when such services may have to be obtained out of state, however, these out-of-area and out of state services will need to be authorized, paid and monitored by the MCPN. Transportation should be provided when necessary.
Out of Jurisdiction Letter	A letter sent to the consumer, parent or legal representative stating that his/her complaint is outside of the Detroit Wayne Community Mental Health Services jurisdiction.
Out-of-Network Services	Services provided by a mental health professional who does not participate in the Provider Network. Out-of-Network services also refers to services provided outside of the Person’s MCPN, but within the network
Out of Pocket Costs	A term used to define the costs that a beneficiary is responsible for, after all carriers have reimbursed the provider. This is limited to items such as co-pays and deductibles, not the difference between a billed amount and a contracted reimbursement level.
Outreach	Efforts to extend services to those Consumers who are under-served or hard-to-reach that often require seeking individuals in places where they are most likely to be found, including hospital emergency rooms, homeless shelters, women's shelters, senior centers, nursing homes, primary care clinics and similar locations.
PASARR	Preadmission screening and annual resident review are requirements of the OBRA program. Preadmission screening must be completed prior to placement of a person with mental illness in nursing homes. Annual review determines the need for continued

	nursing home care and whether specialized services for the mental illness are indicated.

Patient Responsibility	Any amount that is the responsibility of the beneficiary. Usually involves deductibles and co-pays, but may involve other more complex calculations of benefits.
Payor of Last Resort	Medicaid is always the payor of last resort. All other benefits for the covered service must be exhausted prior to Medicaid payment. This definition applies to all Detroit Wayne consumers.
Peer Mentoring	Provides essential services to individuals who have developmental disabilities so that they can become more proactive and responsible in improving the quality of their lives. Those trained as Peer Mentors assist persons in overcoming barriers and helps them achieve daily and long-term goals in the following areas: community inclusion, education, transportation, advocacy, employment, housing, health and wellness, recreation and entitlements. Peer Mentors will also combat stigma in the community and in the workplace through education and self-determination.
Person	Individual with a Developmental Disability who qualifies for Covered Services and selects MCPN for such services.
Person-Centered Planning or PCP	Process for planning and supporting an individual receiving services that builds upon the individual's capacity to engage in activities that promote community life and that honor the individual's preferences, choices, and abilities through the Public Mental Health System. The person-centered planning process involves families, friends, and professionals as the individual desires or requires.
Per-Member-Per-Month (PMPM)	A fixed monthly rate per Medicaid eligible person monthly rate payable to the PHP by the MDHHS for provision of all Medicaid services defined within this contract.
PHP	Pre-paid Health Plan
PIHP	Prepaid Inpatient Health Plan means an entity that (i) provides medical services to enrollees under contract with a State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State plan payment rates, (ii) provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees, (iii) does not have a comprehensive risk contract.
Policy Manuals of the Medical Assistance Program	The MDHHS periodically issues notices or proposed policy for the Medicaid program. Once a policy is final, MDHHS issues policy bulletins that explain the new policy and give its effective date. These documents represent official Medicaid policy and are included in the policy manual of the Medical Assistance Program.

Practice Guideline	MDHHS-developed guidelines for PHPs for specific service, support or systems models of practice that are derived from empirical research and sound theoretical construction and as applied to the implementation of public policy. MDHHS guidelines issued prior to June 200 were called "Best Practice Guidelines". All guidelines are now referred to as Practice Guidelines.
Prepaid Health Plan (PHP)	Organization that manages specialty health care services under the Michigan Medicaid Waiver Program for Specialty Services.
Primary Coverage	Refers to the carrier that is primarily responsible for the cost of healthcare services provided to a beneficiary. The primary carrier is responsible for payment of care to the extent of their benefit package.
Priority Population	Consumers who are at risk for developing serious emotional disturbance (SED) severe mental illness (SMI) or have developmental disabilities (DD). For purposes of managing specialized treatment and support services, SMI and SED are defined by diagnosis, degree of disability and/or duration of illness.
Provider	A legal entity or independent practitioner contracted with DWMHA or MCPN to provide services/ supports as specified by the Authority.
Provider Network	The network of MCPN and all Contracted Providers established to deliver Covered Services to Recipients.
Provider Sponsored Specialty Networks (PSSN)	Vertically integrated, comprehensive service entities that are organized and operated by affiliated groups of service providers that offer relatively complete "systems of care" for beneficiaries with particular service needs. DWMHA uses the term MCPN as an alternative to PSSN.
Psychiatric Partial Hospitalization Program	A nonresidential treatment program that provides psychiatric, psychological, social, occupational, nursing, music therapy, and therapeutic recreational services under the supervision of a physician to adults diagnosed as having severe mental illness or minors diagnosed as having serious emotional disturbance who do not require 24-hour continuous mental health care, and that is affiliated with a psychiatric hospital or psychiatric unit to which consumers may be transferred if they need inpatient psychiatric care.
Q**IDP**	A Qualified **Intellectual Developmental Professional** is a person with specialized training or experience in treating or working with Consumers with **intellectual/developmental disability** and is one of the following: 1. Educator with a degree in education from an accredited program.
	2. Occupational therapist: a. A graduate of an occupational therapy curriculum

	accredited jointly by the Council on Medical Education of the American Medical Association and the American Occupational Therapy Association; or b. Is eligible for certification by the American Occupational Therapy Association under its requirements; or c. Has two years of appropriate experience as an occupational therapist, and has achieved a satisfactory grade on an approved proficiency examination, except that such determination of proficiency does not apply to Consumers initially licensed by the State or seeking initial qualifications as an occupational therapist after December 31, 1977. 3. Physical therapist: a. Licensed as a physical therapist by the State b. has graduated from a physical therapy curriculum approved by the American Physical Therapy Association or by the Council on Medical Education and Hospitals of the American Medical Association c. Has two years of appropriate experience as a physical therapist, after December 31, 1977. 4. Physician of medicine or osteopathy, licensed by the State. 5. Psychologist with a master's degree from an accredited program. 6. Registered nurse: currently licensed by the State of Michigan 7. Social worker with a bachelor's degree in: a. social work from an accredited program; or b. in a field other than social work and at least three years of social work experience under the supervision of a qualified social worker. 8. Speech pathologist or audiologist (qualified consultant): a. Licensed by the State and is eligible for a certificate of clinical competence in speech pathology or audiology granted by the American Speech and Hearing Association; or b. Meets the educational requirements for certification, and is in the process of accumulating the supervised experience required for certification. 9. Therapeutic recreation specialist: a. Graduate of an accredited program; and b. Licensed or registered by the State. 10. Rehabilitation counselor: certified by the Committee on Rehabilitation Counselor Certification.

Quality **Improvement**	

Steering Committee (Q**ISC**)	
Qualified Health Plan (QHP)	A health plan (e.g., HMO, PPO, POS) in which a Medicaid recipient may belong. The QHP pays for mental health services when a consumer is Medicaid eligible, but does not meet the DD, SMI or SED requirements.
Qualified Mental Health Professional	A qualified mental health professional is licensed, certified or registered by the State of Michigan or a national organization to provide mental health services and clinical and administrative supervision.
Reasonable Access (geographic access standard)	Services are available within 30 miles or 30 minutes in urban areas, or within 60 miles or 60 minutes in rural areas
Recovery	The over-arching message of recovery is that hope, and restoration of a meaningful life are possible, despite severe mental illness. Instead of focusing primarily on symptom relief, as the medical model dictates, recovery casts a much wider spotlight on restoration of self-esteem and identity and on attaining meaningful roles in society.
Remittance Voucher (RV)	A document to support he details of a claim check. Also used interchangeably with an EOP.
Resolution Letter	A letter forwarded to the beneficiary explaining the action taken to resolve his/her grievance.
Respite	Respite services are those services that are provided in the individual's/family's home or outside the home to temporarily relieve the unpaid primary caregiver. Respite services provide short-term care to a child with a mental illness/emotional disturbance to provide a brief period of rest or relief for the family from day to day care giving for a dependent family member. Respite programs can use a variety of methods to achieve the outcome of relief from care giving including family friends, trained respite workers, foster homes, residential treatment facilities, respite centers, camps and recreational facilities. Respite services are not intended to substitute for the services of paid support/training staff, crisis stabilization and crisis residential treatment or out-of-home placement.
Root cause analysis	A structured and process-focused framework for identifying and evaluating the basis or causal factors involved in producing a sentinel event. The analysis should include the development of an action plan that identifies the steps that will be implemented to lessen the risk that similar events would happen to have happen.

Scope and Coverage Codes	A classification of a Medicaid beneficiary that determines the level of covered benefits of the individual. COB payment logic is contingent on the Medicaid beneficiary's Scope and Coverage Code.

Screening	Means the CMH has been notified of the Person and has been provided enough information to make a determination of the most appropriate services. The screening may be provided on-site, face-to-face, by CMH personnel, or, over the telephone.
Secondary Coverage	Refers to the carrier that is secondarily responsible for the cost of healthcare services provided to a beneficiary. The secondary carrier is responsible for covering the cost of healthcare services that are left after the beneficiary has exhausted their coverage with the primary carrier. Secondary Carriers typically cover any reduction from the billed charges, including those costs that the patient may be responsible to provide, including deductibles and copays. The Secondary Carrier compares the primary payment with their benefits and fee schedule in determining the amount that they will reimburse the provider of care.
Second Opinion/Reconsideration	An additional clinical evaluation and decision provided in response to a request from an applicant, authorized representative or referring mental health professional, in dispute of an adverse decision when: 1) A specific request for inpatient hospitalization has been denied by a psychiatrist reviewer, and 2) Following a face-to-face assessment by a qualified professional, determination is made that no mental health service is needed and the applicant is referred outside DWMHA network to other human service resources.
Sentinel Event	Unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase "or the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome.

Serious Emotional Disturbance	A diagnosable mental, behavioral, or emotional disorder affecting a minor that exists or has existed during the past year for a period of time sufficient to meet diagnostic criteria specified in the most recent diagnostic and statistical manual of mental disorders published by the American Psychiatric Association and approved by the MDHHS, and that has resulted in functional impairment that substantially interferes with or limits the minor's role or functioning in family, school or community services. The following disorders are included only if they occur in conjunction with another diagnosable serious emotional disturbance: 1. A substance use disorder 2. A developmental disorder 3. A "V" code in the diagnostic and statistical manual of mental disorders

Severe Mental Illness	Diagnosable mental, behavioral, or emotional disorder affecting an adult that exists or has existed within the past year for a period of time sufficient to meet diagnostic criteria specified in the most recent diagnostic and statistical manual of mental disorders, published by the American Psychiatric Association and approved by the MDHHS, in functional impairment that substantially interferes with or limits one or more major life activities. Severe mental illness includes dementia with delusions, dementia with depressed mood and dementia occurs in conjunction with another diagnosable severe mental illness. The following disorders are included only if they occur in conjunction with another diagnosable mental illness: 1. A substance abuse disorder 2. A developmental disorder 3. A "V" code in the diagnostic and statistical manual of mental disorders.
Service Authorization	A process designed to help assure that planned services meet medical necessity criteria, and are appropriate to the conditions, needs and desires of the individual. Authorization can occur before services are delivered, at some point during service delivery or can occur after services have been delivered based on a retrospective review.
Stakeholder	An individual or entity that has an interest, investment or involvement in the operations of a prepaid health plan or affiliate. Stakeholders can include individuals and their families, advocacy organizations, and other members of the community that are affected by the prepaid health plan and the supports and services it offers.
Special Needs Residential for MIA and	Residential facilities, certified by MDICS, to provide intensive mental health service, structured programming, and enhanced

DD Consumers	supervision to individuals deemed clinically appropriate for this level of care. The individual must have a primary, validated DSM-IV (or its successor) diagnosis or a diagnosis of Developmental Disability as defined by the Federal Developmental Disabilities Assistance and Bill of Rights Act.
Spend Down Participant	A category of Medicaid participants that are responsible for a portion of their health care before Medicaid coverage begins.
State Hospital Services	An inpatient program operated by the Michigan Department of Health and Human Services for the treatment of individuals with severe mental illness or serious emotional disturbance.

Status Letter	A letter of progress forwarded to the beneficiary for grievance pending resolution beyond 30 calendar days.
Substance Abuse	A maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of substances. If the primary diagnosis is mental illness, then the CMH will be the lead agency for the determination of necessary services, with coordination with the Substance Abuse Coordinating Agency. If the primary diagnosis is substance abuse, then the Substance Abuse Coordinating Agency will be the lead agency for the determination of necessary services, with coordination with the CMH.
Substance Use Disorders	Substance use disorders include Substance Dependence and Substance Abuse, according to selected specific diagnosis criteria given in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition. Specific DSM IV diagnoses are found in Attachment 7.0.1.1 of the department's contract with CMHSPs.
Technical Advisory	MDHHS – developed document with recommended parameters for PHPs regarding administrative practice and derived from public policy and legal requirements.
Technical Requirement	MDHHS/PHP contractual requirements providing parameters for PHPs regarding administrative practice related to specific administrative functions, and derived from public policy and legal requirements.
Third Party Liability	This is also referred to as TPL. For this document’s purpose, TPL is another name for COB.
TPL	Third Party Liability – refers to any other health insurance plan or carrier (e.g., individual, group, employer-related, self-insured or self-funded plan or commercial carrier, automobile insurance and worker's compensation) or program (E.g., Medicare) that has liability for all or part of a recipient's covered benefit.
UM Designee	Person or entity designated by DWMHA to oversee the Utilization

	Management (UM) Plan.
UM Plan	A Plan developed to manage appropriate utilization of services, e.g. frequency, length of services, etc. The Plan must include written policies and procedures to evaluate the appropriateness and effectiveness of Covered Services provided by the MCPN, CA, and subcontractors, and must be approved by the Authority.
Urgent Situation	A situation in which an individual is determined to be at risk of experiencing an emergency situation in the near future if he or she does not receive care, treatment, or support services.
Utilization Management	Using established criteria to recommend or evaluate the
	Medical necessity of services, effective use of resources, and cost-effectiveness. Using established criteria to recommend or evaluate the medical necessity of services, effective use of resources, and cost-effectiveness.
"What's Coming Up" Calendar	A monthly schedule of Consumer activities compiled by the Partnership Initiative group to keep consumers and mental health professionals updated on current events in the Detroit-Wayne CMH area and across the state. The calendar is reviewed on the first Thursday of each month and is distributed by email and hard copy to individuals, providers, consumer organizations and other DWMHA outreach efforts.
Wraparound Services	Wraparound services are individually designed services provided to minors with SED and their families that include treatment, personal care, or any other supports necessary to maintain child in the family home. Wraparound services are developed through interagency collaboration with the minor's parent or guardian and the minor (if over age 14).
WRAP Training	The Wellness Recovery Action Plan is a structured system for monitoring mental illness symptoms and through planned responses, reduces, modifies or eliminates those symptoms. Persons may be assisted in this process by supporters and health care professionals of their choice.