MCCMH MCO Policy 2-013

Chapter: **CLINICAL PRACTICE**
Title: ACCESS, ELIGIBILITY, ADMISSION, DISCHARGE

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Proposed by: _____ 10/20/2022
Chief Executive Officer Date

Approved by: Al Lorenzo 10/21/2022
County Executive Office Date

I. ABSTRACT

This policy establishes the standards and procedures of Macomb County Community Mental Health (MCCMH), an official agency of the County of Macomb, for access, eligibility, and admission to the service system; transition to various levels of care; and discharge from services.

II. APPLICATION

This policy shall apply to all directly-operated and contract network providers of MCCMH.

III. POLICY

It is the policy of MCCMH that consistent review and coordination of services occur for all prospective and current persons served.

IV. DEFINITIONS

A. County of Financial Responsibility (COFR)

The County which is determined to be financially liable for the cost of specialty mental health services provided to the member. COFR is determined by establishing a person's last independent address in compliance with the standards set forth in the Michigan Mental Health Code and the Michigan Department of Health and Human Services (MDHHS)/ Community Mental Health Service Program (CMHSP) Managed Mental Health Supports and Services Contract.

B. Developmental Disability

1. If applied to an individual older than five (5) years, a severe, chronic condition that meets all the following requirements:

   a. Is attributable to a mental impairment other than a serious mental illness, serious emotional disturbance, or substance use disorder or to a physical impairment or a combination of mental and physical impairments;

   b. Is manifested before the individual is twenty-two (22) years old;

   c. Is likely to continue indefinitely;

   d. Results in substantial functional limitations in three (3) or more of the following areas of major life activity:

      i. Self-care

      ii. Receptive and expressive language

      iii. Learning

      iv. Mobility

      v. Self-direction

      vi. Capacity for independent living

      vii. Economic self-sufficiency

   * For a more detailed description of "substantial functional limitation" in the seven areas of major life activity listed above, see Exhibit A, "MCCMH Determination of Developmental Disability."

2. Reflects the person's need for a combination and sequence of special, interdisciplinary or generic care, treatment, or other services which are of lifelong or extended duration and are individually planned and coordinated.

3. If applied to a minor from birth to age five (5), a substantial developmental delay or a specific congenital or acquired condition with a high probability of resulting in developmental disability as defined above if services are not provided.

C. Criteria for Determination of Developmental Disability

An established criterion for individuals with a developmental disability, as described in the MDHHS Specialty Services Contract and MDHHS Medicaid Provider Manual, used to determine a person's eligibility to receive specialized services and supports.

D. Emergent Need

A situation in which a person is experiencing a serious mental illness or a developmental disability, or a child is experiencing a serious emotional disturbance and one of the following applies:

1. The individual can reasonably be expected within the near future to physically injure himself, herself, or another individual intentionally or unintentionally;

2. The individual is unable to provide himself or herself food, clothing, or shelter to attend to basic physical activities such as eating, toileting, bathing, grooming, dressing, or ambulating, and this inability may lead in the near future to harm to the individual or to another individual; or

3. The individual's judgment is so impaired that they are unable to understand the need for treatment and, in the opinion of the mental health professional, their 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.

E. Primary Diagnosis(es)

The diagnosis or diagnoses which are the focus of service/treatment.

F. Routine Need

A situation where an individual has been determined to be eligible for admission for mental health services and supports but has not been determined to be in "emergent" or "urgent" need.

G. 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 (DSM), published by the American Psychiatric Association. The disorder has resulted in functional impairment that substantially interferes with or limits a minor's achievement or maintenance of one or more developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills. 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; and/or

3. Disorders in the most recent Diagnostic and Statistical Manual of Mental Disorders (DSM).

H. Serious Mental Illness

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

1. A substance use disorder;
2. A developmental disorder; and/or
3. Disorders in the most recent Diagnostic and Statistical Manual of Mental Disorders (DSM).

I. Service Review

A process by which the MCCMH Managed Care Operations Division (MCO) reviews the medically necessary level of care, if any, an individual may receive. The purpose of this process is to help assure that planned services are:

1. Delivered in accordance with federal and state standards for timeliness and in a location that is accessible to the person served;
2. Responsive to particular needs of multi-cultural populations and furnished in a culturally relevant manner;
3. Responsive to the particular needs of persons served with sensory or mobility impairments and provided with the necessary accommodations;
4. Provided in the least restrictive, most integrated setting; and
5. Delivered consistent with, where they exist, available research findings, health care practice guidelines, best practices and standards of practice issued by professionally recognized organizations or government agencies.

J. Urgent Need

A situation in which an individual is determined to be at risk of experiencing an emergency situation in the near future if they do not receive appropriate care, treatment, or support services.

V. STANDARDS

A. Eligibility requirements for mental health services and supports and decisions regarding admission to and provisions of levels of care shall be determined according to the Michigan Department of Health and Human Services (MDHHS) – MCCMH Medicaid Managed Specialty Supports and Services Contract; MDHHS Medicaid Provider Manual; Michigan Mental Health Code; MDHHS Administrative Rules; Michigan Certified Community Behavioral Health Clinic (CCBHC) Handbook; and other applicable laws and regulations.

B. Discharge from mental health services shall occur when the person served has achieved the planned service outcomes or is determined, based upon an established set of criteria, to be unable to productively use any of the various levels of mental health care within MCCMH's range of services.

C. CCBHC services are available to all Michigan residents regardless of where the person lives, homelessness/lack of permanent address, or where he/she contacts the system and are not restricted to individuals who live in a particular geographic region.

D. Eligibility Criteria to Receive Public Mental Health Services

1. Mental health services and supports shall be provided to individuals who have been determined through the MCCMH MCO Division to meet medical necessity criteria for one or more of the following conditions:

   a. Adults with serious mental illnesses;

   b. Children with serious emotional disturbances;

   c. Adults and children with developmental disabilities;

   d. Individuals with substance use and co-occurring disorders; or

   e. Any CCBHC eligible recipient with a mental health or substance use disorder.

2. Apart from individuals receiving CCBHC services, individuals receiving services shall be residents of Macomb County, or where Macomb County has been determined to be the service applicant's county of financial responsibility.

3. Applicants requesting services who do not meet eligibility criteria shall be referred to a more appropriate community service, or, when appropriate, referred to the Prepaid Inpatient Health Plan (PIHP) in their county of residence.

E. Admission Criteria

1. Medicaid beneficiaries shall be provided Medicaid-covered services in accordance with federal entitlements as reflected in MCCMH's contracts with MDHHS and the Medicaid Provider Manual.

2. Applicants and established recipients in emergency situations shall be served immediately upon request by MCCMH. Prior authorization for emergency assessment is not required.

F. Transitioning to and from Levels of Care

Determination of need for referrals for services, transitions to other levels of care, or for discharge shall be developed through the person-centered planning process set forth in MCO Policy 2-001, "Person-Centered Planning Practice Guideline." Transition planning may be initiated at the earliest possible point in the delivery of supports and services.

G. Unplanned Discharges

1. When an unplanned discharge occurs, MCCMH shall make every available effort to develop and complete a discharge/transition plan to ensure continuity of care for persons served.

2. MCCMH staff document all attempts to re-engage individuals in the person's electronic medical record (EMR). Documentation includes evidence that reasonable attempts have been made to inform the person of risks related to early discharge.

3. Attempts to re-engage the person in services and supports may include:

   a. Attempts to locate the person served at their last known residence;

   b. An outreach letter; and

   c. Attempts by phone or face to face using all available resources and appropriate treatment matching interventions.

4. When the discharge is unplanned, the discharge plan must reflect formal notification to the person served.

5. Discharge from services shall be coordinated with and communicated to the treating physician, as applicable.

H. Discharge Criteria

1. Discharge criteria shall be established for each person served at the point of admission and development of the individual plan of service (IPOS).

2. Persons served shall be discharged from service when one or more of the following criteria are met:

   a. The person has achieved the goals of the service plan.

   b. The person has not met the goals of the service plan and there is evidence that no further progress is likely, and the person's level of functioning and array of natural supports is sufficient for safe community living.

   c. The person is deceased.

   d. The person withdraws from service.

3. The person served may be discharged from treatment when, despite documented attempts to resolve issues and renegotiate the person's plan of service, the person is non-compliant with the plan of service to which they have agreed, and the person does not meet Michigan Mental Health Code criteria and MCCMH Service Selection Guidelines for involuntary hospitalization. Evidence of non-compliance includes but is not limited to:

   a. The person is overtly resistant or obstructive to meeting service requirements. This includes unwillingness to provide necessary information or make reasonable

attempts to participate in interventions or activities as specified in the service plan;

b. The person refuses to sign or otherwise agree to informed consents for treatment or service plans;

c. The person refuses to follow through with major recommendations from the treating staff, including but not limited to, refusal to obtain required assessments, medical or other ancillary treatment, or more intensive services;

d. The person engages in illegal activities that have some pertinence to treatment concerns (e.g., the sale or transfer of medications prescribed by MCCMH); and/or

e. The person engages in aggressive and/or assaultive behavior that has not been ameliorated with treatment.

4. When a person is discharged or removed from a program, the clinician/ case manager shall be responsible for follow-up to determine whether the person will need further services and shall offer or refer the person to needed services when possible.

5. When a person is discharged or removed from a program for aggressive and/or assaultive behavior, the primary case holder/provider shall conduct outreach attempts within seventy-two (72) calendar hours to ensure linkage to appropriate care. All attempts shall be documented in the person's service progress notes.

6. For all individuals terminating services, a written discharge summary shall be prepared to ensure that their treatment episodes and results of treatment are documented. The discharge summary shall:

a. Include the date of admission;

b. Describe the services provided;

c. Identify the presenting condition;

d. Describe the extent to which established goals and objectives were achieved;

e. Identify the person's current:

(1) Progress in recovery or move toward well-being

(2) Gains achieved during program participation

(3) Strengths

(4) Needs

(5) Abilities

(6) Preferences

f. Describe the reason(s) for discharge;

g. Identify the person's status at last contact;

h. Identify the person's need for support systems or other types of services that will assist in continuing recovery or well-being;

i. List recommendations for services or supports;

j. Include information on the person's medication(s), as applicable;

k. Include the date of discharge from the program;

l. Indicate follow-up will be provided to ensure ongoing care, as applicable; and

m. Include a list of current community resources for the individual and mail the list with the corresponding discharge summary and/or advanced action notice.

7. For planned discharges, an aftercare plan is developed which reflects the person's preferences and includes:

a. Referrals and appropriate releases;

b. Dates for scheduled aftercare appointments (if any);

c. Primary care physician notification;

d. Instructions to maintain treatment outcomes and for relapse prevention, recovery, and instructions for crisis intervention;

e. Notifications to other involved care organizations/natural supports, as appropriate;

f. Formal notification to the person served using the Advance Action Notice process;

g. Linkages to cultural and ethnic communities as appropriate;

h. Summary of the person's satisfaction and a statement of their reaction to care received or evidence of a post discharge satisfaction survey being offered to the person;

i. Prognosis and risks associated with discharge; and

j. Recommendations for aftercare and referrals, verified following the cessation of treatment and within thirty (30) calendar days of the planned discharge.

I. Discharge from Institutions

1. When a person served is discharged from an institutional setting:

a. The person must be seen within 7 calendar days of discharge by a primary provider for care coordination and follow-up.

b. The provider's treatment staff must document care coordination services provided.

c. The provider must make referrals, as appropriate, for additional community supports

and services. Referrals must be documented in the person's EMR.

VI. PROCEDURES

A. New Requests for Service or Requests for Readmission:

1. New requests and readmission requests for services requiring MCCMH's prior authorization will be screened through the MCO Division for eligibility.

2. MCO will open the admission in the MCCMH electronic medical record (EMR) system for persons who appear eligible for services; provide an initial authorization, as appropriate; and arrange for an initial assessment at the MCCMH provider site appropriate to the person's needs within the time frames stated within this policy.

3. Whenever possible, service denials will be accompanied by recommendations for accessing needed services from sources outside the MCCMH system, as well as information pertaining to a request for a second opinion.

4. All service denials or limitations will be accompanied by the appropriate due process notice.

B. Request for Continued Stay Services at Same or Less Intensive Level of Care:

1. Prior to the expiration of a person's current level of care approval or whenever changes in a person's needs necessitate change in level of care, provider staff shall review the plan of service with the person, documenting the service plan review according to MCCMH MCO Policy 2-010, "Standards for Clinical Service Documentation."

2. Based on the outcome of the service plan review, approval for continued stay in the level of care or movement to another level of care may be sought from MCO. The request for approval from MCO can be made up to 60 days but no less than 14 days prior to the effective date of the new authorization.

   a. For persons served with mental illness, emotional disturbance, developmental disability, or a co-occurring condition, supporting documentation shall indicate the rationale for providing a continued level of care, and shall be entered into the person's EMR or otherwise transmitted to MCO for approval.

   b. Continued services at a level of care may not be provided unless approved by MCO.

   c. For persons served, whose individualized plan of service requires an associated budget, the revised plan of service and budget shall be completed by the assigned provider staff as appropriate to type and amount.

   d. Requests for continued stay or movement to another level of care shall be submitted to MCO according to current, published procedures. See Exhibits B and C for additional detail.

3. MCO shall either approve or deny the request within 14 days of receipt.

C. Provider-specific procedures necessary for the implementation of this policy shall be contained in the provider manuals of each network provider as relevant to that provider's role (if any) in eligibility, admission, and discharge processes. Such procedures shall be reviewed and approved by MCCMH.

VII. REFERENCES / LEGAL AUTHORITY

A. Michigan Mental Health Code, MCL 330.1001 et seq.

B. MDHHS – MCCMH Medicaid Managed Specialty Supports and Services Contract (in effect, and as amended)

C. Commission on Accreditation of Rehabilitation Facilities (CARF) Standards Manual

D. MDHHS Medicaid Provider Manual

E. Diagnostic and Statistical Manual of Mental Disorders: DSM-5. Arlington, VA: American Psychiatric Association, 2013. Print.

F. MCCMH MCO Policy 2-010, "Standards for Clinical Service Documentation"

G. MCCMH MCO Policy 2-042, "Service Referrals / Recommendations, Coordination of Care and Follow-Up"

H. MCCMH MCO Policy 4-020, "Notices of Advance and Adequate Action and Appeal Rights (Medicaid)"

I. MCCMH MCO Policy 9-110, "Authorization and Functions"

J. MCCMH MCO Policy 4-005, "Second Opinion Rights"

K. Olmstead v. L.C., 527 US. 581 (1999).

L. MCCMH Notices of Advance and Adequate Action and Appeal Rights (Non-Medicaid)

VIII. EXHIBITS

A. MCCMH Determination of Developmental Disability

B. MCCMH Specialized Residential Service Request Procedure

C. MCCMH Change in Level of Care Requests Procedure