Macomb County Community Mental Health

Guide to MI Health Link Behavioral Health Services

in Macomb County

Macomb County
Community Mental Health,
guided by the values, strengths, and informed choices of the people we serve,
provides quality services
which promote recovery, community participation, self-sufficiency, and independence.

Mission Statement
of the Macomb County Community Mental Health Board
Adopted August 24, 2011

Welcome to Macomb County Community Mental Health and MI Health Link !

We want your experience with us to be as satisfying and effective as possible. Throughout this booklet, you will find all the information you need while you receive services through MI Health Link from MCCMH, or from any of our contract agencies. Use this booklet like a dictionary — as a resource when you have questions or want more detailed information about your services. Any time you have questions, talk with your Supports Coordinator, Case Manager or Therapist; or call the Office of Community Relations/ Customer Service.

What is the MI Health Link Program?
MI Health Link is a program that provides coordinated medical, mental health, and substance use disorder services to residents in Macomb County who are covered by both Medicare and Medicaid.

How does MI Health Link work ?
Macomb County Community Mental Health contracts with your health plan to provide both Medicare and Michigan Medicaid benefits to MI Health Link members who need specialty behavioral health services.

What are Medicare and Michigan Medicaid?
Medicare is the federal health insurance program for:

- people 65 years of age or older,
- some people under age 65 with certain disabilities, and
- people with end-stage renal disease (kidney failure).

Michigan Medicaid
Michigan Medicaid is a program run by the Federal government and the State of Michigan that helps people with limited incomes pay for long term supports and services and medical costs. It also covers extra services and drugs not covered by Medicare.

Each state has its own Medicaid program. This means that each state decides what counts as income and resources and who qualifies for Medicaid. Each state also decides what services are covered by Medicaid, and the approved cost for those services. States can decide how to run their own Medicaid programs, as long as they follow the federal rules.

Eligibility for Specialty Mental Health Services

You may be eligible for specialty mental health, developmental disability, or substance use treatment services provided by MCCMH if you are a MI Health Link member and:

- You are referred to MCCMH by your Health Plan, or
- You have had a Level II health assessment provided by MCCMH at the request of your Health Plan that indicates that you might benefit from services.

The specific programs and services offered by the MCCMH network may have their own eligibility requirements, in addition to those above. Talk to your Care Manager or the Access Center about the requirements, rights, privileges, and responsibilities within the programs that serve you.

Eligibility for MI Health Link

You are eligible for the MI Health Link Plan as long as all of these things are true:

- you live in Macomb County
- you have Medicare Part A, Part B, and Part D
- you are eligible for full Michigan Medicaid benefits (without a "spend down" or deductible.)
- you are **not** enrolled in hospice*
- you are **not** enrolled in the MI Choice waiver program or the Program of All-inclusive Care for the Elderly (PACE)*.

* If you are enrolled in either of these programs, you need to dis-enroll before enrolling in the MI Health Link program.

You can get MI Health Link services through MCCMH as long as:

- you are eligible to participate in MI Health Link
- we choose to offer the plan, and
- Medicare and the State of Michigan approve the plan.

Even if MI Health Link stops operating in the future, you will still be eligible for Medicare and Michigan Medicaid.

What are the Advantages of the MI Health Link Program?

As a MI HealtlLInk member, you will get all your covered Medicare and Michigan Medicaid behavioral health services from MCCMH and your health plan, including prescription drugs. You do not pay extra to join this health plan.

MCCMH and your Health plan will work together to help make your Medicare and Michigan Medicaid benefits work better together and work better for you.

Some of the advantages of MI Health Link include:

- You will not pay a deductible or copayment when you get services from a provider or pharmacy in the plan's provider network.
- You will have your own Care Coordinator/Care Manager who will ask you about your health care needs and choices and will work with you to create a personal care plan based on your goals.
- Your Care Coordinator/Care Manager will help you get what you need, when you need it. This person will answer your questions and make sure that your health care issues get the attention they deserve.
- You will be able to address both medical as well as behavioral health issues at the same time.

What to Expect When You First Join MI Health Link Program

You will receive a basic health assessment from your health plan, called a Level I Assessment, within the first 45 days of joining the MI Health Link Program. If a possible need for behavioral health services is identified based on the Level I assessment, you will receive a specialty assessment, called a Level II Assessment, from Macomb County Community Mental Health within 15 days.

What if You are New to Macomb County Community Mental Health ?

If you have been receiving mental health services from another provider not connected to MCCMH, you can keep receiving behavioral health services and seeing the doctors and other providers you go to now for at least 180 days from your enrollment start date. If you receive services through the Habilitation Supports Waiver or the Specialty Services and Supports Program through Macomb County Community Mental Health, you will be able to receive services and see the doctors and providers you go to now for up to 180 days from your enrollment start date. Your Care Manager will work with you to choose new providers and arrange services within this time period if your current provider is not part of Macomb County Community Mental Health's provider network.

Only people who live in Macomb County can receive services from Macomb County Community Mental Health. If you move outside of Macomb County, you cannot stay with Macomb County Community Mental Health.

You have the right to leave MI Health Link at any time
No one can make you stay in the MI Health Link program if you do not want to. You can leave the plan at any time. If you leave MI Health Link, you will still be covered by the Medicare and Michigan Medicaid programs.

You have the right to get most of your health care services through Original Medicare or a Medicare Advantage plan. You can get your Medicare Part D prescription drug benefits from a prescription drug plan or from a Medicare Advantage plan. You can get your Michigan Medicaid benefits through Michigan's original (fee-for-service) Medicaid.

Paying for Services

If you are enrolled in MI Health Link and meet the criteria for specialty mental health, developmental disability, or substance abuse services, the total cost of your authorized treatment will be covered. No fees will be charged to you. You will have no premiums or co-pays under the MI Health Link program.

Network providers cannot bill you directly
Doctors, hospitals, and other providers in our network cannot make you pay for covered services. They also cannot charge you if we pay for less than the provider charged us. If a network provider tries to charge you for covered services, please call the MI Health Link Customer Services representative at 1-855-996-2264.

What Should You Do if You Are Billed?
If a provider sends you a bill instead of sending it to Macomb County Community Mental Health, you should not pay the bill yourself. If you do, we may not be able to pay you back. If you have paid for your covered services or if you have gotten a bill for covered medical services, see page 71 to learn what to do.

See page 71 for more detail about paying for services.

Communication Assistance

We want to provide services to you in the way that you can best understand and use them. If you or a family member need an American Sign Language (ASL) interpreter, or if you best use a language other than English and you would like to receive your services in your native language, you have the right to an independent interpreter to help you use mental health or substance abuse services. You may also request translation of written materials. **If you need an interpreter, one will be provided at no charge to you.**

يحقُّ لك الاستعانة بمترجم لمساعدتك في استخدام خدمات الصحة النفسيّة ومعالجة الادمان

Avete diritto ad un interprete indipendente che vi assista nell'uso dei servizi di salute mentale o di abuso di sostanze.

Podczas korzystania z usług służby zdrowia psychicznego lub usług w zakresie walki z nałogami masz prawo do pomocy ze strony niezależnego tłumacza.

Tiene derecho a un intérprete independiente para que le ayude a utilizar los servicios para la salud mental o para el abuso de sustancias.

If you prefer an interpreter for another language, or you prefer this information in English on tape, call

1-855-927-4747

If you are a person who is deaf or hard of hearing, you can use the Michigan Relay Center (MRC) to contact MCCMH or your service provider. Please call 7-1-1 and ask MRC to connect you to the number you are trying to reach. If you prefer to use a TTY to contact us, call the Crisis Center at the following TTY phone number: 586-307-9100.

All MCCMH offices are equipped with alternative language interpreter services to assist callers whose primary language is not English. Tell us, in any language, that you need an interpreter when you call. You will be put on hold briefly while we connect to the service. An interpreter will join the call to assist with your needs.

If you need an ASL or language interpreter and you are receiving services from us, your treatment team will set up the interpreter for you. You do not need to make the arrangements for the interpreter yourself.

Accessibility and Accommodations

In accordance with federal and state laws, all buildings and programs of MCCMH are physically accessible to individuals with disabilities.

Any individual who receives emotional, visual, or mobility support from a qualified, trained, and identified service dog will be given access, along with the service animal, to all buildings and programs of MCCMH.

If you need to request an accommodation on behalf of yourself or a family member, please tell your service provider about your needs.

We will work with you to accommodate your accessibility needs in an effective and reasonable way. If you need an accommodation and you feel that we have failed to provide it for you, you may contact the Ombudsman or the Office of Recipient Rights for assistance.

Alternative Formats

This Member Information Handbook is available on tape for persons who prefer an alternative to printed materials. Other printed materials can also be made available on tape, or in other formats as needed. Contact your Care Manager or the MCCMH MI Health Link Customer Service Representative for assistance.

Accreditation

MCCMH services are accredited by the **Commission on Accreditation of Rehabilitation Facilities**, usually called CARF. **CARF** is a national organization that independently reviews the services of mental health and disability service organizations. Accreditation is your assurance that the services you receive meet the highest standards of quality and effectiveness, and that your services are provided in a way that is respectful of you as a person.

Information about MCCMH

MCCMH programs and services are supported and funded by the Macomb County Board of Commissioners and the Michigan Department of Community Health, and are administered by the Macomb County Community Mental Health Board. MCCMH is governed by the **Michigan Mental Health Code**, the Michigan law that governs the delivery of public mental health services, and by the **Public Health Code**, the Michigan law that governs the delivery of public substance abuse treatment services.

If you wish, you may request additional information about the structure and operations of MCCMH by calling the Office of Community Relations. You may request information about MCCMH, its contract agencies, or your individual services, at any time.

Non-Discrimination

MCCMH is a public provider of mental health, developmental disability, and substance abuse treatment services. MCCMH cannot and does not discriminate on the basis of race, color, nationality, religious or political belief, gender, age, disability status, or relationship to a person with disabilities, or against any other legally protected group. If you believe you have been denied services or have been mistreated because of who you are, contact the MCCMH Office of Recipient Rights. You may also have the right to pursue independent legal action.

MI Health Link Customer Service

If you aren't sure who to call at MCCMH, call the Toll Free MCCMH Access Line at 1-855-996-2264. Ask for the MI Health Link Customer Service Representative. That person will help you sort out your questions and concerns, and will help you get a solution.

The Ombudsman can also be reached by calling this number. Unless you ask the Ombudsman for help solving a problem related to your services, your calls will not involve any of the people who provide services to you. We will not tell others that you have called, and we will not tell others whether or not you use MCCMH services.

Calling MI Health Link Customer Service

MI Health Link Customer Services and Ombudsman 1-855-996-2264

Service Hours: Monday thru Friday, 8:00 a.m. to 8:00 p.m.
After Regular Business Hours: The Crisis Center 1-855-927-4747

Remember: These offices are equipped with telephone interpreter services for those who best use a language other than English. If you use a TTY, call the Michigan Relay Center at 711 to reach any MCCMH office.

Becoming Involved at MCCMH

There are many ways for persons who use MCCMH services, their family members and friends, as well as interested community members, to be involved in the design, delivery, and ongoing evaluation of MCCMH services. If you would like to learn more about how you can help MCCMH improve our services, call the office of Community Relations for more information.

Crisis Services

The Macomb County Crisis Center offers many services to help in difficult situations. The Crisis Center is available to anyone in Macomb County 24 hours a day, seven days a week. Crisis Center services are confidential and are free. You do not need to call the Access Center or use any other MCCMH service to use Crisis services. Contact the MCCMH Crisis Line for help with any of these issues:

- Suicidal thoughts or feelings
- Information on mental health/illness
- Substance abuse/addiction/ recovery information
- Relationship problems
- Abuse/violence
- Economic problems causing anxiety/depression
- Loneliness
- Family problems
- Any other concern that is causing you distress
- To help a friend or loved one

Crisis Center services include:

Crisis Counseling: Trained counselors are available by phone to provide support to callers facing any situation. Counselors provide referrals to many community resources, listen to concerns, and help find solutions.

Community Education: The Crisis Center offers on-site presentations to groups in the community. Topics include suicide awareness and sexual assault prevention.

Macomb Emergency Response Group (MERG): MERG offers trained crisis teams who respond on-site to community disasters affecting groups of people. MERG helps to stabilize the work, school, or community setting by responding immediately to the stress of unexpected community crisises.

Survivors of Suicide (SOS): Professional facilitators lead a peer support group for family and friends of persons who have died by suicide. SOS aids the healing process by providing information and resources and by allowing members to share their feelings in a non-judgmental, confidential setting

Urgent Behavioral Healthcare

Urgently Needed Care

Urgently needed care is care you get for a sudden onset or change of symptoms, or condition that isn't an emergency but needs care right away. For example, you might have a flare-up of an existing condition and need to have it treated.

In most situations, we will cover urgently needed care only if you get it from our providers. However, if you can't get to one of our providers, such as when you are outside of Macomb County, we will cover urgently needed care you get from any provider, including an out-of-network provider.

Macomb County Crisis Center 1-855-927-4747
800-442-HOPE
800-237-TALK

MCCMH Crisis Services are available 24/ 7/ 365. The phone call is free.

Remember: If you prefer, we will call you back at any number you give us. The Crisis Center is also equipped with telephone interpreter services for those who best use a language other than English.

Mental Health Emergencies

A "mental health emergency" is when a person is experiencing symptoms and behaviors that can reasonably be expected to lead the person to harm him/ herself or another in the near future. A situation can also be a mental health emergency if, because of mental illness, a person is unable to meet his/her basic needs, putting themselves at risk of harm. If the person's judgment is so impaired that he or she is unable to understand the need for treatment, placing themselves at risk of harm, it may be a mental health emergency.

If you have a mental health emergency, you should seek help right away. **At any time during the day or night, call the MCCMH Crisis Center, toll free, at 1-855-927-4747 for help deciding where to go.**

You have the right to receive emergency services at any time, 24-hours a day, seven days a week, without prior authorization for payment of care.

Post Stabilization Services: After you receive emergency mental health care and your condition is under control, you may receive mental health services to make sure your condition continues to stabilize and improve. Examples of post-stabilization services are crisis residential, case management, outpatient therapy, and/ or medication reviews. Before the end of your emergency care, MCCMH will help you to coordinate your post-stabilization services.

Please Note: If you use a hospital emergency room, there may be health care services provided to you as part of the hospital treatment you receive. You may receive a bill for these services and may be responsible for this bill, depending on your insurance status. These services may not be part of the MCCMH emergency services you receive.

Authorization for Emergency Care

If you or someone you care about is experiencing a mental health emergency, you should seek help right away. **You do not need to call the Access Center to seek prior authorization for payment of emergency care;** the treatment staff will do that for you.

What to do in a Mental Health Emergency

If you or someone else is experiencing a mental health emergency, seek help right away. If you are experiencing a mental health emergency, **go to the nearest hospital** with a psychiatric care unit.

In Macomb County and neighboring areas, adults may be taken to:

Harbor Oaks Hospital 35031 Twenty-Three Mile New Baltimore 48047	(586) 725-5777
BCA — StoneCrest Center 15000 Gratiot Ave., Detroit 48205	(313) 245-0649
Havenwyck Hospital 1525 University, Auburn Hills 48326	(248) 373-9200
Henry Ford Kingswood Hospital 10300 W. Eight Mile, Ferndale 48220	(248) 398-3200
Ascension Macomb Oakland, Macomb Center 11800 E. Twelve Mile, Warren 48093	(586) 573-5244
Ascension Macomb Oakland, Oakland Center 27351 Dequindre, Madison Hts. 48071	(248) 967-7660
Ascension St. John, Moross 22101 Moross, Detroit 48236	(313) 343-7000

What Happens at the Hospital

When you go to the hospital for a mental health emergency, the doctor and other hospital staff will talk to you and others about what you are feeling, seeing, or experiencing. They may ask questions or do tests to help them decide how well you understand what is going on around you. This is called a **psychiatric evaluation.** It is important for you to be as honest as possible, so that you can get the best help for you while you are at the hospital.

If you and the hospital staff decide that you do need to be in the hospital, you will stay there until your symptoms are better, usually for a few days or so. You will get medicine and treatments to help you feel better.

Hospital Alternatives and Aftercare

Sometimes, instead of being in the hospital, mental health emergencies can be treated in other kinds of settings. Hospital alternatives include:

Crisis Residential Services: Crisis residential services provide medical, psychological and other services for up to 30 days in a structured, home-like setting within the community. After a crisis residential stay, you will usually continue to receive some outpatient or community-based services to help you manage your illness.

Intensive Crisis Stabilization: Instead of being in the hospital, a specialized mental health team works with you in your home or in another community setting. While your symptoms are being stabilized, you might see the team up to every day. After you are better, you will receive some other outpatient or community services to help you manage your illness. You must have someone at home with you when you receive intensive crisis stabilization services.

Partial Hospital Services: Partial hospital services are sometimes called "Day Hospital" services. These services, like counseling, medication, and different types of therapies, are typically provided in a hospital setting, under a doctor's supervision. Partial hospital services are provided during the day – you will go home at night.

Before you leave the hospital, a **discharge plan** will be created with you that will outline what aftercare services you will receive in the community to help you stay well.

What Situations are Not Mental Health Emergencies?

Some situations, though serious, are not mental health emergencies. **These situations need different kinds of treatment or response.** Some things that might look or feel like mental health emergencies but, on their own, are not, include:

- Dementia
- Seizure disorders
- Intoxication
- Homelessness
- Intentional acts of violence

Other Kinds of Emergencies

If you have an emergency, but you don't want or need to go to the hospital, there are other people and places to call for help.

If you need the police, fire department, or an ambulance, call 911.

If you would like to talk to a trained Crisis Counselor about a problem you are having, or if you aren't sure where to go for help, call the Macomb County CMH Crisis Center. The Crisis Center is available 24/7/365. All calls are confidential (private) and there is no charge for Crisis Center services.

If you would like to talk to a Crisis Counselor, call 1-855-927-4747.
You may call the Crisis Center at any time of the day or night.

If you would like information about other community resources serving Macomb County and the surrounding area, call United Way Tel-Help, 211.
211 is a regional information and referral resource center, available 24/7.
You must use a land-based phone to call 211.

Requesting Non-Emergency Services from MCCMH

If you would like to receive non-emergency mental health, developmental disability, or substance use disorder treatment services from Macomb County Community Mental Health, you should call the Access Center.

The Access Center will help both you and MCCMH decide if you are eligible for our services, and, if so, which of our services might best help you. If you call the Access Center and we determine that MCCMH can help you, you will receive an appointment at one of our locations within 14 days.

We must ensure that you get timely access to services.

As a MI Health Link Member:

- You have the right to get covered services from network providers within a reasonable amount of time.
- You have the right to get emergency services or care that is urgently needed without prior approval.
- You have the right to receive services without MCCMH requiring you to get referrals.
- You have the right to choose a provider in the network. A network provider is a provider who works with MCCMH. You also have the right to change your provider within the MCCMH network. Call the Access Center or visit the MI Health Link page of our website, www.mccmh.net for more information.
- You have the right to know when you can use an out-of-network provider. To learn about out-of-network providers, see page 28.
- See page 56, "Making an Appeal" to learn what you can do if you think you are not getting your services within a reasonable amount of time, or what you can do if we have denied coverage for your services and you do not agree with our decision.

When You Call the Access Center

When you call the Access Center, we will ask questions to help us determine if you are eligible for services from MCCMH, and if so, which services can best help you. The Access Center is responsible for reviewing and approving all requests for service from MCCMH.

Your calls to the Access Center are confidential. If your situation is an emergency, you will be directed to immediate help. If the situation is not an emergency, the Access Center will set up an appointment for you at one of our service sites. Your first appointment will usually be within two weeks of your call. If your situation is not one that MCCMH can serve, we will help you identify other community resources that may help.

You should know that sometimes we cannot provide exactly the service you might want in exactly the ways you might want it. This is because MI Health Link has specific rules, like **medical necessity**, that determine who can receive certain services, as well as how, how much and how long services can be provided. (This is called **"Amount, Scope and Duration"** of service.)

All decisions about your care are made by health professionals with appropriate clinical experience for your situation. If we deny any of your requests, we must tell you why in writing, within specific time frames. If you disagree with our decisions, you have specific rights to appeal (See page 56 for detail on these rights.

Calling the Access Center

MI Health Link Customer Services and Ombudsman 1-855-996-2264

Service Hours: Monday thru Friday, 8:00 a.m. to 8:00 p.m.
After Regular Business Hours: The Crisis Center 1-855-927-4747

Remember: These offices are equipped with telephone interpreter services for those who best use a language other than English. If you use a TTY, call the Michigan Relay Center at 711 to reach any MCCMH office.

Your MCCMH Care Manager and Care Plan

What is a Care Manager?
A Care Manager is the person at MCCMH who will help you with coordinating both your behavioral health services and your Health Plan's Care Coordinator and your Primary Care Physician. Your Care Manager collaborates everyone to assure that all necessary supports and services are provided to enable you to achieve your desired outcomes.

Contacting Your Care Manager
You will receive a Care Manager when you start treatment/services with Macomb County Community Mental Health. Your Care Manager you will be able to assist you with coordinating all your behavioral health and medical needs. Your Care Manager will provide you with his or her contact information, so you will be able to call when you need help.

Contact your Care Manager about:
- Questions about your treatment or care
- Questions about getting behavioral health or substance use disorder services
- Questions about any other supports and services you need

Sometimes you can get specialized help with your daily health care and living needs. Your Care Manager will help you decide if you might be able to get these services:

- Skilled nursing care
- Physical therapy
- Occupational therapy
- Speech therapy
- Personal Care Services
- Home health care

Requesting a Change in Care Manager
You can request a change in Care Manger either by asking for the change at the clinic where you receive services, or by calling our Access Center.

What is a Care Plan?

A care plan is the plan that outlines the supports and services MCCMH will provide to you, and how we will provide them. Sometimes at MCCMH, you will here this plan also called a Person-Centered Plan. Your right to personalized service planning is protected by the Michigan Mental Health Code, the law that governs public mental health services in Michigan.

After your first Assessment, your care team will meet with you to talk about what health services, including behavioral health services you need and want. Together, you and your care team will make a care plan. At least once a year, or whenever the behavioral health services you need and want change, your care team will work with you to update your care plan.

You have Rights in the Care Planning Process

- You have the right to make decisions about your treatment, with your guardian if you have one.
- You have the right to know your treatment options and make decisions about your care, with your guardian if you have one.
- You have the right to get full information from your providers and other health care professionals when you get services. Your providers must explain your condition and your treatment choices in a way that you can understand.
- You have the right to know your choices. You have the right to be told about all the kinds of treatment available for your condition.
- You have the right to know the risks involved with your treatment choices.
- You must be told in advance if any service or treatment is part of a research experiment. You have the right to refuse experimental treatments.
- You can get a second opinion. You have the right to see another provider before deciding on a course of treatment.
- You can say "no." You have the right to refuse any treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to. You also have the right to stop taking a medicine. If you refuse treatment or stop taking a medicine, you will not be dropped from services. However, if you refuse treatment or stop taking a medicine, you accept full responsibility for what happens to you.
- You can ask us to explain why a provider denied care. You have the right to get an explanation from us if a provider has denied care that you believe you should get.
- You can ask us to cover a service that was denied or is usually not covered.

Participation in the Care Planning Process

Your participation is critical to the development of your Care Plan. To encourage and support your participation, you are also entitled to:

- **Talk about plans for unexpected situations.** At your Care Planning meeting, you should be offered the opportunity to develop a crisis plan, an advance directive for mental health care, or both, if you want them.

- **Learn about different ways to manage your services.** If you are a MI Health Link member and you are receiving long term care and supports, you should be offered the chance to choose self-determination as an option for managing your services. Self-determination offers an alternative option for arranging and paying for your long term care and supports, and choosing your providers.

- **Visit,** practice, or otherwise "try out" the services that you are considering, whenever possible.

- **Refuse** treatment alternatives or medication that you do not want, unless your services are court-ordered.

- **Think about your plan before you sign it.** Make sure that everything is covered the way you intended it to be.

- **Get a copy of your completed plan.** Your facilitator should follow up with you to make sure you receive a copy of your plan within 15 days after it is completed.

- **Receive your services:** You should receive your services within 14 days of the agreed upon start date for each service. (Start dates may vary by service.)

- **Meet with your Care Manager regularly** to talk about the progress you are making toward your goals, and about your satisfaction with your services.

- **Change your plan** when you need to, including at times other than your regularly scheduled service reviews.

Advance Directives and Advance Crisis Planning

You can help make events like an unexpected hospitalization easier on yourself and those you care about by making your preferences about crisis care known in advance. Under Michigan law, adults with mental health conditions have the right to use a medical advance directive, a psychiatric advance directive, and/ or an advance crisis plan to help do this.

A **Medical Advance Directive:** A medical advance directive is also referred to as Durable Power of Attorney for Health Care. An advance directive is a tool for you to use to tell people your wishes for your care when you are unable to tell them yourself. Some of the decisions you can make include instructions about preferred treatments, do not resuscitate (DNR) orders, or decisions about tissue or organ donation.

A **psychiatric advance directive** is a legal document in which you name someone else, called a patient advocate, who is authorized to make psychiatric care decisions for you if you are unable to make them yourself. In your advance directive, you may also outline your preferences about various types of treatment. You may also choose to have an advance directive for physical health care, or you can combine the two.

Since it is a legal document, there are important things to know about your advance directive. For example, your designated patient advocate must agree to serve **before** you are in a crisis situation. Your patient advocate can't be someone who provides services to you, or who works for an organization that provides your services. Your patient advocate will do the best that he or she can to follow your preferences, but may have to do something different if it means you will get care that is better for the situation you are in at the time. You may change your advance directive, or your designated patient advocate, at any time.

A **crisis plan** is not legally binding, but can be effective in helping you and those around you recognize and respond to an unexpected turn in your illness. You can use a crisis plan to describe to others the changes in your symptoms or behavior that might lead to a crisis, and to tell others what is helpful to you when you are in crisis.

Your Case Manager, Supports Coordinator, or other MCCMH clinician should tell you about advance directives and advance crisis planning during your Person-Centered Planning meeting. Your MCCMH clinician will help you develop these plans, if you want them to do so. You can also ask others to help.

Whether you use an advance directive or an advance crisis plan, or both, you should make decisions about your care while you are well. Talk through your plans with the people who are closest to you, including your designated patient advocate, if you choose to have one. Put your preferences in writing. Give copies to your MCCMH Care Team, to the doctors who provide your care, and to your patient advocate.

You can find copies of the Advance Directive forms you need on our website: wwww.mccmh.net/ For the Community / Brochures. Your doctor's office has advance directive forms available.

Your advance directive may include your preferences about a a do-not-resuscitate order. This part of an Advance Directive gives specific written instruction to health care workers who may be treating you about what to do if you stop breathing or if your heart stops. Your doctor can help you with this if you are interested.

You do not have to use an advance directive, but you may choose to do so.
If you want to use an Advance Directive, here is what to do:

Get the form. You can get a form from your doctor, a lawyer, a legal services agency, or a social worker. Organizations that give people information about Medicare or Michigan Medicaid may also have advance directive forms.

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Fill out and sign the form. The form is a legal document. You should consider having a lawyer help you prepare it.

Give copies to people who need to know about it. You should give a copy of the form to your provider. You should also give a copy to the person you name as the one to make decisions for you. You may also want to give copies to close friends or family members. Be sure to keep a copy at home.

If you are going to be hospitalized and you have signed an advance directive, take a copy of it to the hospital. The hospital will ask you whether you have signed an advance directive form and whether you have it with you. If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

Remember, it is your choice to fill out an advance directive or not.

What to do if your instructions are not followed:
In Michigan, your advance directive has binding effect on doctors and hospitals. However, if you believe that a doctor or a hospital did not follow the instructions in your advance directive, you may file a complaint with the Michigan Department of Licensing and Regulatory Affairs, Bureau of Health Care Services at 1-**800-882-6006.**

For more information about advance directives, talk to your MCCMH Care Manager, or call an advocacy organization like ARC Macomb or Michigan Protection and Advocacy Service.

If you do not believe you have received appropriate information regarding Psychiatric Advance Directives from the MCCMH network, please contact the Ombudsman to file a grievance.

MI Health Link Customer Services and Ombudsman 1-855-996-2264

Service Hours: Monday thru Friday, 8:00 a.m. to 8:00 p.m.
After Regular Business Hours: The Crisis Center 1-855-927-4747

Remember: These offices are equipped with telephone interpreter services for those who best use a language other than English. If you use a TTY, call the Michigan Relay Center at 711 to reach any MCCMH office.

Self-Determination

Self-determination is a model of service delivery that allows you, the person receiving MI Health Link Home and Community Based Waiver Services, to direct the purchase of your approved services yourself, using a fixed amount of public dollars. Your **individual budget**, the amount of funds available to you for purchase of your services, is determined by your care plan and the rules for the MI Health Link Home and Community Based Services Waiver. **It is an option for payment of medically necessary services you receive as a beneficiary of mental health services in Michigan.**

Self-determination is meant to provide persons who use public services more direct control over their own lives. Five principles define self-determination:

- **Freedom**: Your ability, with the help of people you choose, to develop your own lifestyle, and to organize and receive needed supports in ways that are meaningful and effective for you.

- **Authority**: Your ability to control a certain sum of dollars on your own behalf, to purchase supports as needed, and to re-arrange services, supports and funds to meet your needs.

- **Support:** Services and supports, both formal and informal, to help you live a rich, active life in the community, according to your own values.

- **Responsibility:** Your acceptance of a valued, contributing role in community life, including acceptance of the responsibility for proper use of public funds. This may include participation in education, employment, volunteer work, caring for others, or spiritual and personal development, in ways consistent with your own values and desires.

- **Confirmation:** Your acceptance of a leadership role in the community, including participation in improvements to the public service system and through active citizenship participation.

How Self-Determination Works

How to Participate in a Self-Determined Arrangement

Self-determination is an option available to enrollees receiving services through the MI Health Link Home and Community Based Services waiver program. It is a process that allows you to design and exercise control over the services and providers who deliver your care. This includes managing a fixed amount of dollars that pay for your authorized supports and services. Often, this is referred to as an "individual budget." If you choose to do so, you would also have control over the hiring and management of providers.

Who can receive arrangements that support self-determination?
Arrangements that support self-determination are available for enrollees who receive services through the home and community-based services waiver program called MI Health Link HCBS.

How to get help in employing providers
You may work with your care coordinator to get help employing providers.

You may choose to explore a self-determination arrangement at any time. If you would like to learn more about self-determination, talk to your MCCMH Care Manager, or call the MI Health Link Customer Services representative. We will give you more information, and help you start the process.

Choosing and Changing Providers

As a MI Health Link Member, you have the right to choose and/or change the person or agency that provides the services approved for you in your care plan. When we are working with you to develop your services, we will provide you with a list of all the providers on our panel who offer the services you need. You also have the right to information about all available services and providers offered by MCCMH, if you request it.

The provider you choose must be on our panel. If you choose a service provider who is not on our panel, we will work with you either to add the provider to our panel or to find an acceptable service from one of our established providers.

Our provider panel is updated regularly. If we make a change to our provider network that impacts you, we will send you a letter describing the change before it happens.

You may view a list of our providers, including substance abuse treatment providers, on the MI Health Link page of our website, **www.mccmh.net.** Look in the "MI Health Link" section and choose "Complete list of Providers." If you don't have web access, ask your treatment team member for a printed copy, or call the Office of Community Relations/ Customer Services for a printed copy.

The Provider Directory lists all the providers in Macomb County Community Mental Health network, along with information including: specialty, location(s), hospital affiliations, languages spoken, and whether or not the provider is accepting new members.

When you receive MI Health Link services through Macomb County Community Mental Health, you must use network providers to get covered services. There are some exceptions when you first join MI Health Link.

What are "network providers"?
Network providers are doctors, therapists, and other health care professionals that you can go to as a member of our plan. Network providers also include clinics, hospitals, nursing facilities, and other places that provide health services in our plan. They also include home health agencies, medical equipment suppliers, and others who provide goods and services that you get through

Medicare or Michigan Medicaid. Network providers have agreed to accept payment from our plan for covered services as payment in full.

Accessing Care from In-Network or Out-of-Network Providers

In- Network Care
You may choose a provider of your choice from our network to provide your care. We can assist you with choosing a provider from our Provider Directory that may meet your needs. You may request to change your provider for any reason, at any time.

What if a network provider leaves our plan?
A network provider you are using might leave our plan. If one of your providers leaves our plan, we will notify you in writing and we will help you find a new provider. If one of your providers does leave our plan, you have certain rights and protections that are summarized below:

- Even though our network of providers may change, we will give you uninterrupted access to qualified providers.
- When possible, we will give you at least 30 days' notice so that you have time to select a new provider.
- We will help you select a new qualified provider to continue managing your service needs.
- If you believe we have not replaced your previous provider with a qualified provider, or that your care is not being appropriately managed, you have the right to file an appeal of our decision.

If you find out one of your providers is leaving our plan, please contact us so we can assist you in finding a new provider and managing your care. Please contact MCCMH MI Health Link Customer Service at 1-855-996-2264.

Out of Network Care
There may be times in which there are no providers in the MCCMH network that are able to provide you with a service that you need. If there is a service that is a covered Medicare or Michigan Medicaid benefit and it is medically necessary for you, MCCMH and your health plan will work with you to find a provider out of our network to provide the service. This will be at no cost to you.

If you feel that your needs require services from an out of network provider, please contact the MCCMH Ombudsman for assistance.

Please note: If you go to an out-of-network provider, the provider must be eligible to participate in Medicare and/or Michigan Medicaid. We cannot pay a provider who is not eligible to participate in Medicare and/or Michigan Medicaid. If you go to a provider who is not eligible to participate in Medicare, you must pay the full cost of the services you get. Providers must tell you if they are not eligible to participate in Medicare.

Calling MI Health Link Customer Service

MI Health Link Customer Services and Ombudsman 1-855-996-2264

Service Hours: Monday thru Friday, 8:00 a.m. to 8:00 p.m.
After Regular Business Hours: The Crisis Center 1-855-927-4747

Remember: These offices are equipped with telephone interpreter services for those who best use a language other than English. If you use a TTY, call the Michigan Relay Center at 711 to reach any MCCMH office.

MI Health Link –Covered Mental Health Services

This list tells you which mental health, developmental disability, or substance use disorder services are covered by your MI Health Link plan and provided by MCCMH or one of its providers.

You do not pay anything for the services listed as long as you meet the coverage requirements described below. The only exception is if you have a Patient Pay Amount (PPA) for nursing facility services as determined by the local Department of Human Services.

- Your Medicare and Michigan Medicaid covered services must be provided according to the rules set by Medicare and Michigan Medicaid.
- The services (including medical care, services, supplies, equipment, and medicines) must be medically necessary. **Medically necessary** means you need the services to prevent, diagnose, or treat a medical condition. This includes care that keeps you from going into a hospital or nursing home. It also means the services, supplies, or medicines meet accepted standards of medical practice.
- You get your care from a network provider. A network provider is a provider who works with the health plan. In most cases, with some exceptions when you first enroll with MI Health Link, your services must come from a network provider.
- Some of the behavioral health services listed are covered only if your doctor or other network provider gets approval from MCCMH first. This is called prior authorization. Prior authorization should be requested by either you or your provider. Prior authorization is required for all behavioral health services, except emergency psychiatric services.
- Covered services that need a prescription from a doctor are marked by an asterisk (*).

Any time you have questions about your services, or other services that might help you, ask your Care Coordinator or your treatment team, or call the MI Health Link Customer Services Representative for assistance.

Assertive Community Treatment (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. ACT may be provided daily for individuals who participate.

Assessment: Assessments help determine your level of functioning and mental health or substance use treatment needs. Assessment includes a comprehensive psychiatric evaluation, psychological testing, substance abuse screening, or other assessments. Physical health assessments are not part of this MCCMH service.

***Assistive Technology** includes adaptive devices and supplies that are not covered under the Medicaid Health Plan or by other community resources. These devices help individuals to better take care of themselves, or to better interact in the places where they live, work, and play.

Behavior Treatment Review: If a person's illness or disability involves behaviors that they or others who work with them want to change, their individual plan of services may include a plan that talks about the behavior. This plan is often called a "behavior treatment plan." The behavior treatment plan is developed during person-centered planning and then is approved and reviewed regularly by a team of specialists to make sure that it is effective and dignified, and continues to meet the person's needs.

Clubhouse Programs are programs where members (consumers) and staff work side by side to operate the clubhouse and to encourage participation in the greater community. Clubhouse programs focus on fostering recovery, competency, and social supports, as well as vocational skills and opportunities.

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Community Inpatient Services are hospital services used to stabilize a mental health condition in the event of a significant change in symptoms, or in a mental health emergency. Community hospital services are provided in licensed psychiatric hospitals and in licensed psychiatric units of general hospitals.

Community Living Supports (CLS) are activities provided by paid staff that help adults with either serious mental illness or developmental disabilities live independently and participate actively in the community.

Crisis Interventions are unscheduled individual or group services aimed at reducing or eliminating the impact of unexpected events on mental health and well-being.

Crisis Residential Services are short term alternatives to inpatient hospitalization provided in a licensed residential setting.

***Enhanced Pharmacy** includes doctor-ordered nonprescription or over-the-counter items (such as vitamins or cough syrup) necessary to manage your health condition(s) when your Health Plan does not cover these items.

***Environmental Modifications** are physical changes to a person's home, car, or work environment that are of direct medical or remedial benefit to the person. Modifications ensure access, protect health and safety, or enable greater independence for a person with physical disabilities. Note that all other sources of funding must be explored first, before using Medicaid funds for environmental modifications.

Family Support and Training provides family-focused assistance to family members relating to and caring for a relative with serious mental illness, serious emotional disturbance, or developmental disabilities.

Health Services include assessment, treatment, and professional monitoring of health conditions that are related to or impacted by a person's mental health condition. A person's primary doctor will treat any other health conditions they may have.

Housing Assistance is assistance with short-term, transitional, or one-time-only expenses in an individual's own home that his/her resources and other community resources could not cover.

Infant Mental Health Services: These services and supports include mental health intervention for new, at-risk parents, designed to help parent and baby bond in the early stages of the relationship. Supports include help with community resources and education about baby's development.

Intensive Crisis Stabilization is another short-term alternative to inpatient hospitalization. Intensive crisis stabilization services are structured treatment and support activities provided by a mental health crisis team in the person's home or in another community setting.

Intermediate Care Facility for Persons with Mental Retardation (ICF/MR) provide 24-hour intensive supervision, health, and rehabilitative services and basic needs to persons with developmental disabilities.

Medication Administration is when a doctor, nurse, or other licensed medical provider gives an injection, or an oral medication or a topical medication.

Medication Review is the evaluation and monitoring of medicines used to treat a person's mental health condition, their effects, and the need for continuing or changing their medicines.

Mental Health Therapy and Counseling for Adults, Children and Families includes therapy or counseling designed to help improve functioning and relationships with other people.

Nursing Home Mental Health Assessment and Monitoring includes a review of a nursing home resident's need for and response to mental health treatment, along with consultations with nursing home staff.

***Occupational Therapy** includes the evaluation by an occupational therapist of an individuals' ability to do things in order to take care of themselves every day, and treatments to help increase these abilities.

Partial Hospital Services include psychiatric, psychological, social, occupational, nursing, music therapy, and therapeutic recreational services in a hospital setting, under a doctor's supervision. Partial hospital services are provided during the day – participants go home at night.

Peer-delivered and Peer Specialist Services Peer-delivered services such as drop in centers are entirely run by consumers of mental health services. They offer help with food, clothing, socialization, housing, and support to begin or maintain mental health treatment. Peer Specialist services are activities designed to help persons with serious mental illness in their individual recovery journey and are provided by individuals who are in recovery from serious mental illness. Peer Mentors help people with developmental disabilities.

Personal Care in Specialized Residential Settings assists an adult with mental illness or developmental disabilities with activities of daily living, self-care and basic needs, while they are living in a specialized residential setting in the community.

***Physical Therapy** includes the evaluation by a physical therapist of a person's physical abilities (such as the ways they move, use their arms or hands, or hold their body), and treatments to help improve their physical abilities.

Prevention Service Models (such as Infant Mental Health, School Success, etc.) use both individual and group interventions designed to reduce the likelihood that individuals will need treatment from the public mental health system.

Respite Care Services provide short-term relief to the unpaid primary caregivers of people eligible for specialty services. Respite provides temporary alternative care, either in the family home, or in another community setting chosen by the family.

*** Speech and Language Therapy** includes the evaluation by a speech therapist of a person's ability to use and understand language and communicate with others, or to manage swallowing or related conditions, and treatments to help enhance speech, communication, or swallowing.

Substance Abuse Treatment Services (descriptions follow the mental health services, and can be found on pages 39-40.)

Supports Coordination or Targeted Case Management: A Supports Coordinator or Case Manager is a staff person who helps write an individual plan of service and makes sure that the services are delivered. His or her role is to listen to a person's goals and to help find the services and providers, inside and outside of the local community mental health services program, that will help achieve the goals. A Supports Coordinator or Case Manager may also connect a person to resources in the community for employment, community living, education, public benefits, and recreational activities.

Supported / Integrated Employment Services provide initial and ongoing supports, services and training, usually provided at the job site, to help adults who are eligible for mental health services find and keep paid employment in the community.

Transportation may be provided to and from your home in order for you to take part in a covered service. Some transportation services are provided by your health plan. To arrange transportation to your covered services, contact your health plan or your Care Manager.

Treatment Planning assists the person and those of his/her choosing in the development and periodic review of the individual plan of services.

Home and Community-Based Waiver Services

Some MI Health Link participants, who need more intense services in order to remain in their homes and avoid nursing home placement, are eligible for Home and Community-Based Waiver Services. These services are more intense or more frequent than other services like them that are available through MI Health Link. These services are coordinated with your Health Plan. Talk to your Care Manager if you think you might need these services.

Adult Day Program: The plan covers structured day activities at a program of direct care and supervision, if you qualify. Adult Day programs provide personal attention, and promote social, physical and emotional well-being.

****Assistive Technology:** The plan covers technology items used to increase, maintain, or improve functioning and promote independence, if you qualify. Some examples of covered services include:

- Van lifts
- Hand controls
- Computerized voice system
- Communication boards
- Voice activated door locks
- Power door mechanisms
- Specialized alarm or intercom
- Assistive dialing device

Chore Services: The plan covers services needed to maintain your home in a clean, sanitary, and safe environment if you qualify. Examples of services include:

- Heavy household chores (washing floors, windows, and walls)
- Tacking loose rugs and tiles
- Moving heavy items of furniture
- Mowing, raking, and cleaning hazardous debris such as fallen branches and trees
- The plan may cover materials and disposable supplies used to complete chore tasks.

****Environmental Modifications:** The plan covers modifications to your home if you qualify. The modifications must be designed to ensure your health, safety and welfare or make you more independent in your home. Modifications may include:

- Installing ramps and grab bars
- Widening of doorways
- Modifying bathroom facilities
- Installing specialized electric systems that are necessary to accommodate medical equipment and supplies

Expanded Community Living Supports: To get this service, you MUST have a need for prompting, cueing, observing, guiding, teaching, and/or reminding to help you complete activities of daily living (ADLs) like eating, bathing, dressing, toileting, other personal hygiene, etc.

If you have a need for this service, you can also get assistance with instrumental activities of daily living (IADLs) like laundry, meal preparation, transportation, help with finances, help with medication, shopping, go with you to medical appointments, other household tasks. This may also include prompting, cueing, and guiding, teaching, observing, reminding, and/or other support to complete IADLs yourself.

Fiscal Intermediary Services: The plan will pay for a fiscal intermediary (FI) to help you if you are using a self determination arrangement to chose your own staff to work with you. The FI helps you to manage and distribute funds contained in the individual budget. You use these funds to purchase home and community based services authorized in your plan of care. You have the authority to hire the caregiver(s) of your choice.

Goods and Services is a non-staff service that replaces the assistance that staff would be hired to provide. This service, used in conjunction with self-determination arrangements, provides assistance to increase independence, facilitate productivity, or promote community inclusion.

Home delivered meals: The plan covers up to two prepared meals per day brought to your home, if you qualify.

Non-medical transportation: The plan covers transportation services to enable you to access waiver and other community services, activities, and resources, if you qualify.

Out-of-home Non-Vocational Supports and Services is assistance to gain, retain, or improve in self-help, socialization or adaptive skills.

Personal Emergency Response devices help a person maintain independence and safety, in their own home or in a community setting. These are devices that are used to call for help in an emergency.

Preventive Nursing Services: The plan covers nursing services provided by a registered nurse (RN) or licensed practical nurse (LPN). You must require observation and evaluation of skin integrity, blood sugar levels, prescribed range of motion exercises, or physical status to qualify. You may receive other nursing services during the nurse visit to your home. These services are not provided on a continuous basis.

Prevocational Services include supports, services and training to prepare a person for paid employment or community volunteer work.

****Private Duty Nursing (PDN):** The plan covers skilled nursing services on an individual and continuous basis, up to a maximum of 16 hours per day, to meet your health needs directly related to a physical disability. PDN includes nursing assessment, treatment, and observation provided by licensed nurse, consistent with physician's orders and in accordance with your plan of care. You must meet certain medical criteria to qualify for this service.

Respite Care Services: You may receive respite care services on a short-term, intermittent basis to relieve your family or other primary caregiver(s) from daily stress and care demands when they are providing unpaid care.

Respite is not intended to be provided on a continuous, long-term basis where it is a part of daily services that would enable an unpaid caregiver to work elsewhere full time. Respite is not used to provide relief to paid hourly or shift workers.

Substance Use Treatment Services

This page and the next list the substance use treatment services that may be available to you under MI Health Link. Remember that **you will not be eligible for all the services listed** — the services you will receive will be based on your individual needs. You must meet **medically-necessary** criteria for any MI Health Link covered services. Medical necessity means that the service is needed to manage an identified medical issue.

The Substance Abuse treatment services listed below are covered by MI Health Link. These services are available through MCCMH/MCOSA:

Access, Assessment and Referral (AAR) determines the need for substance abuse services and will assist in getting to the right services and providers. In Macomb County, screening is coordinated through the Access Center.

Compliance Monitoring: Covered for the purpose of abstinence or relapse when it is part of the treatment plan or an identified part of the treatment program.

Detoxification/ Withdrawal Monitoring: Covered for the purpose of preventing or alleviating medical complications related to no longer using a substance.

Early Intervention: Includes stage-based interventions for individuals with substance use disorders and individuals who may not meet the threshold of abuse or dependence but are experiencing functional or social impairments as the result of use.

Family Therapy: Face to face counseling with you and your family/ significant other, including non-traditional family members, to help you with your substance use.

Group Therapy: Face to face counseling with three or more beneficiaries, including lectures, therapeutic interventions or counseling, and other group activities.

Individual Treatment planning: Planning your substance use treatment services. Planning must include you, and must include recovery support and relapse prevention activities.

Individual counseling: Face to face counseling with you regarding your substance use.

Intensive/ Enhanced Outpatient (IOP or EOP) is a service that provides more frequent and longer counseling sessions each week and may include day or evening programs.

Outpatient Treatment includes therapy/counseling for the individual, and family and group therapy in an office setting.

Peer Recovery and Peer Support: Peer supported services are designed and delivered by individuals in recovery and offer social, emotional, and educational supportive services to help prevent relapse and promote recovery.

Pharmacological and Alternative Therapies: This may include methadone treatment or other medication-assisted treatment. Medication assisted treatments stabilize your condition and allow other parts of your treatment, like counseling or peer services, to be more helpful.

Referral, Linking, and Coordinating of Services: These services help you follow through with other needed substance use services and to address other needs identified in your assessment, and to help you access other levels of care if you need them.

Residential Treatment is intensive therapeutic services which include overnight stays in a staffed licensed facility.

Sub-Acute Detoxification is medical care in a residential setting for people who are withdrawing from alcohol or other drugs.

Substance Abuse Prevention Services: These are services that are designed to help reduce the risk of using substances or becoming substance dependent. These services promote healthy behaviors, delay the age of first use, reduce consumption, and support recovery. Prevention services are provided in a variety of settings throughout the community.

Targeted Case Management: A Targeted Case Manager is a staff person who helps write an individual plan of service and makes sure that the services are

delivered. His or her role is to listen to a person's goals and to help find the services and providers, inside and outside of the substance use services program, that will help achieve the goals. A Targeted Case Manager may also connect a person to resources in the community for employment, community living, education, public benefits, and recreational activities.

Women's Specialty Services: These substance use treatment services include enhanced supports for pregnant women or women who are caring for dependent children. These services will help women get substance use treatment services and attend physical health appointments.

MCOSA

The Macomb County Office of Substance Abuse (MCOSA) is the division of MCCMH that manages substance abuse services. Through MCOSA, MCCMH subcontracts with community agencies to provide publicly-funded substance abuse prevention and treatment services to residents in Macomb County who qualify for publicly-funded treatment services. MCOSA also provides recipient rights protections and complaint resolution for those who use substance abuse services in Macomb County.

If you would like to learn about Substance Abuse Treatment services, call MCCMH MI Health Link Customer Service.

Calling MI Health Link Customer Service

MI Health Link Customer Services and Ombudsman 1-855-996-2264

Service Hours: Monday thru Friday, 8:00 a.m. to 8:00 p.m.
After Regular Business Hours: The Crisis Center 1-855-927-4747

Remember: These offices are equipped with telephone interpreter services for those who best use a language other than English. If you use a TTY, call the Michigan Relay Center at 711 to reach any MCCMH office.

Participation in Clinical Research Studies

What is a clinical research study?

A clinical research study (also called a clinical trial) is a way doctors test new types of health care or drugs. They ask for volunteers to help with the study. This kind of study helps doctors decide whether a new kind of health care or drug works and whether it is safe.

If you volunteer for a clinical research study, we will pay any costs if Medicare or MCCMH approves the study. If you are part of a study that Medicare or MCCMH has not approved, you will have to pay any costs for being in the study.

Are Services Covered When You Are In A Clinical Research Study?

Once Medicare or MCCMH approves a study you want to be in, someone who works on the study will contact you. That person will tell you about the study and see if you qualify to be in it. You can be in the study as long as you meet the required conditions. You must also understand and accept what you must do for the study.

If you are in a Medicare-approved clinical research study, Medicare pays for most of the covered services you get. While you are in the study, you may stay enrolled in our plan. That way you continue to get care not related to the study.

If you want to participate in a Medicare-approved clinical research study, you do not need to get approval from us or your primary care provider. The providers that give you care as part of the study do not need to be network providers.

You do need to tell us before you start participating in a clinical research study. Here's why:

- We can tell you if the clinical research study is Medicare-approved.
- We can tell you what services you will get from clinical research study providers instead of from our plan.

If you plan to be in a clinical research study, you or your Supports Coordinator should contact the Access Center.

When you are in a clinical research study, who pays for what?

Once you join a Medicare-approved clinical research study, you are covered for most items and services you get as part of the study. This includes:

- Room and board for a hospital stay that Medicare would pay for even if you weren't in a study.
- An operation or other medical procedure that is part of the research study.
- Treatment of any side effects and complications of the new care.

Medicare pays most of the cost of the covered services you get as part of the study. After Medicare pays its share of the cost for these services, MI Health Link will also pay for the rest of the costs.

Learning more

You can learn more about joining a clinical research study by reading "Medicare & Clinical Research Studies" on the Medicare website (http://www.medicare.gov/publications/pubs/pdf/02226.pdf).

You can also call:
1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week.
TTY users should call 1-877-486-2048.

Services in Religious Settings

What is a religious non-medical health care institution?

A religious non-medical health care institution is a place that provides care you would normally get in a hospital or skilled nursing facility. If getting care in a hospital or a skilled nursing facility is against your religious beliefs, we will cover care in a religious non-medical health care institution. You may choose to get health care at any time for any reason. This benefit is only for Medicare Part A inpatient services (non-medical health care services). Medicare will only pay for non-medical health care services provided by religious non-medical health care institutions.

What care from a religious non-medical health care institution is covered by MI Health Link?

To get care from a religious non-medical health care institution, you must sign a legal document that says you are against getting medical treatment that is "non-excepted." **"Non-excepted" medical treatment** is any care that is voluntary and not required by any federal, state, or local law.
"Excepted" medical treatment is any care that is not voluntary and is required under federal, state, or local law.

To be covered by our plan, the care you get from a religious non-medical health care institution must meet the following conditions:

- The facility providing the care must be certified by Medicare.
- MI Health Link's coverage of services is limited to non-religious aspects of care.
- MI Health Link will cover the services you get from this institution in your home, as long as they would be covered if given by home health agencies that are not religious non-medical health care institutions.

If you get services from this institution that are provided to you in a facility, the following applies:

- You must have a medical condition that would allow you to get covered services for inpatient hospital care or skilled nursing facility care.
- **You must get approval from MI HealtlhLink before you are admitted to the facility, or your stay will not be covered.**

Excluded Services

This section tells you what kinds of benefits are excluded for behavioral health treatment by MI Health Link. "Excluded" means that MI Health Link does not pay for these behavioral health benefits.

MCCMH will not pay for the excluded medical benefits listed in this section (or anywhere else in this Member Handbook). Medicare and Michigan Medicaid will not pay for them, either. If you think that we should pay for a service that is not covered, you can file an appeal. For information about filing an appeal, see page 56.

In addition to any exclusions or limitations described anywhere else in this Member Handbook, the following items and services are not covered for the use or treatment of behavioral health care needs by MI Health Link.

- Services that are not considered "reasonable and necessary," according to the standards of Medicare and Michigan Medicaid, unless these services are listed by our plan as covered services.
- Experimental medical and surgical treatments, items, and medicines, unless covered by Medicare or under a Medicare-approved clinical research study. See page 42 for more information on clinical research studies. Experimental treatment and items are those that are not generally accepted by the medical community.
- Private duty nurses, except for those that qualify for the Home and Community Based Waiver service.
- Acupuncture (Note that acupuncture may be covered under your medical benefit for a physical health condition, but it is not a behavioral health benefit.)
- Naturopath services, also known as Homeopathic services (the use of natural or alternative treatments).
- Hospice services: If you choose to enroll in a hospice program, you will be dis-enrolled from MI Health Link, and will receive all of your medical care and services through Original Medicare and Original (fee-for-service) Michigan Medicaid.
- Non-emergency services provided to veterans in Veterans Affairs (VA) facilities.
- Environmental intervention
- Geriatric day programs

- Individual psychophysiological therapy that incorporates biofeedback training (of any kind or type)
- Marriage counseling
- Pastoral counseling
- Report preparation
- Clinical interpretation or explanation of medical or physical health results or data
- Transportation for the purposes of social and community inclusion, and meals. Transportation is provided by your plan for all behavioral healthcare appointments.
- Telephone services

Your Physical Health Care

MI Health Link Health Plan Services

If you are enrolled in MI Health Link, you may be entitled to other medical services not listed in this handbook. Services necessary to maintain your physical health are provided or ordered by your primary care doctor. If you receive MCCMH services, MCCMH will work with your primary care doctor to coordinate your physical and mental health services. If you do not have a primary care doctor, MCCMH or your Health Plan will help you find one.

If you are enrolled in a Medicaid Health Plan, the following kinds of health care services are available to you when your medical condition requires them:

- Acupuncture (for a physical health condition)
- Ambulance
- Chiropractic
- Doctor visits
- Family planning
- Health check ups
- Hearing aids
- Hearing and speech therapy
- Home Health Care
- Immunizations (shots)
- Lab and X-Ray
- Medical supplies
- Medicine
- Nursing Home Care
- Physical and Occupational therapy
- Prenatal care and delivery
- Surgery
- Transportation to medical appointments
- Vision

If you already are enrolled in one of the health plans listed on the next page, you can contact your health plan directly for more information about the services listed above. If you are not enrolled in a health plan or do not know the name of your health plan, you can call the Office of Community Relations/ Customer Service for assistance.

Mi Health Link Health Plans

In Macomb County, these health plans serve persons who are enrolled in MI Health Link. If you aren't sure which health plan covers you, look on the back of your MI Health Link member card for the name and number of your Health Plan.

If you are covered by a MI Health Link Health Plan, you have information rights, appeal rights, and other rights related to the services provided by your health plan. These rights are separate from and in addition to the rights you have while you receive services from MCCMH. If you have questions about the additional services covered by your Health Plan, contact the Customer Services Office for your health plan at the number provided.

Aetna Better Health of Michigan, Inc.
Website:
https://www.AetnaBetterHealth.com

Customer Service: 1-855-676-5772

AmeriHealth Michigan, Inc.
Website:
https://www.Amerihealthcaritas.com

Customer Service: 1-888-667-0318

Meridian Complete
Website: https://mmp.meridian.com

Customer Service: 1-844-239-7387

HAP Empowered
Website: https://www.Hap.org

Customer Service: 1-888-654-0706

Molina Healthcare, Inc.
Website:
https://www.MolinaHealthcare.com

Customer Services: 1-855-735-5604

Transportation to Your Services

Your Health Plan will help you get transportation to your covered services if you need it. Please contact your health plan at the number above for information about how to get transportation to your services.

Coordination of Care

To improve the quality of services, MCCMH will coordinate your care with the medical provider who cares for your physical health. If you are also receiving substance abuse services, your mental health care will also be coordinated with those services. Being able to coordinate with all providers involved in treating you improves your chances for recovery, relief of symptoms and improved functioning.

If you do not have a medical doctor and need one, contact the Community Relations/ Customer Services Office and we will assist you in getting a medical provider.

Enrolling in MI Health Link

If you would like to enroll in MI Health Link, learn about different MI Health Link Health Plans in Macomb County, or change your Health Plan, contact **Michigan Enrolls: 1-888-367-6557.**

Changing Your Health Plan

As a MI Health Link member, you have the right to change your health plan at any time. If you change your health plan, the change will be effective the first day of the month following the change. To change your MI Health Link Health Plan, contact **Michigan Enrolls: 1-888-367-6557.**

Leaving MI Health Link

If you would like to leave MI Health Link, learn about different MI Health Link Health Plans in Macomb County, or change your Health Plan, contact **Michigan Enrolls: 1-888-367-6557.**

See page 86 for more information about leaving MI Health Link.

Making a Complaint

We want to work with you to make sure that your experiences with MCCMH are effective, satisfying, and problem-free. From time to time, concerns about your services may arise. **You have the right, at any time, to tell us if you are dissatisfied** with anything about your services or about your experience with MCCMH.

Calling about a Complaint

MI Health Link Customer Services and Ombudsman 1-855-996-2264

Service Hours: Monday thru Friday, 8:00 a.m. to 8:00 p.m.
After Regular Business Hours: The Crisis Center 1-855-927-4747

Remember: These offices are equipped with telephone interpreter services for those who best use a language other than English. If you use a TTY, call the Michigan Relay Center at 711 to reach any MCCMH office.

As a MI Health Link member, your concern may be resolved in a number of ways:

- **Informal Resolution:** If you are unhappy with something about your services or your experience with MCCMH, we encourage you to tell us. Talk to your therapist, care manager or their supervisors, to see if your concern can be resolved right in the clinic. However, **you don't have to do this** if it makes you uncomfortable. You may try talking while you use other formal methods, too.

- If you are receiving MCCMH services and you are dissatisfied, **you may file a complaint**. A **complaint (also called a grievance)** is a formal expression of dissatisfaction with something about your service delivery or your experience with one of our staff, contractors, or service sites. You may file a grievance verbally or in writing. When you file a grievance, MCCMH must acknowledge your concern in writing and must work with you to resolve it within 90 days.

- If you disagree with our coverage decisions, or with some parts of your Care Plan (Plan of Service), you may file an appeal. The next section of this booklet explains how to file an appeal about our coverage decision.

If you are dissatisfied with something about your services, we want you to tell us. If you tell us you are unhappy with something, the Ombudsman will work with you to try to solve the problem. He or she will help you make a formal complaint, if you want to do so.

What kinds of concerns may be complaints?

The formal complaint process is used for certain types of problems only. Here are examples of the kinds of problems handled by the formal complaint process:

- Concerns about quality
- Concerns about privacy.
- Concerns about customer service.
- Concerns about the ways that a staff member of MCCMH or its contractors treated or spoke to you.
- Concerns about the physical accessibility of our sites, or about a failure to provide a reasonable accommodation for a disability that impacts your access to our services.
- Concerns about a failure to provide you with language assistance, including an interpreter, when you need one.
- Concerns about wait times, timeliness of our responses, or other complaints about the time it takes to get into contact with MCCMH, including the time it takes to get an appointment.
- Concerns about the cleanliness of our service sites or locations.
- Concerns about notices or communications you received from us.
- Concerns about a failure to explain our notices or actions to you in a way you understand.
- Concerns about whether we are meeting required deadlines for making a coverage decision, or about providing a service that has been granted following an appeal.
- Concerns about whether or not we forwarded an appeal to the Independent Reviewer on time, when we are required to do so.

Internal and External Complaints

If you are unhappy with something about your service experience, you can make an Internal Complaint and/or an External Compliant. An **Internal Complaint** is reviewed by MCCMH. An **External Complaint** is reviewed by an organization that is not affiliated with MCCMH.

Please note: Your Health Plan will make coverage decisions for medical care, long term supports and services and drug coverage. Contact your ICO for information about Internal Complaints about medical care.

How to file an Internal Complaint with Macomb County Community Mental Health (MCCMH):

To file an internal complaint, call MCCMH MI Health Link Customer Service, toll free at 1-855-996-2264. Your call will be directed to our Ombudsman, who will help you with our concern.

You can also put your complaint in writing and send it to us. If you put your complaint in writing, we will respond to you in writing. To make a complaint in writing, send it to:

MI Health Link Ombudsman
19800 Hall Road
Clinton Township, MI 4803

Timelines and Deadlines
All of our actions about your care and concerns must be done within certain timelines. Sometimes, you have timelines, too. Important timelines in the complaint process include:

Making the Complaint: If you are requesting action regarding a Medicare issue, **you, or someone helping you, may make the complaint at any time** after you had the problem.

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Responding to your Complaint: When you make a complaint, we will answer you right away, if we can. If you call us with a complaint, we may be able to give you an answer on the same phone call. If you write to us, it may take longer for us to respond. If your health condition requires us to answer quickly, we will do that.

Most complaints must be addressed within 30 days and resolved within 90 days. The timeframe may be extended by up to 14 calendar days if:

- We need more information to resolve the complaint, and/ or we believe the delay is in your best interest. If we need more time, we will tell you why in writing.
- If you request a delay or ask for more time

If you are making a complaint because we denied your request for a "fast coverage decision" or a "fast appeal," we will automatically give you a "fast complaint" and will respond to your complaint within 24 hours.

Even if we do not resolve your complaint in the way you might like, we will tell you why, and we will try to work with you to make your specific concern better, if we can.

External Complaints

In addition to the internal complaint process, you have the right to file complaints with these external organizations, which are independent of MCCMH or your health plan.

You may make complaints about Accessibility and Language Assistance with the Office of Civil Rights

If you have a complaint specifically about **disability access or about language assistance**, you can file a complaint with the Office of Civil Rights at the United States Department of Health and Human Services. The contact information for the Office of Civil Rights is:

233 N. Michigan Ave., Suite 240
Chicago, IL 60601
Phone: 1-800-368-1019
Fax: 312-886-1807
TDD: 1-800-537-7697

You can also contact the Michigan Department of Civil Rights at:
110 W. Michigan Ave., Suite 800
Lansing, MI 48933
Phone: 517-335-3165
Fax: 517-241-0546
TTY: 517-241-1965

You may also have rights under the Americans with Disabilities Act.

You may make complaints about quality of care to the Quality Improvement Organization

The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the federal government to review and improve the care given to Medicare patients.

When your complaint is about quality of care, you have ways to file your external complaint:

- You can make your complaint about the quality of care directly to the Quality Improvement Organization (without making the complaint to us).
- You can make your complaint to us and to the Quality Improvement Organization. If you make a complaint to this organization, we will work with them to resolve your complaint.

To make a complaint with the Quality Improvement Organization call them. Their toll free number is 1-855-408-8557 (TTY: 1-855-843-4776).

You may tell Medicare about your complaint

Medicare takes your complaints seriously, and will use the information to help improve the quality of the Medicare program.

The Medicare Complaint Form is available at: https://www.medicare.gov/MedicareComplaintForm/home.aspx

If you have any other feedback or concerns, or if you feel the plan is not addressing your concern, you can call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users can call 1-877-486-2048. The call is free.

You may tell Medicaid about your complaint

If your concern is about a Medicaid covered service, you can make your complaint to Medicaid. To file a compliant with Medicaid, call the Beneficiary Help Line at 1-800-642-3195 (TTY 1-866-501-5656) The Medicaid Beneficiary Helpline is available Monday through Friday from 8:00 AM to 7:00 PM.

You may tell the MI Health Link Ombudsman about your complaint
The MI Health Link Ombudsman helps solve problems from a neutral standpoint, to make sure that MI Health Link members get all the covered services that we are required to provide. The MI Health Link Ombudsman is not connected with MCCMH, or with any insurance company or health plan.

To find out about the MI Health Link Ombudsman, call toll free at 1-888-746-6456; or email them at help@mhlo.org. You can find more information about the MI Health Link Ombudsman on the MI Health Link Members page of our website, www.mccmh.net. The services of the MI Health Link Ombudsman are free. TTY users may call the MI Health Link Ombudsman using the Michigan Relay Center, 711.

You may tell the State of Michigan if you have a problem with how your provider follows your wishes
For complaints about how your provider follows your wishes, call 517-373-9196

Or write to:
Michigan Department of Licensing and Regulatory Affairs
Bureau of Health Care Services
Enforcement Division
P.O. Box 30454
Lansing, MI 48909-9897

Making a Complaint

MI Health Link Customer Services and Ombudsman 1-855-996-2264
Service Hours: Monday thru Friday, 8:00 a.m. to 8:00 p.m.
After Regular Business Hours: The Crisis Center 1-855-927-4747

Remember: These offices are equipped with telephone interpreter services for those who best use a language other than English. If you use a TTY, call the Michigan Relay Center at 711 to reach any MCCMH office.

Making an Appeal

- **Internal Appeal:** If you, or your provider acting on your behalf, disagree with a decision we made to deny you a service or benefit, you may request an internal appeal within 60 days of the date on the letter that told you about our action.

An Internal appeal is a formal way of asking MCCMH to review a coverage denial, or any action that we took to deny or limit your mental health, developmental disability, or substance use disorder services.

An Internal Appeal (also called a Level 1 Appeal or Local Dispute Resolution) is the first level appeal in MI Health Link. If you request a review of our decision, we will review it to decide if it is correct. The reviewer will be someone who did not make the original decision. When we complete the review, we will give you our decision in writing. We will tell you the reasons for our decision, and what you can do next if you disagree with the decision. We must complete the Internal Appeal within 30 days of your request for one. In some cases, we may request up to 14 additional days to complete the process. If we do so, we will tell you why in writing.

- External Appeal: If your concern is about a Medicaid covered service, you can also request a Medicaid Fair Hearing with the Michigan Administrative Hearing System. You must request a Medicaid Fair Hearing within 120 days of the date on the letter that told you about our internal appeal determination. If your concern is about a Medicaid covered service, your appeal will not automatically be forwarded to MAHS. You can request the Medicaid Fair Hearing yourself. You will be provided with information and assistance to do so, if you wish.

If your concern is about a Medicare covered service, you will automatically get an External Appeal with the Independent Review Entity (IRE) as soon as the Internal Appeal is complete.

If your problem is about a service or item that could be covered by both Medicare and Medicaid, you will automatically get an External Appeal with the IRE. You can also ask for an External Appeal with MAHS.

Only certain actions, called "adverse actions" by MCCMH are appealable. An adverse action is an action, or lack of action, by MCCMH regarding your services. Appealable adverse actions include:

- We denied or limited a service that you or your provider requested;
- We reduced, suspended, or ended coverage that was already approved;
- We did not pay for an item or service that you think is covered;
- We did not resolve your service authorization request within the required timeframes;
- We did not provide a covered service from a provider in our network within a reasonable amount of time;
- We did not act within the required timeframes for reviewing a coverage decision and giving you a decision; or
- We did not resolve your grievance within required timeframes.
- You may also request an internal appeal if you do not agree with the contents of your Person-Centered Plan.

Please note: Your Health Plan will make coverage decisions for medical care, long term supports and services, and medication coverage. Contact your Health Plan for more information. Appeals made to MCCMH are only about your mental health, developmental disability, or substance use disorder treatment or services.

Requesting an Appeal

MI Health Link Customer Services and Ombudsman 1-855-996-2264
Service Hours: Monday thru Friday, 8:00 a.m. to 8:00 p.m.
After Regular Business Hours: The Crisis Center 1-855-927-4747

Remember: These offices are equipped with telephone interpreter services for those who best use a language other than English. If you use a TTY, call the Michigan Relay Center at 711 to reach any MCCMH office.

How do I make an Internal Appeal?
To start your internal appeal, you, your guardian, your representative, or your provider must contact us. Call the Ombudsman toll free at 1-855-996-2264. Call us within 60 days of the date on the letter.

What are the timeframes for resolving my Internal Appeal?
As a MI Health Link Member, your internal appeal must be heard and resolved within 30 days of your request for the appeal. We may ask for an extension of up to 14 days in some situations. This is called "standard timeframes."

Can I get a faster decision?
If you feel that waiting for a decision within standard timeframes will seriously jepordize your life or health, you may ask for an expedited appeal. If we agree that a delay will place you at risk, we must hear your appeal within 24 hours and make a decision within 72 hours. This is called an "Expedited Appeal." If we feel we can safely meet your needs while you wait for an appeal in standard timeframes, we may deny your request for an expedited appeal and provide you with one in the standard time.

Where should I send a letter requesting an Internal appeal?
To request an appeal or an expedited appeal, call us at 1-855-996-2264, or write to us. Send your letter requesting an internal appeal to:

Macomb County Community Mental Health
Hearing Officer
19800 Hall Rd.
Clinton Township, MI 48038
Fax: 586-948-0223

Who Can Request an Internal Appeal for Me?
Ordinarily, you must request the appeal if you are your own legal guardian. If you have a legally appointed guardian, the guardian must request the appeal for you. Your doctor or other provider can also request the appeal for you, with your permission.

You can also direct that someone else make the appeal for you, but if you want someone other than yourself , your guardian, or your provider to make the appeal on your behalf, you must first fill out an **Appointment of Representative Form**. This form tells us that you have given the other person permission to act for you in the appeal process. You can find the form on our website at www.mccmh.net. Go to the MI Health Link tab. The form is also available on the Medicare website. Or, call our Ombudsman at 1-855-996-2264 for help getting the form.

Can I use a Lawyer in the Appeal Process? Yes. You have the right to have a lawyer act for you. If you want to use a lawyer, we still need the Appointment of Representative Form filled out and signed, so that we know the lawyer has your permission to act. If you use a lawyer, you will be responsible for legal fees. **MCCMH will not pay your legal costs, even if you win your appeal.** If you want to use a lawyer and you cannot afford one, there are free legal services available in Macomb County that may be able to help. Contact the Macomb County Bar Association, Lakeshore Legal Services, or a disability rights advocacy organization for help. The MCCMH Ombudsman can help you get these numbers. You usually will not need a lawyer for the internal/ local appeals process.

How do I request a Medicaid Fair Hearing?
If your concern is about a Medicaid covered service, you can also ask for a Medicaid Fair Hearing. To ask for a Medicaid Fair Hearing from the Michigan Administrative Hearing System, you must complete a Request for Hearing form. We will send you a Request for Hearing form with the coverage decision letter. You can also get the form by calling the Medicaid Beneficiary Help Line at 1-800 -642-3195 (TTY: 1-866-501-5656), open Monday through Friday from 8:00 AM to 7:00 PM.

Complete the form send it to:
Michigan Administrative Hearing System
Department of Community Health
PO Box 30763
Lansing, MI 48909
FAX: 517-373-4147

You can also ask for an expedited Medicaid Fair Hearing by writing to the address or faxing to the number listed above.

When MAHS receives your request for a Medicaid Fair Hearing, you will get a letter telling you the date, time, and place of your hearing. At a Medicaid Fair Hearing, the judge is usually on the phone, but you can request that your hearing be conducted in person.

MAHS must give you an answer in writing within 90 calendar days of when it gets your request for a Fair Hearing. If you qualify for an expedited Fair Hearing, MAHS must give you an answer within 72 hours. However, if MAHS

needs to gather more information that may help you, it can take up to 14 more calendar days.

Following receipt of the MAHS final decision, you have 30 calendar days from the date of the decision to file a request for rehearing/reconsideration and/or to file an appeal with the Circuit Court.

What is the External Review Process for a Medicare covered Service?

If your concern is about a Medicare covered service, you must first use the Internal Appeal Process to resolve it. If we uphold the denial at the Internal Appeal level, you will automatically receive an Independent External Review of the decision. You do not need to do anything to request the Independent review.

The Independent Review Entity will do a careful review of the Internal Appeal decision, and decide whether it should be changed. We will automatically send any denials (in whole or in part) to the Independent Review Entity. We will notify you when this happens.

The Independent Review Entity must provide an answer to your External Appeal within 30 calendar days after receiving the appeal information. However, if the Independent Review Entity needs to gather more information that may benefit you, it can take up to 14 more calendar days. If the IRE needs extra days to make a decision, it will tell you by letter.

If you had a faster, or "expedited" appeal at the Internal Appeal, you will automatically receive an expedited appeal at the External Appeal. The review organization must give you an answer within 72 hours of when it gets your expedited appeal. However, if the Independent Review Entity needs to gather more information that may benefit you, it can take up to 14 more calendar days. If the IRE needs extra days to make a decision, it will tell you by letter.

The Independent Review Entity is hired by Medicare and is not connected with the MI Health Link Program, your Health Plan, or MCCMH.

What if my service or item is covered by both Medicare and Medicaid?

If your concern is about a service or item that could be covered by both Medicare and Medicaid, and we uphold the denial in the Internal Appeal, we will automatically send your External Appeal to the Independent Review Entity. You may also request a Medicaid Fair Hearing about the issue. You or your guardian will need to make the request for the Medicaid Fair Hearing. See page 59 for instructions about doing this.

How will I find out about the External Appeal Decision?

If you requested a Medicaid Fair Hearing, MAHS will send you a letter explaining the Medicaid Fair Hearing decision.

If MAHS says Yes to all or part of what you asked for, we must approve the service for you as quickly as your condition requires, but no later than 72 hours from the date we receive MAHS' decision.

If MAHS says No to all or part of what you asked for, it means they agree with the Internal Appeal decision. This is called "upholding the decision" or "turning down your appeal." If the appeal is upheld, we will not provide the service.

If your External Appeal went to the Independent Review Entity, it will send you a letter explaining its decision.

If the Independent Review Entity says Yes to all or part of what you asked for, we must authorize the coverage as quickly as your condition requires, but no later than 72 hours from the date we receive the IRE's decision.

If the Independent Review Entity says No to all or part of what you asked for, it means they agree with the Internal Appeal decision. This is called "upholding the decision" or "turning down your appeal." If the appeal is upheld, we will not provide the service.

What if the External Reviewers have different decisions?

If either MAHS (Medicaid Fair Hearing) or the IRE (Medicare External Review Entity) decide that we should have given you all or part of what you asked for, we will give you the approved service or item that is closest to what you asked for in your appeal.

If the decision is No for all or part of what I asked for, can I make another appeal?

If MAHS and the IRE both uphold our denial ("say no" to your appeal), we will not provide the service. You may continue to appeal the part of your concern that went to a Medicaid Fair Hearing. You may ask for "Reconsideration" or a "Rehearing" from the MHAS system. You may also appeal to the Circuit Court. You must do either or both within 30 days of receiving the Medicaid Fair Hearing Decision. Your disputed services will not continue while you seek further appeals.

As a MI Health Link Member, you have other rights when you use the Appeals processes available to you. Your additional rights include the right to:

Continue Your Services: If you request an Internal Appeal or a Medicaid Fair Hearing, you may request that your previously authorized services continue as they are until the Hearing process has concluded. In order for your services to continue, we must receive your request for an internal appeal or a Medicaid Fair Hearing within 12 days of the date on letter that informed you of our action. If you request continuation of your services and the Hearing Officer agrees with the decision of MCCMH, you may be required to pay for services you received while the Hearing was in process.

Notice in Writing: Whenever MCCMH makes a decision to deny, reduce, terminate or suspend services you have requested or that you have already been receiving, we must provide you with written notice of the action and the reasons for our decision. When your grievance or appeal is resolved, you will also receive a written summary of the decision we made or the action we took, including the reason for the decision.

Notice of Further Appeal Rights: When we make a decision about your services or your appeal, we must provide you with information about your additional appeal rights.

Representation and Witnesses: When you request an Appeal or a Medicaid Fair Hearing, you are entitled to bring information and witnesses and/or to have representation to help you.

Recipient Rights: Any time you file a grievance, request a second opinion, or use the Appeal process, you may also file a Recipient Rights Complaint with the Office of Recipient Rights.

Help with Your Concern

MI Health Link Customer Services and Ombudsman 1-855-996-2264
Service Hours: Monday thru Friday, 8:00 a.m. to 8:00 p.m.
After Regular Business Hours: The Crisis Center 1-855-927-4747

Remember: These offices are equipped with telephone interpreter services for those who best use a language other than English. If you use a TTY, call the Michigan Relay Center at 711 to reach any MCCMH office.

Appealing Decisions about Your Hospital Care

When you are admitted to a hospital for psychiatric care services, you have the right to get all medically necessary covered hospital services to diagnose and treat your symptoms.

During your hospital stay, your doctor and the clinical staff will be working with you to stabilize your symptoms and to prepare for the day when you will leave the hospital. They will also help arrange for any care you may need after you leave. (These are called "Aftercare services.")

The day you leave the hospital is called your "**discharge date**." MI Health Link coverage of your hospital stay ends on this date. Your doctor or the hospital staff will tell you what your discharge date is.

If you think you are being asked to leave the hospital too soon, you can request a longer hospital stay. This section tells you how to ask for a longer hospital stay.

Learning about your Medicare rights

Within two days after you are admitted to the hospital, a caseworker or nurse will give you a notice called An Important Message from Medicare about Your Rights. If you do not get this notice, ask any hospital employee for it. Read this notice carefully and ask questions about things that you don't understand. The Important Message tells you about your rights as a hospital patient, including:

- Your right to get Medicare-covered services during and after your hospital stay. You have the right to know what these services are, who will pay for them, and where you can get them.
- Your right to be a part of any decisions about the length of your hospital stay.
- Your right to know where to report any concerns you have about the quality of your hospital care.
- Your right to appeal if you think you are being discharged from the hospital too soon.
- You should sign the Medicare notice to show that you got it and understand your rights. Signing the notice does not mean you agree to the discharge

date that may have been told to you by your doctor or hospital staff.
- Keep your copy of the signed notice so you will have the information in it if you need it.

To get help getting the Notice if the hospital doesn't provide it to you, please call the MCCMH Ombudsman at 1-855-996-2264. The Ombudsman is available Monday thru Friday during standard business hours. You can also call the Medicare Helpline at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

The MCCMH Ombudsman or the Medicare Helpline will help you get a copy of this Notice in Advance, if you need it.
You can also see the notice online at https://www.cms.gov/BNI/12_HospitalDischargeAppealNotices.asp.

Making a Level 1 Appeal to change your hospital discharge date

If you disagree with your planned discharge date and you want us to cover your inpatient hospital services for a longer time, you must request an appeal. Your first level appeal about hospitalization will be heard by someone outside MCCMH or your health plan. A Quality Improvement Organization will do the Level 1 Appeal review to see if your planned discharge date is medically appropriate for you.

The review entity currently contracted by Medicare to hear hospital appeals is called KePRO.

To make an appeal to change your discharge date, call KePRO (Michigan's Quality Improvement Organization) at: 1-855-408-8557 (TTY: 1-855-843-4776).

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Call right away!
Call the Quality Improvement Organization before you leave the hospital and no later than your planned discharge date. Information about how to contact KePRO is in the Notice you received from the hospital, An Important Message from Medicare about Your Rights. If you call KePRO before you leave, you are allowed to stay in the hospital after your planned discharge date without paying for it while you wait to get the decision on your appeal from the Quality Improvement Organization.

If you do not call to appeal, and you decide to stay in the hospital after your planned discharge date, you may have to pay all of the

costs for hospital care you get after your planned discharge date.

If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you may make your appeal directly to our plan instead.

Understanding How to Use Your Hospital Appeal Rights

We want to make sure you understand what you need to do and what the deadlines are for your hospital appeal.

Ask for help with your appeal if you need it. You can call the Michigan Medicare/Medicaid Assistance Program (MMAP) at 1-800-803-7174. Starting in mid-2015, you can also get help from the MI Health Link Ombudsman. For information about the MI Health Link Ombudsman, visit www.MCCMH.org or call Toll Free at 1-800-676-5814 TTY: 711 (MRC).

What is a Quality Improvement Organization?
It is a group of doctors and other health care professionals who are paid by the federal government. They are paid by Medicare to check on and help improve the quality of care for people with Medicare. These experts are not part of our plan.

Ask for a "fast review"
You must ask the Quality Improvement Organization for a "fast review" of your hospital discharge date. Asking for a "fast review" means you are asking for the organization to use the fast deadlines for an appeal instead of using the standard deadlines. This means your appeal will be heard within 24 hours and resolved within 3 days.

What happens during the review?
The reviewers at the Quality Improvement Organization will ask you or your representative why you think coverage should continue after the planned discharge date. You don't have to prepare anything in writing, but you may do so if you wish. The reviewers will look at your medical record, talk with your doctor, and review all of the information related to your hospital stay.

By noon of the day after the reviewers tell us about your appeal, you will get a letter that gives your planned discharge date. The letter explains the reasons why your doctor, the hospital, and we think it is right for you to be discharged on that date.

What if the answer is Yes?
If the review organization agrees with you about your appeal, we must keep covering your hospital services for as long as the services are medically necessary.

What if the answer is No?
If the review organization says No to your appeal, they are saying that your planned discharge date is medically appropriate. If this happens, our coverage for your inpatient hospital services will end at noon on the day after the Quality Improvement Organization gives you its answer.

If the review organization says No and you decide to stay in the hospital, then you may have to pay the full cost of hospital care you get after noon on the day after the Quality Improvement Organization gives you its answer.

Making a Level 2 Appeal for Hospital Services

If the Quality Improvement Organization turns down your appeal, and you still feel you should stay in the hospital after your planned discharge date, then you may make a Level 2 Appeal.

If the Quality Improvement Organization has turned down your appeal, and you stay in the hospital after your planned discharge date, then you can make a Level 2 Appeal. You will need to contact the Quality Improvement Organization again and ask for another review.

Ask for the Level 2 review within 60 calendar days after the day when the Quality Improvement Organization said No to your Level 1 Appeal. You can ask for a Level 2 appeal only if you stayed in the hospital after the date that your coverage for the care ended.

In a Level 2 Appeal, reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal. Within 14 calendar days, the Quality Improvement Organization reviewers will make a decision.

What happens if the answer is Yes?
If the Level 2 review agrees with you that you should be in the hospital, we must pay you back for our share of the costs of hospital care you have received since noon on the day after the date of your first appeal decision. We must continue providing coverage for your inpatient hospital care for as long as it is

medically necessary. You must continue to pay your share of the costs, and coverage limitations may apply.

What happens if the answer is No?
It means the Quality Improvement Organization agrees with the Level 1 decision and will not change it. The letter you get will tell you what you can do if you wish to continue with the appeal process. If the Quality Improvement Organization turns down your Level 2 Appeal, you may have to pay the full cost for your stay after your planned discharge date.

What happens if I miss an appeal deadline?
If you miss the deadlines for a Level 1 or Level 2 appeal, you may appeal to us instead.

If you miss appeal deadlines, there is another way to make Level 1 and Level 2 Appeals, called Alternate Appeals.

Level 1 Alternate Appeal to change your hospital discharge date
If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to us, asking for an "expedited" or "faster" appeal. An expedited appeal is an appeal that uses the fast deadlines instead of the standard deadlines.

During this review, we take a look at all of the information about your hospital stay. We check to see if the decision about when you should leave the hospital was fair and followed all the rules.

We will use the fast deadlines rather than the standard deadlines for giving you the answer to this review. We will give you our decision within 72 hours after you ask for an "expedited appeal."

If we agree that you still need to be in the hospital after the original discharge date, we will keep covering hospital services for as long as it is medically necessary. It also means that we agree to pay you back for our share of the costs of care you have received since the date when we said your coverage would end, if you paid any costs.

If our review determines that your planned discharge date was medically appropriate, then our coverage for your inpatient hospital services ends on the day we said coverage would end. If you stayed in the hospital after your planned discharge date, then you may have to pay the full cost of hospital care you got after the planned discharge date.

Level 2 Alternate Appeal to change your hospital discharge date

To make sure we were following all the rules when we denied continued hospitalization in the Alternate appeal process, we will automatically send your appeal to the **"Independent Review Entity."** When we do this, it means that your case is automatically going to Level 2 of the appeals process.

The Independent Review Entity is an independent organization that is hired by Medicare. This organization is not connected with our plan and it is not a government agency. Reviewers at the Independent Review Entity will take a careful look at all of the information related to your appeal of your hospital discharge.

We will send the information for your Level 2 Appeal to the Independent Review Entity within 24 hours of giving you our decision. If you think we are not meeting this deadline or other deadlines, you can make a complaint. Information on making a complaint starts on page 50 of this booklet.

During the Level 2 Appeal, the Independent Review Entity reviews the decision we made when we said No to your hospital appeal. This organization decides whether the decision we made should be changed.

The Independent Review Entity does an expedited review of your appeal. This means that the reviewers usually give you an answer within 72 hours.

What happens if the answer is Yes?
If the Independent Review Entity agrees with you that you need to be in the hospital, then we must pay you back for our share of the costs of hospital care you have received since the date of your planned discharge. We must also continue the plan's coverage of your hospital services for as long as hospitalization is medically necessary.

What happens if the answer is No?
If the IRE agrees with us, it means they agree that your planned hospital discharge date was medically appropriate.

The letter you get from the Independent Review Entity will tell you what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal, which is handled by a judge.

Please note: Your Health Plan will make coverage decisions for medical care, long term supports and services, and drug coverage. Contact your ICO for more information about Alternate Appeals for medical health care, items and long term supports and services.

The MI Health Link Ombudsman

To make sure that you understand all the choices you have, and all the ways you can get help solving problems with your MI Health Link services, the State of Michigan offers the help of a Statewide Ombudsman for the MI Health Link program.

The Statewide MI Health Link Ombudsman is an independent source of information about how MI Health Link works.

You can reach the MI Health Link Ombudsman by calling 1-888-756-6456, or 1-888-756-MHLO, Monday through Friday, 8 AM to 5 PM. You can email the MI Health Link Ombudsman any time at HELP@mhlo.org.

if you have questions about MI Health Link, these offices can also help:

- For **questions about enrollment or disenrollment in MI Health Link, or about changing your MI Health Link Health Plan**, call Michigan Enrolls at: 1-800-975-7630, Monday through Friday 8 AM to 7 PM. TTY users should call 1-888-263-5897.

- For **questions about Medicaid benefits**, call the Medicaid Beneficiary Helpline at: **1-800-642-3195**.

- For **questions about Medicare benefits**, call **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048.

- For questions about Medicare and Medicaid in Michigan, you can also call the **Michigan Medicare/Medicaid Assistance Program** (MMAP). MMAP can be reached at 1-800-803-7174.

- For **questions specific to your services at Macomb County Community Mental Health**, call the Macomb County CMH MI Health Link Customer Services Representative at **1-855-996-6224**.

Asking MCCMH to Pay a Bill You Received for Covered Services

If you are enrolled in MI Health Link and meet the criteria for the specialty mental health, developmental disability, or substance abuse services, the total cost of your authorized treatment will be covered. No fees will be charged to you.

Will I have premiums or copays while I am in MI Health Link?
No. You will have no premiums or co-pays as long as you are in the MI Health Link program.

Network providers cannot bill you directly
Doctors, hospitals, and other providers in our network cannot make you pay for covered services. They also cannot charge you if we pay for less than the provider charged us. If a network provider tries to charge you for covered services, please call the Macomb County CMH MI Health Link Customer Services Representative at **1-855-996-6224**.

What Should You Do if You Are Billed?
If a provider sends you a bill instead of sending it to Macomb County Community Mental Health, you should not pay the bill yourself. If you do, we may not be able to pay you back. If you have paid for your covered services or if you have gotten a bill for covered medical services, read this section to learn what to do.

What should you do if services are not covered by our plan?
Macomb County Community Mental Health covers all services:
that are medically necessary, and that are listed beginning on page 31 of this booklet. You must also follow plan rules when you get your services.

If you get services that aren't covered by MI Health Link, you must pay the full cost yourself.

If you want to know if we will pay for any behavioral health service or care, you have the right to ask us. If we say we will not pay for your services, you have the right to appeal our decision.

This section explains what to do if you want the plan to cover a treatment or service you've already received, for which you got a bill. It also tells you how to

appeal our coverage decision. You may also call the MCCMH Ombudsman to learn more about your appeal rights.

When you can ask MCCMH to pay for your services
You should not get a bill for in-network services. In-network providers must bill the plan for services you have recieved. A network provider is a provider who works with the health plan.

What to do if you get a bill
If you get a bill for services, send the bill to us. If the services are covered, we will pay the provider directly. **You should never pay a bill for health services without contacting MCCMH or your Health Plan first**.

If the services are not covered, we will tell you.
Contact Member Services or your Care Manager if you have any questions. If you get a bill and you do not know what to do about it, we can help. You can also call if you want to tell us information about a request for payment you already sent to us.

Emergency, Out of Network Services
If you get emergency or urgently needed health care from an out-of-network provider, you should ask the provider to bill MCCMH. If you paid the full amount when you got the care, please contact MCCMH as soon as possible.

You may get a bill from the provider asking for payment that you think you do not owe. If so, call MCCMH about the bill right away. Don't pay the bill yourself. If the provider should be paid, we will pay them directly. If you have already paid for the service, tell us, so we can talk with you about options.

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If a network provider sends you a bill
Network providers must always bill MCCMH.
If you get a bill from a network provider, contact MCCMH and send us the bill. We will contact the provider directly and take care of the problem. Don't pay the bill yourself. If you have already paid a bill from a network provider, please contact MCCMH to discuss options for repayment.

How and Where to Send Your Request for Payment

Please contact us if you do receive a bill from a provider. **Don't pay the bill** if you haven't already. If you have already paid for the service or made payment on the bill , please contact the MCCMH Claims Department to learn what to do. Ask your Care Manager for help contacting us about the bill.

Mail your request for payment, along with any bills or receipts, to this address:

Macomb County Community Mental Health
Claims Department
19800 Hall Rd.
Clinton Township, MI 48038

You must send the bill to us within **30 days** of the date you received the service or bill.

We Will Make A Coverage Decision

When you send MCCMH a request for payment, we will review your request and decide whether the service should be covered. This is called making a "coverage decision." If we decide that the service is covered and you followed all the rules for getting it, MCCMH will pay for the service. If we decide that only part of the service you received is covered, we will also tell you if there is any part of the bill that is your responsibility, and if so, why.

- If we agree to pay for the service and the provider has not been paid, we will pay the provider directly.
- If we agree to pay for the service and you have already paid all or part of the covered bill, we will contact you about how to pay you back.
- We will let you know if we need more information from you.

If the Service is Not Covered

If we decide that the service is not a covered benefit, or that you did not follow the rules for getting the service, we will not pay for the service. If we do not pay for the service, MCCMH will send you a letter explaining our decision. The letter will also explain your rights to make an appeal.

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You Can Make An Appeal

If you think MCCMH made a mistake in turning down your request for payment, you can ask us to change our decision. This is called making an appeal. You can also make an appeal if you do not agree with the amount we pay.

To learn more about appeals, go to page 56 of this booklet.

Office of Recipient Rights

Every person who receives public mental health services has certain rights. The Michigan Mental Health Code protects your rights when your receive our services. Some of your rights include:

- The right to confidentiality (privacy)
- The right to be free from abuse and neglect
- The right to treatment that meets your needs (also called "treatment suited to condition")
- The right to be treated with dignity and respect

More information about your many rights is contained in the booklet titled "Your Rights." You will be given this booklet, and have your rights explained to you when you first start services, and then once again every year. You can also ask for a rights booklet at any time.

You may file a Recipient Rights complaint *any time* if you think staff violated your rights. You can make a rights complaint either orally or in writing.

If you receive substance abuse services, you have rights protected by the Public Health Code. These rights will also be explained to you when you start services and then once again every year. You can find more information about your rights while getting substance abuse services in the "Know Your Rights" pamphlet.

You may contact MCCMH to talk with a Recipient Rights Officer with any questions you may have about your rights, or to get help to make a recipient rights complaint. You can contact the Office of Recipient Rights at 586-469-6528 or the Community Relations/ Customer Service office at 1-855-996-2264.

Freedom from Retaliation

If you use public mental health or substance use treatment services, you are free to exercise your rights, and to use the rights protection system without fear of retaliation, harassment, or discrimination. In addition, under no circumstances will the public mental health system use seclusion or restraint as a means of coercion, discipline, convenience, or retaliation.

Making a Recipient Rights Complaint

You may make a Recipient Rights complaint at any time if you believe your rights have been violated. You may make a Recipient Rights complaint either verbally or in writing. Others may also make Recipient Rights complaints on your behalf. To make a Recipient Rights complaint, or to learn more about your rights, call:

The Office of Recipient Rights 586-469-6528
19800 Hall Road, Clinton Township, MI 48038
Fax: 586-466-4131
Hours of Operation: 8:30 a.m. to 5:00 p.m. M-F, and by appointment.

Remember: If you prefer, we will call you back at any number you give us. These offices are equipped with telephone interpreter services for those who best use a language other than English. If you use a TTY, call the Michigan Relay Center at 711 to reach any MCCMH office.

Substance Use Recipient Rights

Every person who receives alcohol or drug abuse treatment services has certain rights protected by law. Your rights specific to substance use treatment services are spelled out in the Administrative Rules for Substance Abuse Programs in Michigan, and in other State and Federal laws.

Some of your rights include:

- The right to confidentiality (privacy)
- The right to be free from abuse and neglect
- The right to services that meet your needs
- The right to be treated with dignity and respect

You have many other rights when you receive substance abuse treatment. Ask your treatment team about your rights, or call the Office of Recipient Rights any time to learn about them.

Resolving Concerns about Substance Abuse Services

If you have concerns about substance abuse treatment services provided through MI Health Link, you may file a written or verbal complaint. The complaint will be resolved quickly and informally.

If you have MI Health Link and you have concerns about the quality, type, or amount of services authorized or provided to you, you may use the complaint and or appeal rights process outlined beginning on page 50 of this booklet.

If you believe that your substance abuse recipient rights have been violated, you may also file a Recipient Rights Complaint.

To learn more about your rights when you receive substance abuse treatment services, contact:

The Macomb County Office of Substance Abuse. 586-469-5278
19800 Hall Road, Clinton Township, MI 48038
Hours of Operation: 8:30 a.m. to 5 p.m. Monday thru Friday
After Regular Business Hours: The Crisis Center 855-927-4747

Confidentiality

Keeping your treatment information private is called **confidentiality**. Generally, information about you can only be given to others with your permission. You must sign a "**Release of Information**" to tell us who you want us to talk to about your treatment, and what information we can share. Sometimes this is simply called a "release."

You have the right to have information about your mental health treatment kept private. You also have the right to look at your own clinical records and add a formal statement about them if there is something with which you do not agree. Generally, information about you can only be given to others with your permission. However, there are times when your information is shared in order to coordinate your treatment or when it is required by law.

The Office of Recipient Rights will help you understand how confidentiality works for you, and will help you resolve any concerns about your confidentiality.

If you are receiving substance abuse treatment services, information about your alcohol or drug treatment is kept strictly confidential, as protected under federal law. The treatment program will give you a written statement that describes the federal confidentiality law and the exceptions to that protection. The treatment program or MCOSA can answer questions you have about the confidentiality of your substance abuse treatment records.

Confidentiality and Your Family

Except as required by law, we cannot tell anyone, even your family members, that you receive services from us, unless you give us permission. But, if you receive public mental health or developmental disability services, your family members may provide information to MCCMH about you to help with your treatment. Even if they do so, we cannot give information about you or your care to a family member without a Release of Information signed by you. Sign a release of information to tell us if there is anyone you want us to talk with about your treatment. Parents with legal and physical custody may give and receive information about their minor children (under the age of 18). Parents must sign a release to allow us to share their child's information with others.

The legally appointed guardian(s) of adults may also give and receive information about those for whom they have responsibility, and may authorize release of information to others.

If you receive substance abuse services, you have rights related to confidentiality specific to substance abuse services. Ask your substance use treatment provider for more information.

If you feel your confidentiality rights have been violated, you can call the Recipient Rights Office where you get services.

HIPAA

There are many laws that govern your privacy. One is **HIPAA**, the Health Insurance Portability and Accountability Act. HIPAA gives you specific rights to privacy, including notice about where and when your information is shared, and the right to request communication in certain ways or places.

Under HIPAA, you will be provided with an official Notice of Privacy Practices from MCCMH. You've probably received them from your other doctors, too. This notice will tell you all the ways that information about you can be used or shared. It will also include a listing of your rights provided under HIPAA and how you can file a complaint if you feel your right to privacy has been violated.

We Must Protect Your Personal Health Information

We must protect your personal health information as required by federal and state laws, including HIPAA. Your personal health information includes the information you gave us when you enrolled in this plan. It also includes your medical records and other medical and health information.

You have rights to get information and to control how your health information is used. We will give you a written notice that tells about these rights. The notice is called the "Notice of Privacy Practice." The notice also explains how we protect the privacy of your health information.

We will send you a new notice if we change our privacy practices, or you may ask for a Privacy Notice at any time. Information about HIPAA is posted at every MCCMH service location.

How we protect your health information

We make sure that unauthorized people do not see or change your records. In most situations, we do not give your health information to anyone except people who are providing your care or paying for your care. If we do, we are required to get written permission from you first. Written permission to share your information can be given by you, or by someone who has the legal power to make decisions for you.

There are certain cases when we do not have to get your written permission to share your information. These exceptions are allowed or required by law, and include:

- We are required to release health information to government agencies that are checking on our quality of care.
- We are required to give Medicare and Michigan Medicaid your health information. If Medicare or Michigan Medicaid releases your information for research or other uses, it will be done according to Federal and State laws.
- We are required to give information to law enforcement, when they ask for it according to certain legal requirements.

Access to Your Records

You have a right to see your medical records

- You have the right to look at your medical records and to get a copy of your records. We are allowed to charge you a reasonable fee for making a copy of your medical records.
- You have the right to amend or correct information in your medical records. The correction will become part of your record.
- You have the right to know if and how your health information has been shared with others.
- If you are an adult and you do not have a legal guardian, we cannot restrict your access to your records. If you have a legal guardian, or if you want us to disclose your records to someone else, we may deny or restrict your request if we believe the information is potentially harmful to you or someone else. If we deny your request, we must tell you why in writing.

We are allowed up to 30 days to fulfill your request to see or add to the record. If you are denied access to your record, you or someone on your behalf may appeal the decision to the MCCMH Office of Recipient Rights.

If you have questions or concerns about the privacy of your personal health information, call the MCCMH Privacy Officer, 1-855-996-2264.

Ethics of Service

MCCMH strives to provide its services within the framework of the highest ethical standards. Some important things for you to know about what you can expect while you are treated by MCCMH or its contractors include:

- You and your family can expect to be treated with dignity and respect at all times by all MCCMH direct and contract staff.

- Services will be provided in the least restrictive environment appropriate for you. Your services will be provided in safe, sanitary, and humane ways. You will not be subject to abuse, neglect, mistreatment or deliberate injury.

- MCCMH services are provided by staff who are professionally trained and appropriately licensed within their disciplines. Each staff person is required to uphold the ethical standards of his/ her profession, as well as those of MCCMH. MCCMH staff may not misrepresent their qualifications, education, licensure, or credentials to you or anyone else.

- MCCMH staff who provide your services cannot initiate or maintain personal, social, or sexual relationships with you or your family members, even with your consent. This is so that those who provide your services can remain objective, and so that you are not placed in any uncomfortable or compromising situation. MCCMH staff cannot use their professional relationships with you for their personal gain or advantage.

- Aside from your fees, we cannot accept money or items of value from you in exchange for the services provided by MCCMH, and cannot use relationships with you for personal financial gain or business interests outside of MCCMH.

If you have questions about confidentiality, access to your records, or the ethics of your service delivery, you may contact the Office of Recipient Rights. If you believe that your confidentiality has been violated or access to your records has been incorrectly denied, contact the Office of Recipient Rights. Call:

The Office of Recipient Rights 586-469-6528
19800 Hall Road, Clinton Township, MI 48038
Fax: 586-466-4131
Hours of Operation: 8:30 a.m. to 5:00 p.m. M-F, and by appointment.

Remember: These offices are equipped with telephone interpreter services for those who best use a language other than English. If you use a TTY, call the Michigan Relay Center at 711 to reach any MCCMH office.

Contacting MCCMH

The following is a list of the addresses, phone numbers, and websites you might need to contact MCCMH.

MCCMH offices are equipped with telephone interpreter services for those who best use a language other than English. If you use a TTY, call the Michigan Relay Center at 711 to reach any MCCMH office.

MCCMH Access Center **1-855-996-2264**
Service Hours: Monday thru Friday, 8:00 a.m. to 8:00 p.m.
After Regular Business Hours: The Crisis Center 1-855-927-4747

MI Health Link Customer Services and Ombudsman. . . . 1-855-996-2264
Service Hours: Monday thru Friday, 8:00 a.m. to 8:00 p.m.
After Regular Business Hours: The Crisis Center 1-855-927-4747

Macomb County CMH Crisis Center 1-855-927-4747
800-442-HOPE
800-237-TALK

Crisis Center Hours of Operation: 24/ 7/ 365.

The MCCMH Administrative Office. 586-469-5275
19800 Hall Road, Clinton Township, MI 48038
Website: www.mccmh.net
Fax: 586- 469-7674

The Office of Recipient Rights 586-469-6528
19800 Hall Road, Clinton Township, MI 48038
Fax: 586-466-4131

Remember: These offices are equipped with telephone interpreter services for those who best use a language other than English. If you use a TTY, call the Michigan Relay Center at 711 to reach any MCCMH office.

Emergency Psychiatric Services — Adults
Hospital services for emergencies are available 24/ 7/ 365.
See page 15 for options and information about hospitalization.

Culturally-Specific Programs and Services: Contact the Access Center for information about culturally-based services available through MCCMH.

Peer-Run Programs and Services

Clubhouse Programs
Crossroads Clubhouse 586-759-9100
27041 Schoenherr Rd., Warren 48088
Fax: 586-759-9176
Hours of Operation: 8:30 a.m.- 4:30 p.m.

Friendship House Clubhouse 586-465-4780
277 N. Groesbeck Hwy., Mt. Clemens 48043
Fax: 586-465-4811
Hours of Operation: 8:30 a.m.- 4:30 p.m.

Consumer-Run Drop-In Centers
Liberties North 586-954-1590
230 N. Ave, Suite 10, Mt. Clemens, MI 48043

Liberties South 586-779-8092
26345 Gratiot, Roseville 48066

Hours of Operation: Hours for both Liberties North and South vary slightly by season. Liberties also holds special events for weekends and holidays. Call either location for more specific information about hours and activities.

Contact the Access Center for information about other peer-run services available through MCCMH.

After Regular Business Hours

If you need help after regular business hours (in the evenings, through the night, or on weekends and holidays), call the Crisis Center. The Crisis Center will help you with your concern, or will connect you to another source of help.

If you need help after regular business hours, call 1-855-927-4747.

Community Resources

These local community agencies may provide additional support, information, or services to help with your needs. These agencies are not part of MCCMH. Phone numbers were verified at the time of printing; however, agencies change phone numbers without notice to MCCMH. Hours and services vary by agency. If you have trouble reaching any of these services, call the Crisis Center for the new phone number.

Mental Health

Agoraphobics in Motion (AIM)	248-547-0400
Depression and Bi-Polar Support Alliance (DBSA)	248-677-3380
NAMI Macomb	586-817-1925
Schizophrenics Anonymous (SA) (At Liberties North)	586-954-1590

Developmental Disabilities

ARC Macomb	586-469-1600
Autism Society of Michigan	800-223-6722
Epilepsy Foundation of Michigan	800-377-6226
United Cerebral Palsy Assn. of Metro-Detroit	800-827-4843

Addiction Support Groups

Alcoholics Anonymous	877-337-0611
Al-Anon Family Groups	888-425-2666
Michigan Gambling Helpline	800-270-7117
Narcotics Anonymous	248-543-7200
NAR-Anon Family Groups	586-447-2868
Dual-Recovery Anonymous (persons diagnosed with mental illness and substance abuse — at Liberties South.)	586-777-8094

Other Resources

MCCMH Crisis Center The Crisis Center can direct callers to over 400 community resources for a wide variety of situations.	1-855-927-4747
Michigan Protection and Advocacy Service	800-288-5923
United Way Tel-Help (Referral to other services.)	211
The Michigan Relay Center	711

Ending Your Membership in MI Health Link

You have the right to leave the MI Health Link program at any time, if you want to do so. This chapter tells you about how to end your membership in MI Health Link, about and your health coverage options if you leave. **You will still qualify for both Medicare and Medicaid benefits if you leave MI Health Link.**

When Can You End Your Membership In MI Health Link?
You can end your membership in MI Health Link at any time. The change will be effective the first day of the next month after MI Enrolls gets your request.

How to Get More Information about Leaving MI Health Link
To get more information about ending your MI Health Link membership, you can call one of these three resources:

- Call **Michigan ENROLLS** at 1-800-975-7630, Monday through Friday 8 AM to 7 PM. TTY users should call 1-888-263-5897.
- Call the State Health Insurance Assistance Program (SHIP). In Michigan, the SHIP is called the **Michigan Medicare/Medicaid Assistance Program** (MMAP). MMAP can be reached at 1-800-803-7174.
- Call **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048.

When you call, tell them that you want to leave MI Health Link. Ask them for help with any forms you need to fill out, and ask about your care options when you leave MI Health Link.

How Do You Join A Different Plan?
If you want to keep getting your Medicare and Michigan Medicaid benefits together from a single plan, you can join a different Medicare-Medicaid Plan. To enroll in a different Medicare-Medicaid Plan, call one of the resources above. Tell them you want to leave MI Health Link and join a different Medicare-Medicaid Plan. If you are not sure what plan you want to join, they can tell you about other plans in your area.

If You Leave MI Health Link and You Don't Want Another Medicare-Medicaid Plan, How Do You Get Medicare and Michigan Medicaid Services ?
If you do not want to enroll in a different Medicare-Medicaid Plan after you leave MI Heath Link, you will go back to getting your Medicare and Michigan Medicaid services separately.

How you will get Medicare services
If you leave MI Health Link, you will have a choice about how you get your Medicare benefits. There are three ways to get Medicare services. By choosing one of these plans, you will automatically end your membership in MI Health Link.

You can change to:
1. A Medicare health plan, such as a Medicare Advantage plan or Program of All-inclusive Care for the Elderly (PACE)

2. Original Medicare with a separate Medicare prescription drug plan

3. Original Medicare without a separate Medicare prescription drug plan.
NOTE: If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you tell Medicare you don't want to join the drug plan.

Be careful! You should only drop Medicare prescription drug coverage if you get drug coverage from an employer, union or other source. If you have questions about whether you need drug coverage, call the Michigan Medicare/ Medicaid Assistance Program at 1-800-803-7174.

You will automatically be dis-enrolled from MI Health Link when your new plan's coverage begins. Your coverage with MI Health Link will end on the last day of the month that MI Enrolls your request.

How you will get Michigan Medicaid services
Your Michigan Medicaid services include most long term supports and services and behavioral health care. If you leave the Medicare-Medicaid Plan, you can see any provider that accepts Michigan Medicaid.

Until You Leave MI Health Link, You Will Continue To Receive Your Benefits

If you leave MI Health Link, it may take time before your membership ends and your new Medicare and Michigan Medicaid coverage begins. During this time, you will keep getting your benefits and services through MI Health Link.

If you are hospitalized on the day that your membership ends, your hospital stay will usually be covered by MI Health Link until you are discharged. This will happen even if your new health coverage begins before you are discharged.

Your MI Health Link Will End in Certain Situations

There are some reasons why your MI Health Link membership may be ended, even if you didn't want it to end. These are the reasons when MI Health Link must end your membership:

- If there is a break in your Medicare Part A and Part B coverage.
- If you no longer qualify for Michigan Medicaid. MI Health Link is for people who qualify for both Medicare and Michigan Medicaid.
- If you move out of our service area.
- If you are away from our service area for more than six months.
- If you go to prison.
- If you lie about or withhold information about other insurance you have for prescription medicines.

We can make you leave MI Health Link for the following reasons only if we get permission from Medicare and Michigan Medicaid first:

- If you intentionally give us incorrect information when you are enrolling in MI Health Link and that information affects your eligibility for our plan.
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan.
- If you let someone else use your ID card to get medical care. If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.

MI Health Link cannot ask you to leave the plan due to a reason related to your health

If you feel that you are being asked to leave MI Health Link for a health-related reason, you should call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may call 24 hours a day, seven days a week.

You may also call the Medicaid Beneficiary Help Line at 1-800-642-3195 (or 1-866-501-5656 for TTY users), Monday through Friday, 8 AM to 7 PM.
The MI Health Link Ombudsman may also help. See page 70 for information about contacting the MI Health Link Ombudsman.

You Have The Right To File A Complaint If Your Membership Is Ended
If your membership in MI Health Link is ended, you must be told the reasons in writing. The letter will tell you how you can make a complaint about the decision to end your membership. See page 50 for information about how to make a complaint.

Legal Notices

Notice About Laws
Many laws apply to this Member Handbook. These laws may affect your rights and responsibilities even if the laws are not included or explained in this handbook. The main laws that apply to this handbook are federal laws about the Medicare and Medicaid programs. Other federal and state laws may apply too.

Notice About Discrimination
Every company or agency that works with Medicare must obey the law. You cannot be treated differently because of your race, color, national origin, disability, age, religion, or sex. If you think that you have not been treated fairly for any of these reasons, call the Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019. TTY users should call 1-800-537-7697. You can also visit http://www.hhs.gov/ocr for more information. You can also call the Michigan Department of Civil Rights at 1-800-482-3604.

Notice About Medicare As A Secondary Payer
Sometimes someone else has to pay first for the services we provide you. For example, if you are in a car accident or if you are injured at work, insurance or Workers Compensation has to pay first. We have the right and responsibility to collect for covered Medicare services when Medicare is not the first payer.

Glossary of Terms

This is a list of some of the important words and phrases used in this booklet. If you have other questions about what is in this booklet, ask your Therapist or Case Manager, or call the MI Health Link Customer Service representative.

Access: The entry point to the Prepaid Inpatient Health Plan (PIHP), sometimes called an "access center," where Medicaid beneficiaries call or go to request mental health services. The access center at MCCMH is now called the Managed Care Operations (MCO) Department.

Action (Adverse Action): is a decision that negatively impacts your ability to get a service, or the amount of the service you want, when you want it. It may also mean that MCCMH did not make a decision about what services you would receive, or did not begin to provide you the services you were authorized, within certain time frames.

Advance Directive for Mental Health Care: Also known as a **"Psychiatric Advance Directive"** is a legal document in which you name someone else, called a Patient Advocate, who is authorized to make medical care decisions for you if you are unable to make them yourself.

Amount, Duration, and Scope: Terms to describe how much, how long, and in what ways the Medicaid services that are listed in a person's individual plan of service will be provided.

Appeal: A formal request for a review of an action made by MCCMH. You may file an Appeal if you do not agree with our decision to reduce, suspend, or terminate your services, or if you don't agree with the contents of your person -centered plan (your plan of service), or if you don't agree with certain other actions we have made about your services.

Beneficiary: An individual who is eligible for and enrolled in the MI Health Link program in Michigan.

CA: An acronym for Substance Abuse Coordinating Agency. The CAs in Michigan manage services for people with substance use disorders.

Care Coordinator: One main person who works with you, your Health Plan, and your care providers to make sure you get the care you need.

Care Plan: The plan of service that tells you what services you will receive, how much, how, and when.

Care Team: A team of people who work with you to give you the care you need. Your care team might include doctors, nurses, counselors, or others who get you the care you need. The team will also work with you to develop your care plan.

Centers for Medicare and Medicaid Services (CMS): The Federal agency in charge of Medicare and Medicaid.

Commission on Accreditation of Rehabilitation Facilities, usually called CARF: **CARF** is a national organization that independently reviews the services of mental health and disability service organizations. MCCMH is accredited by CARF.

Complaint: A written or spoken statement expressing dissatisfaction with something about your covered services or your care. This includes any concerns about the quality of your care, network providers, or network pharmacies.

Confidentiality: Privacy. If you are receiving services from MCCMH, you have the right to have information about your services kept private.

Coordination of Care: When MCCMH talks with your primary doctor to make sure that your physical and mental health care, including all the medicines you take and any other treatments you receive, work together well.

Coverage Decision: A decision about what services we will cover. This includes decisions about what services we will provide, how much, how often, and about what services we will pay for.

Covered Services: The general term used to mean all the health care, long term care, supports and services, supplies, prescriptions, and over the counter medicines, equipment, and other services covered by MI Health Link.

Developmental Disability: As defined by the Michigan Mental Health Code means either of the following: (a) If applied to a person older than five years, a severe chronic condition that is attributable to a mental or physical impairment or both, and is manifested before the age of 22 years; is likely to continue indefinitely; and results in substantial functional limitations in three or more

areas of the following major life activities: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency; and reflects the need for a combination and sequence of special, interdisciplinary, or generic care, treatment or other services that are of lifelong or extended duration; (b) 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 a developmental disability.

Discharge Plan: A plan created with you before you leave the hospital that will outline what mental health services you will receive in the community to help you stay well.

Disenrollment: The process of ending your membership in MI Health Link. Your membership may end by your choice, or, depending on certain conditions, may end not by your choice.

DSM: The Diagnostic and Statistical Manual of Mental Disorders. This handbook used by physicians lists the diagnostic criteria for various forms of mental illness and emotional disturbance.

Fair Hearing: A state level review of Medicaid beneficiaries' disagreements with MCCMH's denial, reduction, suspension or termination of Medicaid covered services. State Administrative Law Judges who are independent of the Michigan Department of Community Health perform the reviews. These are also called "Medicaid Fair Hearings."

Fiscal Intermediary: A person who helps you manage your budget and pay your providers if you are using a self-determination approach.

Grievance: An expression of dissatisfaction with something about your service delivery or your experience with one of our staff, contractors, or service sites.

Health Insurance Portability and Accountability Act of 1996 (HIPAA): This legislation is aimed, in part, at protecting the privacy and confidentially of patient information. "Patient" means any recipient of public or private health care, including mental health care, services.

Individual Budget: The amount of funds available to you for purchase of your services if you are using a self-determination approach. Your individual budget is determined by your person-centered plan.

Individual Plan of Service: The written plan that provides you with the detailed information about the approved services you will receive from MCCMH and who will provide them. Your Individual Plan of Service is also known as your Person-Centered Plan, and is developed using the Person-Centered Planning model.

Integrated Health Care: The comprehensive monitoring of all your health needs by all of your healthcare providers, including managing the impact of each treatment on the other health conditions you may have. Integrated care is whole-person care.

Long term supports and services (LTSS): Long term supports and services are services that help improve a long term condition. LTSS includes nursing home services as well as home and community-based services. The home and community-based services help you stay in your home so you don't have to go to a nursing home or hospital.

MDCH: An acronym for Michigan Department of Community Health. This state department, located in Lansing, oversees public-funded services provided in local communities and state facilities to people with mental illness, developmental disabilities and substance use disorders.

Medicaid-Covered Services: The health care services paid for by Medicaid.

Medically Necessary: A term used to describe one of the criteria that must be met in order for a beneficiary to receive covered services. It means that the specific service is expected to help the beneficiary with his/her mental health, developmental disability or substance use (or any other medical) condition. Some services assess needs and some services help maintain or improve functioning. MCCMH is unable to authorize (pay for) or provide services that are not determined as medically necessary for you.

Medicare-Covered Services: The health care services paid for by Medicare.

Medicare-Medicaid enrollee: A person who qualifies for Medicare and Medicaid coverage. A Medicare-Medicaid enrollee is also called a "dual eligible beneficiary."

Medicare Part A: The Medicare program that covers most medically necessary hospital, skilled nursing facility, home health and hospice care.

Medicare Part B: The Medicare program that covers services (like lab tests,

surgeries, and doctor visits) and supplies (like wheelchairs and walkers) that are medically necessary to treat a disease or condition. Medicare Part B also covers many preventive and screening services.

Medicare Part C: The Medicare program that lets private health insurance companies provide Medicare benefits through a Medicare Advantage Plan.

Medicare Part D: The Medicare prescription drug benefit program. ("Part D") Part D covers outpatient prescription medicines, vaccines, and some supplies not covered by Medicare Part A or Part B or Medicaid.

Medicare Part D medicines: Medicines that can be covered under Medicare Part D. Congress specifically excluded certain categories of medicines from coverage as Part D medicines. Medicaid may cover some of these medicines.

Michigan Mental Health Code: The state law that governs public mental health services provided to adults and children with mental illness, serious emotional disturbance, and persons with developmental disabilities by local community mental health services programs and in state facilities.

Michigan Public Health Code: One of many laws that govern the delivery of publicly-funded substance abuse treatment services, and other health/ medical services in Michigan.

Michigan Relay Center provides telephone relay service to callers with hearing or speech difficulties. The Relay Center is available 24/ 7/ 365 and will help you contact any office, business, or residence, whether or not the other party has a TTY. You may contact any MCCMH office directly by using the Michigan Relay Center. To reach the Michigan Relay Center, call **7-1-1.**

MI Health Link: MI Health Link is a program that provides coordinated medical, mental health, and substance use disorder services to residents in Macomb County who are covered by both Medicare and Medicaid and who are enrolled in the program.

MI Health Link Health Plans: The health insurance providers authorized by the State of Michigan to manage health services for MI Health Link beneficiaries. If you are enrolled in MI Health Link in Macomb County, your health plan will be either Aetna Better Health, Amerihealth Michigan, Fedlis Secure Care, HAP Midwest, or Molina. See page 48 for information about contacting your health plan.

Network Providers: These are the providers your health plan, and MCCMH, will send you to when you need services. Generally, you must use a MI Health Link network provider to get your services.

Office of Recipient Rights (ORR): The Office of Recipient Rights is the place at MCCMH that will help you learn about your rights. ORR will help you learn about your rights or file a Recipient Rights complaint.

Ombudsman: The Ombudsman is the person at MCCMH who will help you use informal dispute resolution processes, or will help you with a grievance. The Ombudsman is part of the Office of Community Relations.

Original Medicare (traditional Medicare or fee-for-service Medicare): Original Medicare is offered by the government. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers' amounts that are set by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. Original Medicare has two parts: Part A (hospital insurance) and Part B (medical insurance). Original Medicare is available everywhere in the United States. If you do not want to be in our plan, you can choose Original Medicare.

Out-of-network provider or Out-of-network facility: A provider or facility that is not under contract to provide services to MI Health Link members.

Peer Facilitator: A Peer Facilitator is a person with mental illness or developmental disability who has been trained to support others as a Person-Centered Planning (PCP) facilitator. Peer facilitators are paid to facilitate PCP meetings, but don't provide other services to you.

Person-Centered Planning: The process we use to design your services. PCP is based on your goals, strengths, abilities, and choices. PCP should build on your ability to be part of your community, and help you achieve your goals. Your person-centered plan defines what services you will get from MCCMH.

PIHP: An acronym for Prepaid Inpatient Health Plan. There are 10 PIHPs in Michigan that manage the Medicaid mental health, developmental disabilities, and substance abuse services in their geographic areas. All 10 PIHPs are also community mental health services programs.

Primary care provider (PCP): Your primary care provider is the doctor or

other provider you see first for most health needs. He or she makes sure you get the care you need to stay healthy. He or she also may talk with other doctors and health care providers about your care and refer you to them.

Prior authorization: Approval needed before you can get certain services or medicines. Some network medical services are covered only if your doctor or other network provider gets prior authorization from your MI Health Link health plan.

Psychiatric Evaluation: Questions or tests to help a doctor understand what you are feeling, seeing, or experiencing, and how well you understand what is going on around you. An evaluation is done before you receive treatment.

Recovery: A journey of healing and change allowing a person to live a meaningful life in a community of their choice, while working toward their full potential.

Release of Information: A form that tells MCCMH who you want us to talk to about your treatment, and what information we can share or receive. Sometimes this is simply called a "release."

Self-determination: A model of service delivery that allows the person receiving MI Health Link Home and Community Based Waiver services to direct the purchase of approved services using a fixed amount of public dollars.

Specialty Supports and Services: The mental health, developmental disabilities and substance use treatment supports and services that are managed by the Pre-Paid Inpatient Health Plans and paid for by MI Health Link.

Serious Mental Illness: Is defined by the Michigan Mental Health Code to mean 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 Diagnostic and Statistical Manual of Mental Disorders; and that has resulted in function impairment that substantially interferes with or limits one or more major life activities.

Service Authorization: The approval process MCCMH uses to decide if a service you have requested will be provided to you. Generally, your services must be authorized before you can receive them. Your care manager or treatment team will usually get your services authorized for you. In an emergency, the hospital will get the authorizations they need from us to

provide treatment to you.

Substance Use Disorder (or substance abuse): Is defined in the Michigan Public Health Code to mean the taking of alcohol or other drugs at dosages that place an individual's social, economic, psychological, and physical welfare in potential hazard or to the extent that an individual loses the power of self-control as a result of the use of alcohol or drugs, or while habitually under the influence of alcohol or drugs, endangers public health, morals, safety, or welfare, or a combination thereof.

Supplemental Security Income (SSI): A monthly benefit paid by Social Security to people with limited incomes and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security (SS) or Social Security Disability (SSDI) benefits.

Treatment Planning / Service Planning: The development and review of your individual plan of services. At MCCMH, treatment/ service planning is done using the person-centered planning model.

Urgently needed care: Care you get for a sudden illness, injury, or condition that is not an emergency but needs care right away. You can get urgently needed care from out-of-network providers when network providers are unavailable or you cannot get to them.

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The Vision behind the Mission

"Macomb County Community Mental Health, guided by the values, strengths, and informed choices of the people we serve..."

Macomb County Community Mental Health (MCCMH) respects the inherent dignity of each person we serve, designing individual services in partnership with them, building from their unique abilities, preferences, and needs. MCCMH works together with each person to help create a life of belonging, rich in relationships, activities, goals, and support systems that are unique to each person.

"...provides quality services..."

Working together with the people we serve, families, healthcare and community partners, Macomb County Community Mental Health is committed to offering value-based behavioral health services aimed at addressing the specific needs of persons with mental health, developmental disability, and substance abuse concerns. MCCMH strives to be an up-to-date and reliable source of information, education, resources, outreach, and assistance to develop solutions for managing these conditions. Assistance is provided through recovery-based interventions that respect each person's cultural, religious, social, and personal beliefs, incorporating these beliefs as a critical part of each person's system of support. Macomb County Community Mental Health encourages and supports the participation of the support systems the people we serve describe as important to individual recovery.

"...which promote recovery, community participation, self-sufficiency, and independence."

MCCMH staff speak in terms of "Recovery" and "Wellness" when interacting with others. We believe persons with behavioral health needs are a meaningful part of the community who have the same rights as any other citizen. We work with other agencies and systems to eliminate the social and political obstacles confronting those we serve. We believe that behavioral health needs are not the single defining aspect of a person. The function of Macomb County Community Mental Health; therefore, is not only providing services to people, but helping individuals be respected, heard, and understood within our system and the larger community. This includes assisting individuals to move toward their goals, encouraging participation in the community, supporting the development of additional relationships, improving physical health as well as mental health, and supporting individual, ongoing personal growth. Our services help build the skills and develop the strategies that ensure active engagement and recovery that is based on individual strengths and passions. Our system instills hope, a sense of possibility, and a positive sense of self for each person we serve.

Vision Statement
of the Macomb County Community Mental Health Board
Adopted August 24, 2011

Macomb County Community Mental Health

A CARF Accredited Organization

19800 Hall Road
Clinton Township, MI 48038

MCCMH MI Health Link Customer Service
Toll Free: 1-855-996-2264
Crisis Center
Toll Free: 1-855-927-4747
On the Web: www.mccmh.net

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