MCCMH MCO Policy 2-013

(was MCCMH Policy 7-02-040)

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

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Executive Director — Date

I. ABSTRACT

This policy establishes the standards and procedures for consumer access, eligibility, admission to the service system, transitions to various levels of care and discharge from services of the Macomb County Community Mental Health (MCCMH) Board.

II. APPLICATION

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

III. POLICY

It is the policy of the MCCMH Board that:

A. A centralized access service center shall be available to all Michigan residents seeking services and supports from MCCMH;

B. Eligibility requirements for mental health services and supports shall be determined according to the Michigan Department of Health and Human Services (MDHHS) – MCCMH Medicaid Managed Specialty Supports and Services Contract; the Michigan Department of Health and Human Services (MDHHS) Medicaid Provider Manual, Behavioral Health and Intellectual an Developmental Disabilities Services and Supports (Medicaid Provider Manual); the Michigan Mental Health Code; MDHHS Administrative Rules and other applicable laws and regulations;

C. Decisions with regard to admission to and provision of various levels of care shall be made based upon application of the provisions of the MDHHS Medicaid Provider Manual, Managed Specialty Supports and Services Contract and the Mental Health Code.

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

IV. DEFINITIONS

A. County of Financial Responsibility (COFR)
The general rule for adults served is that the COFR is the county where they last lived independently. For children, the general rule is that the COFR is the county where the child and parents have their primary residence.

B. Developmental Disability

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

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

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

   c. Is likely to continue indefinitely;

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

      (1) Self-care
      (2) Receptive and expressive language
      (3) Learning
      (4) Mobility
      (5) Self-direction
      (6) Capacity for independent living
      (7) Economic self-sufficiency

      For a more detailed description of "substantial functional limitation" in the seven areas of major life activity listed above, see Exhibit A, MCCMH Determination of Developmental Disability, 1.d.(1)-(7);

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

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

C. Criteria for Determination of Developmental Disability
An established criteria used for the purpose of determining the consumer's eligibility to receive specialized services and supports for persons with developmental disability as described in the MDCH Specialty Services contract and MDHHS Medicaid Provider Manual. (See Exhibit A, MCCMH Determination of Developmental Disability.)

D. Emergent Need
A situation in which an individual is experiencing a serious mental illness or a developmental disability, or a child is experiencing a serious emotional disturbance and one of the following applies:

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

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

3. The individual's judgment is so impaired that he or she is unable to understand the need for treatment and, in the opinion of the mental health professional, his or her continued behavior as a result of the mental illness, developmental disability, or emotional disturbance can reasonably be expected in the near future to result in physical harm to the individual or to another individual.

E. Functional Impairment

1. With regard to serious emotional disturbance, substantial interference with or limitation of a minor's achievement or maintenance of one or more developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills.

2. With regard to serious mental illness, substantial interference or limitation of role functioning in one or more major life activities including basic living skills such as maintaining a household, managing money, getting around the community, taking prescribed medication, and functioning in social, vocational, and educational contexts.

F. Primary Diagnosis(es)
The diagnosis or diagnoses which are the focus of service/treatment.

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

H. Serious Emotional Disturbance
A diagnosable mental, behavioral, or emotional disorder affecting a minor that exists or has existed during the past year for a period of time sufficient to meet diagnostic criteria specified in the most recent DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (DSM-IV), Fourth Edition, published by the American Psychiatric Association that has resulted in functional impairment that substantially interferes with or limits the minor's role or functioning in family, school, or community activities. The following disorders are included only if they occur in conjunction with another diagnosable serious emotional disturbance:

1. A substance use disorder

2. A developmental disorder

3. Disorders constituting "V" Codes in the DSM-IV.

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

1. A substance use disorder

2. A developmental disorder

3. Disorders constituting "V" Codes in the DSM-IV.

J. Service Approval
A process by which the MCCMH Access Center reviews and analyzes the medically necessary level of care, if any, an individual may receive. The purpose of level of care is to help assure that planned services are:

1. Delivered in accordance with federal and state standards for timeliness in a location that is accessible to the consumer;

2. Responsive to particular needs of multi-cultural populations and furnished in a culturally relevant manner; and

3. Responsive to the particular needs of consumers with sensory or mobility impairments and provided with the necessary accommodations; and

4. Provided in the least restrictive, most integrated setting; and

5. Delivered consistent with, where they exist, available research findings, health care practice guidelines, best practices and standards of practice

issued by professionally recognized organizations or government agencies.

K. Service Package
A pre-established combination of specified numbers of units of various services and supports within which a service plan may be developed with the consumer using a person-centered planning process. Additional units of services/supports, not included in the service package, may be added to any package as authorized through the MCCMH Access Center.

L. Urgent Need
A situation in which an individual is determined to be at risk of experiencing an emergency situation in the near future if he or she does not receive care, treatment, or support services.

V. STANDARDS

A. Access Standards

1. The MCCMH Access Center shall be available to all Michigan residents, regardless of where the person lives, or where he/she contacts the system, and is not restricted to individuals who live in a particular geographic region. Access is available 24 hours a day, seven days per week. Access system services do not require prior authorization and are to be provided without charge to the individual being served.

2. The MCCMH Access Center staff shall be welcoming, accepting, and helping with all applicants for services, including individuals with a co-occurring mental health and substance use disorder.

3. The MCCMH Access Center's telephone response system shall be answered by a live voice and shall demonstrate a welcoming atmosphere.

4. The MCCMH Access Center's crisis/emergent telephone calls are immediately transferred to a qualified practitioner without requiring an individual to call back.

5. Individuals who walk into the MCCMH Access Center shall be provided a timely and effective response to their requests for assistance.

6. Individuals who have special access needs shall be accommodated according to the standards and procedures of applicable MCCMH MCO policies, including but not limited to MCO Policy 5-001, "Accessibility," 5-002, "Cultural and Linguistic Competency," and 9-670, "Services For Recipients Affected by Physical Barriers."

B. Eligibility Criteria to Receive Public Mental Health Services

1. Mental health services and supports shall be provided to individuals who have been determined through the MCCMH Access Center to meet the medically necessary criteria set forth in the Medicaid Provider Manual, ,

the Michigan Mental Health Code (P.A. 258 of 1974, as amended), the Board's contract with MDHHS, and MDHHS grant program requirements, who are:

a. Adults with serious mental illnesses;
b. Children with serious emotional disturbances;
c. Adults and children with developmental disabilities; or
d. Individuals with co-occurring disorders.

2. Mental health services may be provided to individuals having other mental disorders only when:

a. The mental disorder meets criteria specified in DSM IV; and
b. All consumers included in the mandated populations specified in section A above can be accommodated without waiting lists; and
c. The individual is uninsured or underinsured for the needed services or reimbursement for needed services is authorized by the individual's health care insurer.

3. With the exception of those individuals receiving services to ameliorate emergency situations, individuals receiving services shall be residents of Macomb County, or where Macomb County has been determined to be the service applicant's County of Financial Responsibility.

4. Applicants requesting services who do not meet eligibility criteria shall be referred to a more appropriate community service, put on the MCCMH waiting list, or, when appropriate, referred to the CMH Board in their county of residence.

5. Applicants may be placed on a waiting list for non-Medicaid covered services, including licensed specialized residential services, prioritized by the urgency of situation and severity of symptoms.

C. Admission Criteria

1. Medicaid consumers shall be provided Medicaid-covered services in accordance with federal entitlements as reflected in the Board's contract with MDHHS and the Medicaid Provider Manual. For all other Macomb County residents, priority for receipt of services shall be given to individuals with the most severe forms of these diagnoses whose illness/disability causes them to be in emergency or urgent situations.

2. Applicants in emergency situations shall be served immediately upon request at one of the Board's inpatient emergency assessment sites. Prior authorization for emergency assessment is not required.

3. Eligible applicants in urgent situations shall be provided an initial assessment within twenty-four (24) hours of request for service. Prior authorization through the Access Center is required.

4. Eligible applicants for non-emergent / non-urgent outpatient services shall be provided an initial assessment within ten (10) days of receipt of the request/referral for service, but in no cases later than fourteen (14) calendar days of receipt of the request/referral for service.

5. Individuals discharged from a psychiatric inpatient unit (or other setting that requires meeting Michigan Mental Health Code criteria for involuntary hospitalization), or from a substance abuse detoxification unit, shall be provided follow-up care no later than seven (7) calendar days from the date of discharge.

6. For adults with serious mental illness, children with serious emotional disturbance, and consumers with developmental disabilities, decisions regarding admission to and provision of various levels of care shall be based on the provisions of the Medicaid Provider Manual; the MDHHS-MCCMH Managed Specialty Supports and Services Contract; and the Mental Health Code. All determinations shall be made using the findings of the initial assessment, and any additional necessary clinical assessments, in conjunction with sound clinical judgment. Except for MIChild consumers, diagnoses shall include an assessment of functional impairment and duration in the decision-making process, pursuant to the requirements of the Mental Health Code.

7. Prior approval of assignment to level of care shall be provided through the MCCMH Access Center. Prior approval for continued stay in a level of care, or for change in level of care, is also required through the MCCMH Access Center. Movement of consumers to and from levels of care, and openings into shared (multiple) RU's require Access Center approval, as well as closings within those shared RU's.

8. For directly-operated programs, Access Center approval is <u>not</u> required for individual services for consumers where those services are encompassed <u>within</u> a particular RU.

9. A presumptive short term amount of service that does not require Access Center approval can be delivered immediately to a consumer who is still open in the RU providing those services.

10. For contracted service providers, Access Center authorization is required for both level of care and individual services.

D. Transitioning To and From Levels of Care

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

E. Discharge Criteria

1. Discharge criteria shall be established for each consumer at the point of admission and development of the individual plan of service.

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

   a. The consumer has achieved the goals of the service plan,

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

   c. The consumer is deceased or is no longer a resident of Macomb County, or

   d. The consumer withdraws from service.

3. The consumer **may** be discharged from treatment when, despite documented attempts to resolve issues and renegotiate the consumer's Plan of Service, the consumer is non-compliant with the Plan of Service to which he/she has agreed, and the consumer does not meet Michigan Mental Health Code criteria and MCCMH Service Selection Guidelines for involuntary hospitalization. Evidence of non-compliance includes but is not limited to:

   a. The consumer does not keep scheduled appointments resulting in a failed appointment rate of 50% or more over a period of ninety days;

   b. The consumer is overtly resistant or obstructive to meeting service requirements including, for example, unwillingness to provide necessary information or unwillingness to make reasonable attempts to participate in interventions/activities as specified in the service plan;

   c. The consumer refuses to sign or otherwise agree to informed consents for treatment or service plans;

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

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

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

4. When a consumer is discharged or removed from a program, the clinician / case manager shall be responsible for follow-up to determine whether the consumer will need further services, and shall offer or refer the consumer to needed services when possible. When discharged or removed from a program for aggressive and/or assaultive behavior, follow-up shall occur within seventy-two (72) hours to ensure linkage to appropriate care.

5. For all consumers terminating services, a written discharge summary shall be prepared to ensure that the consumer's treatment episodes and results of treatment are documented. The discharge summary shall:

   a. Include the date of admission;

   b. Describe the services provided;

   c. Identify the presenting condition;

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

   e. Identify the consumer's current:

      (1) Progress in recovery or move toward well-being;
      (2) Gains achieved during program participation;
      (3) Strengths;
      (4) Needs;
      (5) Abilities;
      (6) Preferences.

   f. Describe the reasons for discharge;

   g. Identify the status of the consumer at last contact;

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

   i. List recommendations for services or supports;

   j. Include information on the consumer's medication(s), when applicable;

   k. Include the date of discharge from the program;

   l. Indicate what follow-up will be provided to ensure ongoing care where applicable.

F. Discharge from Institutions
When an individual is being discharged from an institutional setting:

1. The network provider's treatment staff must determine that the placement is appropriate;

2. The individual must not object to being released from the institution; and

3. The provider must be able to provide supports and services that enable the individual to live successfully in the community.

VI. PROCEDURES

A. New Requests for Service or Requests for Readmission:

1. New requests and readmission requests will be screened through the Access Center to ascertain potential eligibility for MCCMH services. For consumers who appear eligible for services, the Access Center will open the admission in the MCCMH electronic medical record system (FOCUS EMR), provide an initial authorization, and arrange an appointment for initial assessment at the MCCMH provider site appropriate to the consumer's needs within the time frames stated within this policy (see V.B.1-4).

2. Upon completion of the initial assessment, the provider will notify the Access Center if the consumer's eligibility for services is in question or if the consumer appears to require services which are not available at that service site. Subsequently the provider will forward a complete copy of the initial assessment package and any supporting documentation to the Access Center either electronically or by FAX.

3. If the consumer's needs can be met by the provider that conducted the initial assessment, the provider shall complete the required documentation, assure that it is entered into the FOCUS EMR system or, for providers who do not use FOCUS, shall transmit the required documentation to the Access Center, documenting the findings of the assessment and the services to be provided as determined in consultation with the consumer. The Access Center will process an authorization for services based upon the provider's documented need for services.

4. For persons with mental illness, emotional disturbance, or developmental disability, an Assessment Summary shall be completed in full including selection of the needed service package and any additional services. The Assessment Summary is authorized verified by the signature of the assigned staff / clinician and supervisor prior to data entry and transmission to the Access Center. The Plan of Service is then developed with the consumer using a person-centered planning process and within the available service array.

5. If the consumer's plan of service requires an associated budget, the plan is developed with the consumer and his/her support system through the person-centered planning process. The resulting Plan of Service and associated budget as recommended by the provider are reviewed and authorized by the assigned provider staff, e.g. Clinician, Therapist, Program Supervisor, and/or MCCMH Clinical Services Manager or Contractor Director as appropriate to the type and amount of the request prior to data entry and transmission to the MCCMH Access Center.

6. If, based upon the initial assessment, the consumer does not appear eligible for MCCMH services or appears to need services not provided at the initial assessment site, the Access Center will review the initial assessment and service recommendations, make decisions as to the consumer's status, and arrange for MCCMH service alternatives or denial of MCCMH services as appropriate. Whenever possible, service denials will be accompanied by recommendations for accessing needed services from sources outside the MCCMH system, as well as information pertaining to a request for a second opinion. All service denials or limitations will be accompanied by the appropriate due process notice (see MCCMH MCO Policy 4-020, "Notices of Advance and Adequate Action and Appeal Rights (Medicaid)" and Non-Medicaid Adequate and Advance Action Notices).

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

1. Prior to expiration of the consumer's current level of care approval or whenever changes in consumer's needs necessitate change in level of care, provider staff shall review the Plan of Service with the consumer, documenting the consumer's service plan review according to the standards and procedures of MCCMH MCO Policy 2-010.

2. Based upon the outcome of the service review, approval for continued stay in the level of care or, as applicable, movement to another level of care, may be sought from the Access Center. The request for approval from the Access Center can be made up to 60 days but no less than 14 days prior to the expiration of the current authorization.

   a. For consumers with mental illness, emotional disturbance, developmental disability, or dual MI/SA condition, supporting documentation shall indicate the rationale for providing a continued level of care, and shall be entered into the consumer's FOCUS EMR or otherwise transmitted to the Access Center for approval. Continued services at a level of care may not be provided unless approved by the Access Center.

   b. For consumers whose individualized plan of service requires an associated budget, the revised plan of service and budget shall be completed by the assigned provider staff as appropriate to type and amount. Requests for continued stay or movement to another level of care shall be submitted to the Access Center.

3. If an authorization is requested less than 14 days prior to the expiration of the current authorization and results in a delay in a consumer receiving a service, Access Center shall file a Recipient Rights complaint on behalf of that consumer.

4. The Access Center shall either approve or deny the request within 14 days of receipt.

C. Request for More Intensive Level of Care:

1. Prior to requesting that a consumer be moved to a more intensive level of care in the community, the appropriate reassessments/screening, and person-centered plan or plan review will be completed. The results of the reassessments and plan development or review, along with the rationale for recommending a more intensive level of care, shall be documented and signed by the provider's assigned staff and supervisor for submission to the Access Center. For providers using FOCUS, the results shall be entered into the consumer's FOCUS EMR. Providers not utilizing the FOCUS EMR system shall immediately transmit the signed and documented clinical packet to the Access Center and request approval for a change in level of care.

2. The Access Center will review the request and, if appropriate, approve the level of care by the receiving provider. If the receiving provider is not using the FOCUS EMR system, the Access Center will send the clinical packet to the receiving provider.

3. The receiving provider will review the assessments and documentation packet, arrange for an initial meeting with the consumer, and begin treatment / services.

4. Once the level of care is approved by the Access Center, the provider and consumer may develop a new Plan of Service within the level of care using the person-centered planning process, if the previous plan is inadequate.

D. Discharge Planning

1. Case manager / clinician shall meet with the consumer to determine whether the consumer has achieved the goals of the service plan, and whether further services are needed. Case manager / clinician shall refer or offer to refer the consumer to needed services.

2. The case manager / clinician shall prepare a written discharge summary that shall include the information in V.C.4.

3. When discharge is unplanned (for example, due to non-compliance, aggressive and/or assaultive behavior, voluntary withdrawal, inability to meet residency requirements or establish County of financial responsibility) case manager / clinician shall, within 72 hours post-

discharge, contact the consumer to ensure that the consumer has access to alternative services and provide linkage to appropriate care.

4. Discharge planning for individuals being released from an institution shall ensure that the standards set forth in V.F.1.-3. are followed and met.

E. Provider-specific procedures necessary for the implementation of this policy shall be contained in the provider manuals of each network provider as relevant to that provider's role (if any) in the eligibility, admission, and discharge process. Such procedures shall be reviewed and approved by the MCCMH Internal Services Administrator or designee or the Contractor Director or designee for contracted network providers.

VII. REFERENCES / LEGAL AUTHORITY

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

B. MDHHS – MCCMH Medicaid Managed Specialty Supports and Services Contract

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

D. MDHHS Medicaid Provider Manual

E. American Psychiatric Association, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (DSM-IV) (4th ed. 1994)

F. American Association on Mental Retardation (1997) Mental Retardation: Definition Classification & Systems of Supports, 9th Edition. AAMR Publishing, Washington, D.C.

G. The Center for Outcome Analysis (July, 1996) "Personal Life Quality Protocol for the New Hampshire Self-Determination Project". Version 28.

H. Nihira, K., Leland, H., & Lambert, N., (1993) "Adaptive Behavior Scale - Residential & Community" 2nd Edition. American Association on Mental Retardation, Austin, Texas.

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

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

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

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

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

VIII. EXHIBITS

A. MCCMH Determination of Developmental Disability