NORTHERN MICHIGAN REGIONAL ENTITY
ACCESS TO CARE PLAN
PLAN #: 06-05-001
October 2016

I. MISSION

The mission of the Northern Michigan Regional Entity (NMRE) is: Develop managed care structures to support publically funded behavioral health services.

II. AUTHORITY

The Access to Care Program operates under the direction and management of the NMRE. The Northern Michigan Regional Entity is a regional entity created by AuSable Valley Community Mental Health, Manistee-Benzie Community Mental Health d.b.a. Centra Wellness Network, North Country Community Mental Health, Northeast Michigan Community Mental Health and Northern Lakes Community Mental Health, under the authority of Section 204b of the Michigan Mental Health Code. The NMRE is a Medicaid Specialty Prepaid Inpatient Health Plan (PIHP). The NMRE has a contract with Michigan Department of Health and Human Services (MDHHS) as the Medicaid Specialty PIHP for a twenty-one county area (Region 2 in the State of Michigan). The Access to Care Plan is annually approved by the Operations Committee and the NMRE Board.

III. STRUCTURE

The NMRE has an Access Center serving one of the five Member CMHSP Boards; North Country CMH. In addition, the Access Center provides authorization of continued inpatient psychiatric hospitalization for North Country CMH. The Access to Care Program is a single point of access system for 6 of the 21 counties for the NMRE, which provides a centralized triage screening and phone assessment for referrals, and a system designed to ensure consumers timely access to the most clinically appropriate and cost-effective treatment, services, and care available. The Access Center also provides a centralized triage screening and appropriate phone assessment for the intensive Substance Use Disorder services in the NMRE 21 county region for the purpose of placement and determination of medical necessity. Access to Care for mental health and intellectual/developmental disability services for the remaining four CMHSPs is a delegated function for AuSable Valley CMH, Manistee-Benzie CMH, Northern Lakes CMH, and Northeast Michigan CMH. Providers can also obtain consultation and information regarding covered services and /or referrals to specialists or other providers. The system is structured to provide a “no wrong door” approach for all callers. If an individual calls the NMRE Access Center seeking services, he or she will be directly connected to an appropriate screener, whether at the NMRE or at the appropriate CMHSP. Similarly, any individual calling a CMHSP seeking services will be directly connected to the appropriate screener, whether seeking mental health or SUD services. Whether the access system is centralized or delegated, the activities will meet the standards of state and federal regulations.

IV. STANDARDS

A. <u>Expectations of the Access System</u>

1. Functions as the front door for obtaining services.

2. Is comprised of clinical staff who may be called upon to respond to crises, complete screenings, and provide intake assessments.
3. Provides an opportunity for individuals with perceived problems to be heard, understood, and provided with options.
4. Is available and accessible to all individuals by telephone or on a walk-in basis.
5. Links persons with available resources.
6. Provides outreach throughout the community to ensure that people who need services are aware of the services and are encouraged to make contact.
7. Access staff are skilled at listening and assisting the person with trauma, crisis, or functioning difficulties.
8. Access staff is culturally competent.
9. Access staff is able to address the needs of persons with co-occurring mental illness and substance use disorder.
10. Staff reflects the MDHHS philosophies of person-centered, self-determined, recovery-oriented, trauma-informed, least restrictive environments and integrated care.

B. Key Functions of the Access System

1. Welcome individuals by listening to their situation, problems, and functioning difficulties using good clinical skills in a non-judgmental way.
2. Screen individuals to see if they are in crisis and if so, provide a timely, appropriate response.
3. Determine the individual's eligibility and priority for services.
4. Collect information for decision-making and reporting purposes.
5. If not eligible, refer in a timely manner to the appropriate community resources and supports.
6. Reach out to the under-served and hard-to-reach populations and be accessible.

C. Welcoming

1. Staff will be available, accepting, welcoming, and helpful to all residents of the State of Michigan regardless of where they live or where they contact the system.
2. A toll-free access phone line is available 24 hours a day and 7 days per week. There is access to the phone line for hearing impaired and Limited English Proficient (LEP) individuals.
    a. Phone systems have electronic caller identification.
    b. Callers do not encounter phone trees and are not put on hold until they have spoken with a live person and had an opportunity to discuss their situation.
    c. All crisis/emergent calls are immediately transferred to a qualified professional without having to call back.
    d. No individual seeking a non-emergent screening is placed on hold for more than 3 minutes without being offered a callback.
    e. All non-emergent call backs are returned within one business day of initial contact.
3. The access system provides timely, effective response to all individuals who walk in.
    a. Urgent or emergent needs are immediately referred to the appropriate professional.
    b. Non-emergent needs are screened or other arrangements are made within 30 minutes.

c. It is expected that the Access Center/unit or function will operate minimally eight hours daily, Monday through Friday, except for holidays.

4. The access system can immediately accommodate individuals with:
   a. LEP and other communication needs.
   b. Diverse cultural and other demographic backgrounds
   c. Alternative communication needs
   d. Mobility challenges
   e. Visual impairments
5. The access system:
   a. Does not require prior authorization for crisis intervention or an access screening.
   b. Does not require any financial contribution for phone screening and referral.
   c. Addresses financial considerations including COFR, only after addressing urgent and emergent needs.
   d. Provides applicants with a summary of their rights including rights to person-centered planning.
   e. Offers new consumers an orientation to services, emergency procedures, and the Guide to Services Handbook.
   f. Assures that the applicant has access to pre-planning as soon as the eligibility has been determined.
   g. Notifies the individual of their privacy and confidentiality.

D. Screening for Crises

1. Access staff, with empathy, will assure that urgent and emergent needs are identified and addressed first. This includes understanding when issues are urgent or emergent from the person's point of view.
2. Crisis Services completes timely assessments, provides appropriate interventions, and timely admissions to inpatient units or alternate services when appropriate.
3. Crisis staff will ask if the individual has existing advanced directives.
4. Necessary post-stabilization services will be referred back to the access system for assistance.

E. Determining Coverage

Determination of coverage for behavioral health or substance use disorder treatment services will be in accordance with the MDHHS/PIHP and PIHP/CMHSP Contracts and the following:

1. The Mental Health and Substance Abuse chapter of the Medicaid Provider Manual for a Medicaid beneficiary
2. Healthy Michigan Plan (HMP) chapter of the Medicaid provider manual for Healthy MI beneficiaries.
3. The Michigan Mental Health Code and Administrative Rules if the beneficiary is not eligible for Medicaid, or HMP.
4. Eligibility determined by intake or a clinical screening by phone or in person.
5. The organization shall be capable of providing the Early Periodic Screening, Diagnostic and Treatment (EPSDT) corrective or ameliorative services that are required by the MDHHS/PIHP specialty services and supports contract.
6. When a clinical screening is conducted, the applicant and legal representative if applicable, will be offered a written determination of eligibility based upon established admission criteria. The written decision will include:

a. Presenting problems and need for services and supports
b. Initial identification of the population group that qualifies the person for services and supports (I/DD, MI, SED, SUD).
c. Urgent and emergent needs including how to be linked for crisis services.
d. Screening disposition.
e. Rationale for admission or denial.

7. Any third party payer source will be identified for linkage to an appropriate referral source, in or out of network.
8. No individual will be denied service because of individual/family income or third party payer sources (Mental Health services).
9. The referral source will be identified whether in or out of network. With the consent of the person served, the referral source will be informed of the determination of eligibility for services.
10. Individuals with mental health needs but who are not eligible for Medicaid or HMP
11. may be placed on a waiting list with a written explanation as to why.
12. The organization shall assure that an individual who has been discharged back into the community from outpatient services, and is requesting entrance back into the CMHSP or provider, within one year, will not have to go through the duplicative screening process. They shall be triaged for presenting mental health needs per urgent, emergent, or routine.
13. Individuals requesting medication assisted Substance Use Disorder services may be placed on a waiting list only after being offered other appropriate options such as drug-free treatment.

F. Collecting Information

1. Access staff avoid, to the greatest extent possible, duplication of information gathering, screening and assessments. Information gathered during screening or assessments is forwarded to the provider in accordance with federal and state confidentiality guidelines.

2. Information is coordinated between internal and external providers including Medicaid Health Plans and primary care physicians.

G. Referrals to CMHSPs and Providers

1. Appointments are made with mental health or substance use disorder service professionals of the applicant's choice within 14 days of the assessment.
2. Staff will follow up with the applicant to make sure that the appointment was kept.
3. Persons accepted for services have access to the person-centered-planning process.
4. Referrals are made in compliance with confidentiality of state and federal regulations.

H. Referral to Community Resources

1. Medicaid beneficiaries who request mental health services but do not meet eligibility for specialty support and services are referred to their Medicaid Health Plans or Medicaid fee-for-service providers.

2. Individuals who request mental health or substance abuse services but who are not eligible for Medicaid or HMP mental health and substance abuse services, nor who meet the "priority population to be served" criteria in the Michigan Mental Health Code or the Michigan Public Health Code for substance abuse services, shall be referred to alternative mental health or substance abuse treatment services available in the community.
3. The access system shall provide information about the other non-mental health community resources or services that are not the responsibility of the public mental health system to individuals who request it.

I. Providing other information

1. General
   The access system shall provide information about and help people connect as needed, with Customer Service; peer supports specialists, and family advocates; and local community resources such as: transportation services, prevention programs, local community advocacy groups, self-help groups, service recipient groups, and other avenues of support, as appropriate and available.
2. Rights
   a. The access system shall provide Medicaid or HMP beneficiaries information about the local dispute resolution process and the state Medicaid Fair Hearing process. When an individual is determined ineligible for Medicaid specialty services and supports or HMP mental health services, he/she is notified both verbally and in-writing of the right to request a second opinion; and /or file an appeal through the local dispute resolution process; and/or request a state Fair Hearing.
   b. The access system shall provide individuals with mental health needs or persons with co-occurring substance use/mental health needs with information regarding the local community mental health Office of Recipient Rights (ORR) and/or the local substance abuse coordinating Office of Recipient Rights.
   c. When an individual with mental health needs who is not a Medicaid beneficiary is denied CMH services for whatever reason, he/she is notified of the right under the Mental Health Code to request a second opinion, the local dispute resolution process, and the MDHHS Alternative Dispute Resolution Process.
   d. The access system shall schedule and provide for a timely second opinion, when requested from a qualified health care professional within the network, or arrange for the person to obtain one outside of the network at no cost. The person has the right to a face-to-face determination if requested.
   e. The access system shall provide the reasons for denial to the person denied and to any referral source (with the person's consent). The person shall be informed of the disposition and as appropriate, alternative services, and supports.
   f. The access system shall provide reports of disputes, complaints, and grievances to the PIHP Quality Oversight Committee on a quarterly basis as part of the QAPIP.
3. Services and Providers Available
   a. Applicants will be provided comprehensive and up-to-date information about mental health and substance abuse services that are available and the contact information about the providers who deliver them.

b. The access system shall assure that there are available alternative methods for providing information to individuals who are unable to read or understand written material or who have LEP.
c. The access system shall routinely refer individuals to community resources that not only include alternatives to public mental health or substance abuse treatment services, but also resources that may help them meet their other basic needs.

V. PROVIDER NETWORK

1. The CMHSPs or provider shall have written policies, procedures and plans that demonstrate the capability of its access system to meet the standards.
2. Community Outreach and Resources
   a. Active outreach and education efforts are in place to ensure the network providers and the communities are aware of the access system and how to use it.
   b. A regular and consistent outreach effort to commonly un-served or underserved populations who include children and families, older adults, homeless persons, members of ethnic, racial, linguistic and culturally-diverse groups, persons with dementia, and pregnant women has been established.
   c. Linkages with the community's crisis/emergency system, liaison with local law enforcement, and a protocol for jail diversion have been established.
3. Oversight and Monitoring
   a. The Medical Director shall be involved in the review and oversight of access system policies and clinical practices.
   b. The access system staff are qualified, credentialed and trained consistent with the Medicaid Provider Manual or , Healthy Michigan Provider Manual, the Michigan Mental Health Code, the Michigan Public Health Code, and the MDHHS/PIHP contract.
   c. Mechanisms have been put in place to prevent conflict of interest between the coverage determination function and access to, or authorization of, services.
   d. The access system monitors capacity to accept new individuals, and has awareness of any provider organizations not accepting referrals at any point in time.
   e. The access system shall routinely measure telephone answering rates, call abandonment rates, and timeliness of appointments and referrals. Any resulting performance issues are addressed through the PIHP's Quality Improvement Committee.
   f. The access system maintains medical records in compliance with state and federal standards.
4. Waiting Lists
   a. Policies and procedures have been developed for maintaining a waiting list for individuals not eligible for Medicaid or HMP who request community mental health services but cannot be immediately served. The policies and procedures shall minimally assure:
      - No Medicaid or HMP beneficiaries are placed on waiting lists for any medically necessary Medicaid or HMP service.
      - A local waiting list shall be established and maintained when the CMHSP is unable to financially meet requests for public mental health services received from those who are not eligible for Medicaid or HMP. Standard criteria will be

developed for whom must be placed on the list, how long they must be retained on the list, and the order in which they are served.

- Persons who are not eligible for Medicaid or HMPwho receive services on an interim basis that are other than those requested shall be retained on the waiting list for the specific requested program services. Standard criteria will be developed for who must be placed on the list, how long they must be retained on the list, and the order in which they are served.
- Use of a defined process, consistent with the Mental Health Code, to prioritize any service applicants and recipients on its waiting list.
- Use of a defined process to contact and follow-up with any individual on a waiting list who is awaiting a mental health service.
- Reporting, as applicable, of waiting list data to MDHHS as part of its annual program plan submission report in accordance with the requirements of the Mental Health Code.

VI. GRIEVANCE AND APPEALS

Individuals requesting service from the NMRE shall have the right to appeal a denial and/or request a second opinion when denied services and or authorization following their initial request for services (Michigan Mental Health Code: Sec. 705(1), (2)). Additionally, for Medicaid beneficiaries, consumers and providers have the right to appeal denials for requested services throughout their episode of care. Individuals denied their requests for hospitalization may request a second opinion (Michigan Mental Health Code: Sec. 409(4), 498e (f4) and 498h (5)). A dispute resolution and grievance process also exists wherein consumers may resolve concerns and disputes with the NMRE or their providers. The intent is to provide an easy and timely process to consumers that encourages discussion, negotiation and resolution of disputes. Complaint, grievance, and appeal procedures are detailed in the NMRE Administrative Manual, or MDHHS – PIHP Contract Attachment P6.3.1.1.1.

These policies and procedures do implement the rights to appeal provided in the Michigan Mental Health Code, Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) /Waiver Program , Rights to Notice and Fair Health for Medicaid Eligible contained in 42CFR, Chapter IV, Subpart E, Section 431.200, or the Michigan Public Act 238, Section 6231 (1) of 1978, as amended.

VII. DEFINITION OF TERMS

Appeal: A request for a review of an action. An action is a decision that adversely impacts an individual's claim for services due to denial or limited authorization; reductions, suspension or termination of services; or failure to make an authorization decision within allowable timeframes.

Assessment: The process established by an organization for obtaining appropriate and necessary information about each individual seeking entry into a health care setting for service. The information is used to match an individual's need with the appropriate setting, care level, and intervention.

Beneficiary: An individual who is eligible for Medicaid and who is receiving or may qualify to receive services under the Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Program

Community Mental Health Services Program (CMHSP): A program operated under Chapter 2 of the Mental Health Code - Act 258 of 1974 as amended (Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Program.

Consumer: An individual who receives services from the Michigan Department of Health and Human Services or a Community Mental Health Services Program. It also means a person who has received the equivalent mental health services from the private sector (Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Program).

Co-occurring disorder: Co-occurring disorders refer to co-occurring substance use (abuse or dependence) and mental health disorders. Consumers said to have co-occurring disorders have one or more disorders relating to the use of alcohol and /or other drugs of abuse as well as one or more mental disorders. (Substance Abuse Treatment for Persons with Co-Occurring Disorders. TIP 42, USDHHS, Substance Abuse and Mental Health Services Administration Center for Substance Abuse Treatment, 2005).

Emergent Need: A life threatening condition in which the consumer is suicidal, homicidal, actively psychotic, displaying disorganized thinking or reporting hallucinations and delusions which may result in self harm or harm to others; and/or is displaying vegetative signs and is unable to care for self.

Medical Necessity: Medical necessity is commonly defined as a determination that a specific service is medically (clinically) appropriate, necessary to meet the person's mental health/substance abuse needs, consistent with the persons, diagnosis, symptomatology and functional impairments, is the most cost-effective option in the least restrictive environment, and is consistent with clinical standards of care. (Current Medicaid Provider Manual).

Person-centered Planning: The process for planning and supporting the individual receiving services. It builds upon the individual's capacity to engage in activities that promote community life. It honors the individual's preferences, choices, and abilities (Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Program).

Prepaid Health Plan (PHP): Organization that manages specialty health care services under the Michigan Medicaid Waiver Program for Specialty Services States approved concurrent 1915 (b)/1915(c) Waiver Program, on a prepaid, shared risk basis, consistent with the requirements of 42 CFR part 401 et al June 14, 2002, regarding Medicaid Managed Care. (Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Program).

Recovery: Mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential. (Substance Abuse and Mental Health Services Administration Center for Substance Abuse Treatment, National Mental Health Information Center).

Routine Need: A condition in which the consumer describes signs and symptoms which result in impairment and functioning of life tasks, impact the consumer's ability to participate in daily living, and/or have markedly decreased the consumer's quality of life.

Urgent Need: A condition in which the consumer is not actively suicidal or homicidal, denies having a plan, means, or intent for suicide or homicide but expresses feelings of hopelessness, helplessness or rage, and has the potential to become actively suicidal or homicidal without immediate intervention. This consumer displays a condition which could rapidly deteriorate without immediate intervention, and without diversion and intervention will progress to the need for emergency services and care.

REFERENCE
Michigan Medicaid Managed Specialty Services and Supports Contract, attachment P.4.1.1

REVISED: **September 28, 2016, September 23, 2015; August 27, 2014**

REVIEWED:

APPROVED: **April 23, 2014**

Signed copy is on file with NMRE
Dave Schneider
Northern Michigan Regional Entity Chief Executive Officer

Date

Signed copy is on file with NMRE
Dennis Priess
Northern Michigan Regional Entity Board Chair

Date