PROVIDER MANUAL FY 23/24

This provider manual is a working document, for Detroit Wayne Integrated Health Network (DWIHN) contracted providers of services that contain instructions and guidelines to enable providers to know standard forms, performance measures, claims submission and processing, provider participation and other information related to standard practices for the Medicaid program(s) participation as same may be amended from time to time by MDHHS.

DWIHN OPERATIONS AND PROCEDURES
www.dwihn.org

CONTENTS

SECTION 1: INTRODUCTION

OVERVIEW

Welcome to the Detroit Wayne Integrated Health Network's (DWIHN) Comprehensive Provider Network Manual. As a contractor and DWIHN partner, you will assist DWIHN in meeting its mission of service to the people it serves who may have severe mental illness (SMI), serious emotional disturbance (SED), autism, intellectual/development disabilities (IDD), and/or substance use disorders (SUD).

This manual provides details and contractual requirements for participants in the DWIHN Provider Network and is intended to assist contractors in performing day-to-day operational activities. In some instances, it may direct you to a specific policy or additional documents that provides more detail.

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

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

For direct services provided by our Integrated Partnership Network the DWIHN Access Center can be reached 24 hours a day, 365 days per year by phone, fax or email.

Phone: 1-800 241-4949

TTY/TDD Line for Hearing Impaired: 1-866-870-2599)'

Email: accesscenter@dwihn.org

Fax: 877-909-3950

MISSION STATEMENT

We are a healthcare safety net organization that provides access to a full array of integrated services that facilitate individuals to maximize their level of function and create opportunities for quality of life.

VISION

To be recognized as a national leader that improves the behavioral and physical health status of those we serve, through partnerships that provide programs promoting integrative holistic health and wellness.

VALUES

- We are an advocate, person-centered, family and community-focused organization.
- We are an innovative, outcome, data-driven, and evidence-based organization.
- We respect the dignity and diversity of individuals, providers, staff, and communities.
- We are inclusive, culturally sensitive, and competent.
- We are fiscally responsible and accountable with the highest standards of integrity.

- We achieve our mission and vision through partnerships and collaboration.

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

HISTORY OF DETROIT WAYNE INTEGRATED HEALTH NETWORK

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

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

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

In 2019 the Board of Directors approved a name change to Detroit Wayne Integrated Health Network (DWIHN).

DWIHN: YOUR LINK TO INTEGRATED HEALTHCARE

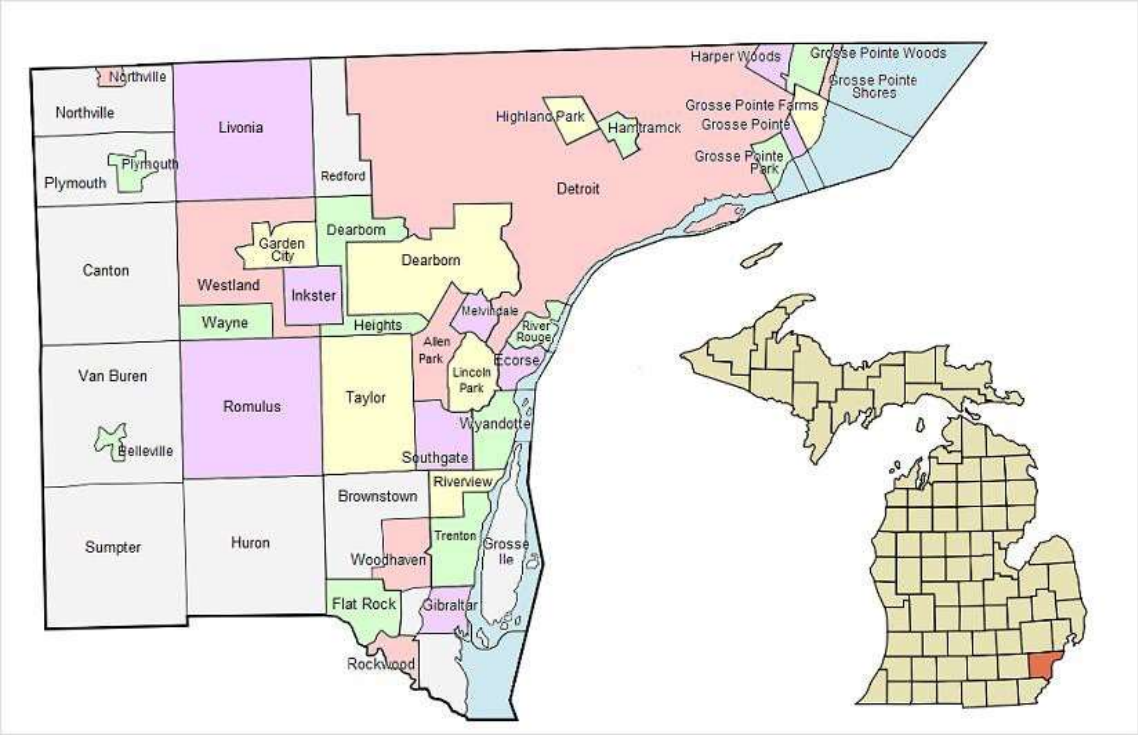
WHAT IS DETROIT WAYNE INTEGRATED HEALTH NETWORK?

The Detroit Wayne Integrated Health Network (DWIHN) is a safety net organization that provides a full array of services and supports to adults with serious mental illness (SMI), individuals with intellectual and developmental disabilities (IDD), children with serious emotional disturbances (SED) and persons with substance use disorders (SUD). DWIHN provides empowerment to persons within our behavioral health system, serving nearly 75,000 citizens in Detroit and Wayne County.

The DWIHN network is a comprehensive group of contracted organizations that provide services for the SMI, SED, SUD, and I/DD eligible populations in Wayne County. The network is comprised of DWIHN Direct Contractors which includes Behavioral Health providers, Substance Use Disorder providers, MI Health Link Dual Eligible providers, and Autism Spectrum Disorders Benefit providers.

DWIHN GEOGRAPHIC AREA

DWIHN services members across all 43 communities within Wayne County, Michigan.



GOVERNANCE

As defined by the Michigan Mental Health Code, the DWIHN governing body must include individuals in the system. At least one-third of the governing body must be primary or secondary Members. At a minimum, 50% of the one-third member representatives must be primary Members (people receiving services).

DWIHN must have a policy and program Advisory Council comprised of people served. The Advisory Council must meet monthly to review and provide input for existing, new, and revised policies, procedures, and programs. Documentation of the Advisory Council meetings must include registration/sign-in of attendees, agenda and minutes of the meeting, and a record of the directives of the Council.

DWIHN must also provide Member representatives with transportation to and from meetings of the governing body. Availability of transportation must be publicized so that primary Member representatives can take advantage of the available transportation.

CONTACTING DWIHN

Detroit Wayne Integrated Health Network Address:

707 W Milwaukee, Detroit, MI 48202

Access Call Center Phone: 313-344-9099

Crisis Care Center Phone: 313-989-9444

Mobile Crisis Units: 844-462-7474

24 Hour Helpline: 1-800-241-4949-Toll Free

Fax: 313-833-2156 or 877-909-3950

Email: accesscenter@dwihn.org

Customer Service 313-833-3232

Toll Free: 1-888 490-9698

Recipient Rights 1-888-339-5595-Toll Free

TDY Line: 1-888-339-5588-Toll Free

TTY: 711

REACHUSDETROIT.ORG (free text line) 313-488-4673

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

PROVIDER RESOURCES

DWIHN'S ELECTRONIC SYSTEMS

Providers are encouraged to use DWIN's electronic systems to do business with DWIHN. Providers can sign up for access to the following electronic systems:

- Mental Health Wellness Information Network (MH-WIN), DWIHN's secure provider portal. Providers use MH-WIN to:
- Verify a member's eligibility and benefits and see the history
- Check the status of claims and encounters
- Submit and check the status of authorization requests

Providers who are not already MH-WIN users can sign up by contacting the MH-WIN Help Desk at mhwin@dwmha.com.

Note: MH-WIN users are encouraged to log in to MH-WIN on a monthly basis. Providers must log in at least once every 3 months to keep their account active. If the account becomes disabled or is no longer active, contact MH WIN Support by sending an email to: mhwin@dwmha.com

OTHER PROVIDER RESOURCES ON DWIHN WEBSITE:

For DWIHN policies, procedures, meetings, training, announcements, and documents, visit our website at www.dwihn.org.

Access the documents found under the Provider tab https://www.dwihn.org/for-providers

OBSERVED HOLIDAYS

DWIHN is closed the following holidays, excluding the Access Center Staff and Utilization Management staff performing Authorizations which are both 24x7 operations.

- New Year's Day
- Martin Luther King's Birthday
- Memorial Day
- Juneteenth
- Independence Day
- Labor Day

- Veteran's Day
- Thanksgiving Day
- Day following Thanksgiving
- Christmas Eve
- Christmas Day
- New Year's Eve
- New Year's Day
- State (Gubernatorial) and National (Presidential) General Election Days

SECTION 2: ACCESS CALL CENTER

DEPARTMENT OVERVIEW

The Detroit Wayne Integrated Health Network's Access Call Center 's mission is to allow the people we serve better access to services and supports that are provided by the DWIHN Provider Network. The Access Call Center is the front gate to enroll and verify eligibility for our Members.

Through its courteous staff, the emphasis is placed on providing prompt and efficient service, while ensuring that everyone is treated with dignity and respect. Access Call Center staff is sensitive to those customers that need special accommodations i.e., hearing and /or language assistance. It is their responsibility to accommodate each individual's specific need with the specific need of the individual so that appropriate service is always provided

The DWIHN Access Call Center is overseen by professional staff with decades of mental health, crisis and customer service experience. Call Center staff are trained in the areas of behavioral health, Substance Use Disorders, disability relate concerns, crisis intervention and providing referrals as needed.

Serving as the central front door and screening agent for DWIHN, the Access Call Center is operated twenty-four (24) hours a day, seven (7) days a week, including holidays.

Hours for non-emergent calls will be from 8am-8pm Monday through Friday.

After 8pm and on weekends, the following services will be provided:

Warm transfer to the crisis line
Dispatch of Children's Crisis Teams from Emergency Departments
Hospital discharge follow-up appointments
A mental health clinician will be available for SUD screening only

If you have any questions or concerns regarding the DWIHN Access Call Center, please send an email to: accesscenter@dwihn.org.

ACCESS, TRIAGE AND REFERRAL PROCESS FOR BEHAVIORAL HEALTH SERVICES:

Members and Providers can contact the Access Call Center at 1- 800-241-4949 or the TYY/TDD number 1-866-870-2599 for the hearing impaired. Translation services are offered.

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

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

ENROLLMENT

The Detroit-Wayne Integrated Health Network provides mental health and substance use disorder services for Members with or at risk for serious emotional disturbance, severe mental illness, intellectual/developmental disabilities, and substance use disorders. Our programs are designed to give individuals, within the identified populations, greater choice, and involvement in their treatment.

The cornerstones of this program are:

- Providing choice,
- Person-Center Planning principals, and
- Maximizing the use of and developing new community-based services.

Services are provided through the DWIHN Direct Contracted Providers. The enrollment process is centralized through DWIHN's Access Call Center. The Access Call Center provides screening and eligibility determinations for all applicants seeking community mental health and substance use disorder services. However, there are currently exemptions to the Centralized Access Center process, which are the following:

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

Eligibility for Enrollment

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

Based on the Michigan Mental Health Code, services are available to eligible Members regardless of the ability to pay. Therefore, neither the lack of funds nor the ability to directly pay through private funds or insurance can be a barrier to receiving services if the person is in the priority population. The clinically responsible service provider assists Members that lack insurance with applying for their entitlements.

DWIHN benefit package for the uninsured allows for the Members to receive specific services for a limited time. Wayne County residents who are in the priority population and have private insurance or are able to directly pay the cost of services are eligible for community mental health services.

Registering New Members for Enrollment

Registering new members is a two-step process:

1. For Members that are not listed in MH-WIN but are seeking mental health services, the Member/family/guardian must contact DWIHN Access Center, at 1-800-241-4949 to initiate the screening and eligibility process.

    a. A face to face screening shall be provided based on choice/individual need. The Access Center shall inquire as to the existence/desire to complete an Advance Directive. As part of its triage process,
    b. The Access Center determines if the Person is requesting and is appropriate for Behavioral Health Services.
    c. Once eligibility for Behavioral health services is determined, the Person is offered options of intake locations. The Access Center will assign a behavioral health provider, based on Person's choice, and then enter the potential member into MH-WIN.

2. The Access Center will schedule the first intake appointment with the Member/family/guardian based on their choice of provider locations and available appointments which have been entered in MH-WIN by providers.

a. Non-emergent intake appointments shall be scheduled within fourteen (14) days,
b. Persons discharged from hospitals shall receive an appointment within seven (7) days.

Confirmation Of Enrollment

The Access Center will make a determination of eligibility immediately following the telephonic/face to face screening process. The Access Center will send a Welcome Packet within 24 hours of enrollment. The Welcome letter shall include the information specific to Advance Directives, Provider Directory. Recipient Rights brochure, Member Rights and Responsibilities.

Hospital Enrollments

Hospital calls requesting hospitalization / authorization for a Member will all be OUTPATIENT HOSPITAL ENROLLMENTS. We can enroll any age for the hospital. The hospital staff must fax the face sheet and proof of Wayne County residency to the access center and complete an eligibility checklist telephonically with an access center representative.

Outpatient Hospital Enrollment – Hospitals requesting a Member (adult or child) be enrolled with DWIHN for Routine Outpatient services. These will only be voluntary. Please remember that an outpatient enrollment will require proof of Wayne County Residency. If they have Wayne County Medicaid that can count as proof.

Inpatient Hospital Enrollment – Hospital requesting inpatient services for a Member (adult or child). All Adult Inpatient hospital request will need to be directed to COPE: 1-844-296-2673. The Call Center does not do INPATIENT ENROLLMENTS FOR ADULTS. If the hospital is requesting inpatient enrollment for a child, we will need to complete a CHILDREN'S INPATIENT SCREENING.

Children's Inpatient

Approved Screener contact information for this process will be emailed to the access center every Monday. This is time sensitive as the screeners have a limited amount of time to screen the child in the hospital.

The first page should include the following:

1. Inpatient/crisis screening request
2. Medically cleared, date and time
3. Parent or legal guardian present. DHHS worker contacted (court wards)
4. Medicaid number or private insurance-have they contacted private insurance and verified there is not mental health coverage

This process is ONLY for CHILDREN INPATIENT HOSPITAL OR CHLDREN CRISIS SCREENING REQUEST.

Hospital Discharge Appointments

DWIHN Call Center Representatives will schedule Outpatient Mental Health appointments for Members upon the request of the hospital or case manager at the time of inpatient discharge.

It is a requirement of hospitals to have an outpatient mental health appointment scheduled for Member within **seven days (7)** of hospital discharge from an inpatient setting.

The hospital representative is required to call the access center to request a discharge appointment and is also required to provide discharge information packet via fax so that the outpatient mental health provider can access the information within 24 hours of the Members discharge from the hospital.

The fax queue for the discharge documents (VIEW INCOMING FAX QUEUE FOR POST HOSPITAL DISCHARGE APPOINTMENTS AND START ACCESS/CALL INQUIRY) number is: **1-248-406-1364.**

Disability Designation/Program Change Procedures

Individuals may need to have a correction or change in their disability designation due to: additional assessments/evaluations, incorrect data, or an error. A CRSP provider must follow the steps below and complete the form found on the DWIHN website under Access our Services/Access Call Center tab to initiate the change. An individual must be enrolled in MH-WIN for a change to be considered.

Procedural Steps:

5. The Disability Designation/Program Change form must be completed by the CRSP and submitted to DWIHN Access Call Center / Children's Initiatives/ Adult Initiatives via the link on the DWIHN Website:
    a. https://app.smartsheet.com/b/form/a713f14ee3ca4463ad67b1fb88b80467

6. Upon receipt, the Access Center will log in the request and forward it Clinical review of submitted documentation and recommendation for approval or denial.
7. Approved Disability Designation/Program Changes will be effective within three business days of the notice being sent to the Provider. However, enrolled persons shall have the opportunity to change designations outside of the assigned effective dates due to extenuating circumstances. Use of this process is an exception and not the rule.

    a) Extenuating circumstances may be:
        (i) Incorrect designation documented with no clinical documentation to support
        (ii) Significant change in mental health, emotional and or physical condition wherein specified treatment or support services or qualified mental health care provider are not sufficient in the existing network to provide the treatment service to the enrollee in accordance to his/her plan of service.

8. Requests for changes in disability designations will be reviewed by the DWIHN Physician or clinical review team. Requests for change in disability designation that have not been approved can be appealed. Appeals should be requested by contacting the Access Call Center or DWIHN Customer Service Department.
9. CRSP will receive notification of approvals and denials.
10. Documentation of approval/denials will be uploaded in MH-WIN in the Members record.

CRSP CHANGE

Individuals may choose to change their CRSP. Once an individual makes the decision to change their CRSP, the individual should coordinate with their current CRSP or the new CRSP to submit the CRSP change form during the transfer process. A CRSP provider must follow the steps below and complete the form found on the DWIHN website under Access our Services /Access Call Center tab to initiate the change. An individual must be enrolled in MH-WIN for a change to be considered.

1. Complete CRSP Change form in its entirety.
2. Send the completed form to the Access Center via email at crspprovider@dwihn.org or fax 877 909-3950.
3. Effective dates are the 1st and 15th of each month

Note: In instances where verbal consent is obtained, the person attesting to receiving verbal consent should sign and print their name, credentials and contact phone number and also document the name of the person providing the consent, the date and contact phone number, to be reached should any questions arise regarding the request.

This process should be done before the new CRSP has seen the individual or shortly after the individual's first appointment.

ACCESS STANDARDS

Detroit Wayne Integrated Health Network Access Call Center maintains the National Call Center Standards for Performance as follows: Abandonment Rate <5%, Average Speed to Answer within 30 seconds, an average of 80% of all call received are to be answered and answered and meeting the Service Level standard defined as 80% of all calls answered exactly within a 30 second, The Access Call Center supports the following Access Standards as per the Michigan Mission Based Performance Standards as well as the standards to meet the MI Health Link contract, 42 CFR 438.206 and Contract Schedule A by screening and scheduling appointments on the same day or within 24 hours of the request. Appointments are referred per the regulatory standard whenever available.

Contracted DWIHN providers are expected to maintain established office/service hours and access to appointments within established regulatory standards or as may be required by a given client of DWIHN or specific government sponsored health benefit program. DWIHN requires that the hours of operation of all of our network providers are convenient to the population served and do not discriminate against members (e.g., hours of operation may be no less than those for commercially-insured or public fee-for-service-insured individuals), and that services are available twenty-four hours a day, seven days a week, when medically necessary.

It is the expectation of DWIHN that providers ensure access is made available per the contracts for Access Standards that are to be met are:

WELCOMING

1. Services shall be available to all residents of Wayne County, regardless of where the person lives, or where he/she contacts the system. Staff shall be welcoming, accepting, and helping with all applicants for service.
2. Providers shall operate or arrange for an access line that is available 24 hours per day, seven days per week, including in-person and by-telephone access for hearing impaired individuals. Telephone lines are toll-free, accommodate Limited English Proficiency (LEP), are accessible for individuals with hearing impairments, and have electronic caller identification, if locally available.
    a. Callers encounter no telephone "trees" and are not put on hold or sent to voicemail until they have spoken with a live representative from the provider office, and it is determined, following an empathetic opportunity for the caller to express their situation and circumstances, that their situation is not urgent or emergent.
    b. All crisis/emergent calls are immediately transferred to a qualified practitioner without requiring an individual to call back
    c. For non-emergent calls, a person's time on hold awaiting a screening must not exceed three (3) minutes without being offered an option for callback or talking with a nonprofessional in the interim.
    d. All non-emergent callbacks must occur within one (1) business day of initial contact.
    e. For providers with decentralized Access Systems, there must be a mechanism in place to forward the call to the appropriate access portal without the individual having to redial.
3. The providers shall provide a timely, effective response to all individuals who walk in.
    a. For individuals who walk in with urgent or emergent needs, an intervention shall be immediately initiated.
    b. Those individuals with routine needs must be screened or other arrangements made within thirty (30) minutes.
    c. The providers shall maintain the capacity to immediately accommodate individuals who present with:
        i. LEP and other linguistic needs
        ii. Diverse cultural and demographic backgrounds

iii. Visual impairments
iv. Alternative needs for communication5. Mobility challenges

4. Reasonable Access:
    a. 30 Minutes/ 30 Miles: Members must have reasonable access to all types of covered services. Members receiving services must not be required to travel greater than 30 minutes or 30 miles to receive services.
    b. 20 Minutes /10 Miles: MI-Health Link Members must have reasonable access to all types of covered services. Members receiving services must not be required to travel greater that 20 minutes or 10 miles to receive services.
    c. Emergent: Must be seen immediately by a provider for a face-to-face evaluation by a mental health professional.
    d. Urgent: Must be seen by a mental health professional for a face-to-face evaluation within 24 hours of the request for services (including transfer between levels of care during a chemical dependency episode).
    e. Routine: Must be seen by a mental health professional for a face-to-face intake/evaluation within 14 calendar days of the request for service.
    f. Ongoing Services: Must be established within 14 calendar days from the intake/evaluation.
    g. Acute Inpatient: Assessment, determination, and disposition must be made following medical clearance and within 3 hours of the request

Discharge from Hospital: A psychiatrist must see Members within seven (7) calendar days of discharge from a state, community, or partial hospital program.

Timeframes and Procedural Steps for Priority Population Management

1. Walk-In
    a. Individual who walk in with urgent or emergent needs, an intervention shall be immediately initiated.
    b. Individuals with routine needs must be screened or other arrangements made within (30minutes).
2. Pregnant Injecting Drug User Admission Requirements
    a. Screened and referred within 24 hours
    b. Detoxification, Methadone, or Residential – Offer admission within 24 business hours.
    c. Other Levels of Care – 0ffer admission within 48 business hours
    d. **Interim services**
        i. Begin treatment within 48 hours
        ii. Individuals are to receive counseling and education on the following topics:
            1. HIV and TB.
            2. Risks of needle sharing.
            3. Risks of transmission to sexual partners and infants.
            4. Effects of alcohol and drug use on the fetus.
        iii. Referral for prenatal care
        iv. Early intervention clinical services
3. Pregnant Women (SUD)
    a. Screened and referred to treatment in 24 hours
    b. Detoxification, Methadone, or Residential - Offer admission within 24 business
    c. Other Levels of Care – offer admissions within 48 business hours
    d. **Interim Service Requirements**
        i. Begin treatment within 48 hours
        ii. Individuals are to receive counseling and education on the following topics:

iii. HIV and TB.
iv. Risks of transmission to sexual partners and infants.
v. Effects of alcohol and drug use on the fetus.
vi. Referral for prenatal care.
vii. Early intervention clinical services

4. Injecting Drug User
    a. Screened and referred within 24 hours
    b. Offer admission within 14 days.
    c. **Interim Service Requirements**
        i. Treatment shall begin within 48 hours.
        ii. The wait time is not to exceed 120 calendar days.
    d. Individuals are to receive counseling and education on the following topics: a) HIV and TB.
        i. Risks of needle sharing.
        ii. Risks of transmission to sexual partners and infants.
        iii. Early intervention clinical services.
5. Parent at Risk of Losing Children
    a. Screened and referred within 24 hours.
    b. Offer admission within 14 days.
    c. **Interim Service Requirements**
        i. Begin treatment within 48 hours
        ii. Early intervention clinical services
6. All Other Populations
    a. Screened and referred within 7 calendar days.
    b. Capacity to offer admission within 14 days.
    c. **Interim Service Requirements**
        i. None required

It is the expectation that the providers provide SUD services to priority population clients before any other non-priority client is admitted for any other treatment services. Exceptions can be made when it is the client's choice to wait for a program that is at capacity

REFERRAL TO PIHP OR CMHSP PRACTITIONERS

1. DWIHN assures that applicants are offered appointments for assessments with mental health professionals of their choice within the MDHHS PIHP and CMHSP contract-required standard timeframes.
2. Providers must update their calendars providing the status of referred appointments.
3. Providers shall ensure that, at the completion of the screening and coverage determination process, individuals who are accepted for services have access to the PCP process.
4. DWIHN ensures that the referral of individuals with co-occurring mental illness and SUDs to practitioners are in compliance with confidentiality requirements of 42 CFRB. Providers who refer for services ensure individuals have access to the PCP process

BEHAVIORAL HEALTH AND SUBSTANCE ABUSE SCREENING PROGRAM

Detroit Wayne Integrated Health Network (DWIHN) is committed to excellence in behavioral health service delivery. DWIHN strives not only to meet but also to surpass standards set forth by the National Council for Quality Assurance

(NCQA) for Managed Behavioral Health Organizations (MBHO). NCQA is an accrediting organization intended to assist behavioral health organizations in achieving the highest level of performance possible, reducing member risk for untoward health outcomes, and creating an environment of continuous improvement.

To best serve our members with the provision of appropriate behavioral health and substance use services, and to continue to exceed quality standards, DWIHN is dedicated to advancing wellness and taking action to reduce negative effects of mental illness and substance use disorders through the promotion of early screening and assessment.

Towards this effort and dedication, DWIHN has implemented two screening programs, one for coexisting mental health and substance use disorders using the Bio-psychosocial Assessment, and a second screening program, for screening for depression in adults, the Patient Health Questionnaire-9 (PHQ-A). These two screening measures are based on scientific evidence, best practice, and industry standards. DWIHN will review scientific evidence and update these programs every two years, or more often, where appropriate if new evidence becomes available in between scheduled reviews. The selection of screening measures, identification of population screened, recommended frequency of the screenings, and overall program design has been a collaborative effort between DWIHN and its Network Providers, consisting of practitioners and provider stakeholders.

According to SAMHSA (Substance Abuse and Mental Health Services Administration), approximately 8.2 million adults have co-occurring disorders, meaning, they have both a mental health and substance use disorder, and only 6.9% of these individuals receive treatment for both conditions (SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2016 and 2017).

CONTACT INFORMATION FOR CALL CENTER

Access Center phone: 1- 800-241-4949 or the TYY/TDD number 1-866-870-2599 for the hearing impaired

SECTION 3: CLAIMS AND FINANCE

DEPARTMENT OVERVIEW - CLAIMS

It is the policy of Detroit Wayne Integrated Health Network (DWIHN) to provide guidelines for enrollees/members receiving and providers requesting behavioral health, substance use disorder and autism services to access the Detroit Wayne Integrated Health Network (DWIHN) Claims appeals process consistent with the Michigan Department of Health and Human Services (MDHHS) and the Center for Medicare and Medicaid Services (CMS) requirements, contracts, policy guidelines and technical advisories as well as accreditation requirements. Please refer to DWIHN website at DWIHN.ORG for detailed appeal policies and procedures.

As part of our effort to deliver the best possible outcome on every claim, we continuously evaluate our claims process as we process claims for contracted and non-contracted providers. Claims are submitted electronically via 837 file or via fax for services rendered. Claims are processed for four lines of business: Medicaid, Substance Use Disorder (SUD), Autism and MI Health Link. No matter the type or complexity of your claim, our commitment to delivering high-quality and consistent claims service remains the same. For detailed claims processing please reference Policies and Procedures on DWIHN website.

Claims personnel works closely with other units such as Office of Fiscal Management (Finance), Utilization Management, MCO, Quality, Compliance, and Information Technology to ensure a smooth process for paying out claims.

CLAIMS POLICIES AND PROCEDURES

Always refer to the most recent version of DWIHN policies, procedures, and documents, by visiting our website at https://www.dwihn.org/for-providers.

https://www.dwihn.org/providers_policy_Claims_Processing.pdf

CLAIMS FILING INSTRUCTIONS

When required data elements are missing or are invalid, claims will be rejected by DWIHN for correction and re- submission.

Claims for billable services provided to DWIHN members must be submitted by the provider who performed the services.

CLAIMS FILED WITH DWIHN ARE SUBJECT TO THE FOLLOWING PROCEDURES:

- Verification that all required fields are completed on the CMS 1500 or UB-04 forms.
- Verification that all Diagnosis and Procedure Codes are valid for the date of service.
- Verification for electronic claims against 837 edits. Verification of member eligibility for services under DWIHN during the time period in which services were provided.
- Verification that the services were provided by a participating provider or that the “out of network” provider has received authorization to provide services to the eligible member.
- Verification that an authorization has been given for services that require prior authorization by the DWIHN.
- Verification of whether there is Medicare coverage or any other third-party resources and, if so, verification that DWIHN is the “payer of last resort” on all claims submitted to DWIHN.

Important: Rejected claims are defined as claims with invalid or required missing data elements, such as the provider tax identification number, member ID number, that are returned to the provider or EDI* source without registration in the claim processing system.

- Rejected claims on the front end are not registered in the claim processing system and can be resubmitted as a new claim.
- Rejected claims are considered original claims and timely filing limits must be followed.

Important: Denied claims are registered in the claim processing system but do not meet requirements for payment under Plan guidelines. They should be resubmitted as a corrected claim.

Denied claims must be re-submitted as corrected claims within 60 calendar days of the denial notice.

CLAIM MAILING INSTRUCTIONS

Submit paper claims to DWIHN via Fax to (313) 209-3601. Please include all necessary attachments with the fax.

DWIHN encourages all providers to submit claims electronically. For those interested in electronic claim filing contact your EDI software vendor or DWIHN at mhwin@dwihn.org to get instructions on electronic submission.

CLAIM FILING DEADLINES

Claims must be submitted to DWIHN within 60 calendar days from the date services were rendered or compensable items were provided.

Re-submission of previously denied claims with corrections and requests for adjustments must be submitted within 30 calendar days from the date of the denial notice.

Please allow for normal processing time before re-submitting a claim either through the EDI or paper process. This will reduce the possibility of your claim being rejected as a duplicate claim. Claims are not considered as received under timely filing guidelines if rejected for missing or invalid provider or member data.

EXCEPTIONS

Claims with Explanation of Benefits (EOBs) from primary insurers must be submitted within 365 days of the date of the primary insurer's EOB (claim adjudication).

Claims originally rejected for missing or invalid data elements must be corrected and resubmitted within 30 calendar days from the date of the denial notice.

Requests for adjustments may be submitted in MHWIN claims appeal queue.

ADJUSTED CLAIMS

A **Dispute** is a verbal or written expression of dissatisfaction by a Network Provider regarding decision by DWIHN that directly impacts the Network Provider. Disputes are generally administrative in nature and do not include decisions concerning medical necessity.

An **appeal** is a written request from a Health Care Provider for the reversal of a denial by DWIHN, through its Formal Provider Appeals Process. All appeals including disputes by contracted providers must be submitted in MHWIN claim appeal queue.

Claims with issues where resolution does not require complete re-submission of a Claim can often be easily adjusted. Adjusted Claims cannot involve changing any fields on a Claim (for example an incorrect code) and **cannot** often be corrected over the phone or via pihpclaims@dwihn.org. Adjusted Claims usually involve a dispute about amount/level of payment or could be a denial for no authorization when the Network Provider has an authorization number. If a Network Provider has Claims needing adjustment and there is a manageable volume of Claims (five or less), the Network Provider can send an email to pihpclaims@dwihn.org. All emails sent to pihpclaims@dwihn.org are responded to within 24 hours of receipt.

CONTACT INFORMATION FOR CLAIMS

For questions regarding Claims, please contact: pihpclaims@dwihn.org or call (313) 344-9099 ext. 2653

DEPARTMENT OVERVIEW - FINANCE

The Office of Fiscal Management (Finance) establishes and maintains the financial controls necessary to safeguard the assets of the Detroit Wayne Integrated Health Network (DWIHN) in accordance with generally accepted accounting principles and applicable laws; to manage and accurately report DWIHN financial transactions through our Enterprise Resource Planning (ERP) system; to develop reporting tools and support internal and external stakeholders so they can have the information they need to make data driven decisions and achieve their goals.

Within the DWIHN Finance department are several functions including:

- **Accounting** – Accumulates and reports on the financial position of DWIHN.
- **Accounts Payable** – Processes all DWIHN's payments outside of payroll.
- **Auditing and Grants** – Provides oversight of the financial reporting process, audit process, DWIHN's system of internal controls and compliance with laws and regulations.
- **Budget** – Provides a framework for managing DWIHN's assets, cash flows, income, and expenses.
- **Financial Systems** – Maintains a financial management system with strong internal controls and for monitoring compliance with those controls to ensure the integrity of DWIHN's financial information and the safety of its assets.
- **Fiscal Informatics and Analytics** – Assists in establishing and enhancing data driven and data informed operational and management strategies, methods, processes, and systems. Manages and coordinates analytics and informatics projects related to cost and utilization, revenues, eligibility and other financial and risk related data.
- **Payroll** – Ensures that DWIHN pays its employees accurately and timely.
- **Purchasing and Procurement** – Manages and coordinates the acquisition of goods and services, including requisition processing, commodity code tracking, and bid specifications. Assists with contract management and the issuance of purchase orders.

  DWIHN accepts quotations only when there is a current need. To view current solicitations for major contracts you must register with the Michigan Intergovernmental Trade Network (MITN) at http://www.mitn.info and download theInvitations for Bids (IFBs), Requests for Proposals (RFPs) and Requests for Qualifications (RFQs). Registration on MITN is Free to obtain bid information.

DWIHN requires certain forms to be completed and submitted with quotes, bids, and proposals. The below list of forms and documents are available for download:

- Business Information Questionnaire
- Debarment/Suspension Form
- Ethics in Contracting Form
- First Tier Subcontract Designation Form
- IRS W-9
- Electronic Fund Transfer (EFT) Form

PROVIDER PAYMENTS:

Our providers are paid according to the published payment schedules. Please follow this link to preview our provider payment schedules at: https://www.dwihn.org/finance_payment_schedules

STANDARDIZED RATES:

Detroit Wayne Integrated Health Network operates under a standardized rate for services performed. Rates and codes can be found on our website at: https://www.dwihn.org/rate-charts

ABILITY TO PAY

Access to care is not denied due to ability to pay. Financial determination must be calculated no less than annually by the Clinically Responsible Service Provider (CRSP). It should be updated whenever a consumer's financial situation changes. Clinically Responsible Service Provider (CRSP) will utilize the standard Determination of Eligibility formula available in the DWIHN MHWIN Ability to Pay module. Please refer to the Ability to Pay Policy found at: https://www.dwihn.org/policies

CONTACT INFORMATION FOR FINANCE

General Email for Finance: TeamFinance@dwihn.org

SECTION 4: CLINICAL

CLINICAL RESPONSIBLITIES OF PROVIDERS

COMPLIANCE WITH ADVANCE DIRECTIVES

Advance Directives shall be included in the Welcome packet and during New Enrollee Orientation process. Copies are available through the DWIHN Access Center and the provider networks.

Providers must ensure compliance with Federal and State regulations and contractual responsibilities to inform Members, and their families of the Member's right to understand and to develop Advance Directives for Medical and Mental Health Treatment within the context of the PCP process.

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

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

Members who choose to develop an Advance Directive must be able to give informed consent. The determination of the Member's ability to provide informed consent shall include an assessment of their ability to Understand the Need for Treatment.

The Provider is responsible for helping the Member to:

Understand the treatment options (including no treatment and the potential implications) for the illness/ condition,

Consider the possible benefits and drawbacks (such as side effects from medication) from each treatment, and

Make a reasonable choice among the treatments available.

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

There is no required form for completion of an Advance Directive. DWIHN has developed a pamphlet and handbook respectively entitled "Advanced Directives for Medical and Mental Health Care Choices" and "Advance Directives-Medical and Mental Healthcare Advance Directive Handbook and Forms."

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

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

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

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

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

There is a mental health/medical emergency endangering the life of the Member or the life of another person.

The treatment requested is unavailable.

There is a conflict between the Advance Directive and the provisions set forth in a petition or court- ordered treatment.

Ongoing Services: Must be established within 14 calendar days from the intake/evaluation.

Children's Services/Initiatives

DEPARTMENT OVERVIEW:

DWIHN provides a comprehensive and integrated array of services/supports which inspires hope and promotes recovery/self-determination for children and teens ages 0 to 21st birthday with Serious Emotional Disturbances (SED) and/or Intellectual Developmental Disabilities (I/DD). Children, youth, and families with co-occurring mental health, substance use, and physical health conditions receive services within a System of Care that is:

Values	Goals
• Community Based • Family Centered • Youth Guided • Culturally and Linguistically Responsive • Trauma Informed	1. Increase Access to Services 2. Improve Quality of Services 3. Increase Youth and Parent Voice 4. Improve Quality of Workforce

Autism Spectrum Disorder Benefit

Autism Spectrum Disorder (ASD) can be identified as a developmental disability in some instances. This disorder can impact children and youth in different ways but is characterized by social impairments, communication difficulties, and restricted, repetitive, and stereotyped patterns of behavior. Although ASD varies significantly in character and severity, it occurs in all ethnic and socioeconomic groups and effects every age group. Behavioral or developmental signs to prompt screening include difficulty learning, problems acquiring new skills, problems communicating, and experiencing problem behaviors that get in the way of daily activities.

To be eligible, the child must:

- Be under 21 years of age;
- Be a Wayne County Resident;

- Have a diagnosis of ASD from a qualified practitioner;
- Meet medical necessity criteria for Applied Behavioral Analysis (ABA); and
- Active Medicaid coverage.

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

Refer to Children's Initiative on DWIHN website for additional information on specific services:

- Children Initiatives: https://www.dwihn.org/childrens-initiatives
- Autism Services: https://www.dwihn.org/autism-services
- Contact Information: TeamChildrens@dwihn.org

Waiver Services

Children's Home and Community Based Services Waiver Program (CWP):

The Children's Waiver Program (CWP) makes it possible for Medicaid to fund home and community-based services for children with Intellectual and/or Developmental Disabilities who are under the age of 18 when they otherwise wouldn't qualify for Medicaid funded services.

To be eligible the child must:

- Have an intellectual and/or developmental disability (as defined in the Michigan state law), be less than 18 years of age and in need of habilitation services;
- Reside with birth or legally adoptive parent(s) or with a relative who has been named the legal guardian under the laws of the State of Michigan, provided that the relative is not paid to provide foster care for the child;
- Be at risk of being placed into an ICF/IID (Intermediate Care Facility for Individuals with Intellectual disabilities) facility because of the intensity of the child's care and the lack of needed support, or the child currently resides in an ICF/IID facility but, with appropriate community support, could return home;
- Family income must be above Medicaid limits when viewed as a family of one (applying for the waiver will waive the parent's income thus making them Medicaid eligible); and
- Have intellectual or functional limitations that indicates the child would be eligible for health, habilitative and active treatment services provided at the ICF/IID level of care. Habilitative services were designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings. Active treatment includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services. Active treatment is directed toward the acquisition of the behaviors necessary for the child to function with as much self-determination and independent as possible, and the prevention or deceleration of regression or loss of current optimal functional status.

Habilitation Supports Waiver (HSW) Program:

A program aimed to assist individuals, of all ages, with developmental disabilities in the acquisition of skills that will facilitate their independence, productivity and promote inclusion and participation in the community. The HSW operates under Section 1915 (c) of the Social Security Act, in order to provide specified home and community- based services designed to enroll participants who would otherwise require intermediate care facility for Individuals with Intellectual Disability (ICF/IID) Level of Care. The HSW operates concurrently with the 1915 (c) waiver. The services and supports are provided under the auspices of the PIHP (DWMHA) under contract with Michigan Department of Health and Human Services (MDHHS) and must be specified in the beneficiary plan of services developed through the Person-Centered Planning (PCP) process.

To be eligible the member must:

- Have a developmental disability (as defined by Michigan law) no age restrictions;
- Be Medicaid eligible and enrolled;
- Reside in a community setting or will reside in a community setting;
- Would otherwise require level of services similar to an Intermediate Care Facility/Individual w/Intellectual Disability (ICF/IID);
- Choose to participate in the HSW instead of ICF/IID services; and
- Once enrolled, receive at least one (1) HSW service a month.

Serious Emotional Disturbance (SED) Waiver Program:

A 1915(c) Waiver for Children with Serious Emotional Disturbance (SEDW) available for children with serious emotional disturbance who meet criteria for admission to a state inpatient psychiatric hospital or who are at risk of hospitalization without waiver services. The SED Waiver provides services that are enhancements or additions to the Medicaid State Plan coverage for children ages 0 through their 21st birthday who have an SED. MDHHS operates the SED waiver through contracts with the Community Mental Health Service Programs (CMHSP's).

To be eligible, the child must:

- Be under the age of 18 when initially approved for the waiver, but can remain in the waiver until age 21 if all eligibility requirements continue to be met;
- Reside with birth/adoptive parents or resides in foster care and is either a Temporary Court Ward (TCW) or a Michigan Children's Institute (MCI);
- Meet current MDHHS criteria for state psychiatric hospital for children or at risk of state psychiatric hospitalization;

CLINICAL PRACTICE IMPROVEMENT (CPI)

The Clinical Practice Improvement (CPI) Department develops written policy and procedure on clinical practice guidelines for DWIHN and its network of contracted providers. These policies are drafted with stakeholder feedback, reviewed, and finalized when published for review. The department reviews evidence-based and best practice standards and offers training, technical assistance, monitoring and oversight to improve the quality of care for beneficiaries served by DWIHN. The CPI department facilitates the Improving Practice Leadership Team (IPLT) which consists of a multi-disciplinary team, chaired by the DWIHN Chief Medical Officer and Clinical Officer. IPLT is responsible for overseeing the implementation of evidence-based practices, treatment interventions of individuals with behavioral and physical health challenges and co-occurring disorders.

CPI is also responsible for ensuring that DWIHN and its network of providers are producing measurable outcomes for the least necessary cost over the continuum of the individual's care. CPI completes fidelity reviews that help ensure utilization, certification and credentialing standards are met. The CPI team also drafts and provides feedback on Performance Improvement Projects (PIP) which are developed to ensure all clinical standards of care are clinically appropriate and delivered in accordance to fiduciary and accrediting bodes.

CPI assists in developing sustainability plans and acts as a liaison with the Michigan Department of Health and Human Services (MDHHS) to ensure services such as Assertive Community Treatment (ACT), Mental Health Court, Returning Citizens, and Evidence- Based Supportive Employment are delivered appropriately and within standard. CPI also establishes workgroups and forums to ensure the provider network receives information regarding clinical practice standards applicable to the delivery of services to members.

Contact Information: clinicalpracticeimprovement@dwihn.org

CPI PROVIDER RESPONSIBILITIES

DWIHN contracted providers must:

1. Review and adhere to DWIHN's adopted clinical practice guidelines.
    a. If your clinical judgment leads to a decision that varies from recommendations in a guideline, thoroughly document the reasons in the member's clinical record; and
    b. Provide your medical director, Quality Improvement Unit/Department and the DWIHN Improving Practices Leadership Team (IPLT) with suggestions for improving our guidelines.
2. Participate in quality studies, outcomes research and other initiatives, as requested. Your participation may impact the reimbursement rates you receive from us and your ability to participate in any quality/incentive payments we may offer.

INTEGRATED HEALTH CARE/ MI-HEALTHLINK

Integrated Health Care is a systematic, holistic approach to the overall care of an individual. It is the coordination of services for physical health, mental health, substance use disorder, and intellectual/developmental disabilities.

Persons with behavioral health conditions can be disproportionately affected by preventable and treatable medical conditions like type II diabetes, heart disease, obesity, and hypertension. Combining medical care with behavioral health services allows the full spectrum of health concerns that an individual present will be addressed. Medical and behavioral health professionals work together as a team to improve the overall health and well-being of each individual at any provider location. Integrated care addresses whole person health and aims for the following results:

The Complex Case Management (CCM) program is designed to support individuals with behavioral health and physical health concerns who could benefit from being linked to services and appropriate community resources. Complex Case Management aims to provide early intervention to prevent crisis, increase stabilization and improve overall quality of life. Criteria for acceptance into the CCM program include:

- The presence of behavioral health and physical health concerns
- An active member of outpatient behavioral health services with disability designation of SMI, DD/IDD, or SUD as evidenced by at least one visit within the quarter with a DWIHN provider
- The use of extensive behavioral health utilization within a 12-month period (Adults-10 or more Emergency Department visits within the last 6 months. Children/Adolescents-4 or more Emergency Department visits within the last 12 months)
- Evidence of one or more gaps in services or gaps in medication refills for behavioral health and/or medical conditions
- The individual's willingness to actively participate in CCM as the program is voluntary
- Providers can fill out the CCM Referral form located on the DWIHN website and email to pihpccm@DWIHN.org or fax to (313)989-9529. Members can contact 1-888-490-9698 with questions about the Complex Case Management program. There is no cost to individuals who are interested in participating in the CCM program and participation in the program is voluntary.

MI-HEALTH LINK GENERAL INFORMATION

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

Five Health Plans – Aetna, AmeriHealth, Hap, Michigan Complete Health (formally known as Fidelis) and Molina - function as Integrated Care Organizations (ICO). The ICO organizations manage acute, primary, pharmacy, dental and long-term supports, and services for members.

Detroit Wayne Integrated Health Network (DWIHN), as the designated regional Pre-Paid Inpatient Health Plan (PIHP) for Wayne County, manages the full scope of behavioral health services covered by Medicare and Medicaid for members enrolled in MI Health Link. The PIHP will continue to coordinate and monitor services delivered to individuals with mental illness, intellectual/developmental disabilities, and substance use disorders.

These services include:

- Outpatient visits (Medicaid and Medicare) for individuals with mild to moderate mental illness, severely mentally impaired (SMI), substance use disorders (SUD), and intellectual/developmental disabilities (I/DD)
- Outpatient (Medicaid and Medicare) treatment for alcohol and drug use, including Opioid Treatment Program services
- Individual and group therapies
- Family counseling
- Psychiatric evaluation
- Medication management • Diagnostic tests
- Other Medicaid behavioral health services for individuals with specialized needs related to behavioral health and I/DD beyond covered acute care services
- Partial hospitalization – a structured program of outpatient psychiatric services which are provided as an alternative to inpatient care
- Inpatient mental health services delivered either in a general hospital or in a psychiatric hospital that only cares for individuals with mental health concerns

Individuals eligible for MI Health Link must:

- Be 21 years of age or older at the time of enrollment
- Reside within the demonstration area
- Be eligible for full Medicaid benefits without a spend-down
- Be eligible for full Medicare benefits including Part A and be enrolled in Part B and D Individuals who are either living in a State Facility, are covered under a Medicare Advantage Plan or Medicaid HMO, have a Medicaid spend-down, are receiving Hospice Services, or are Not Guilty by Reason of Insanity (NGRI) status are not eligible for the MI Health Link program.

Please refer to the Michigan Department of Health and Human Services (MDHHS) section on the State of Michigan website for additional and the most current information regarding the MI Health Link demonstration.

ENROLLMENT IN MI HEALTH LINK

Individuals eligible to participate in MI Health Link will be sent information materials from MDHHS Michigan Enrolls regarding MI Health Link approximately 30-60 days prior to enrollment. Individuals can call Michigan Enrolls toll-free at 1-800-975-7630 to enroll in a MI Health Link health plan, change to a different MI Health Link health plan, disenroll from MI Health Link, or opt-out of MI Health Link. Individuals can also contact the Michigan Medicare and Medicaid Assistance Program (MMAP) at 1-800-803-7174 with any questions.

It is important to note that transition of care procedures have been developed and will be implemented to ensure continuity of care. Existing relationships with “out-of-network” medical services providers will be maintained by the ICO during the transition to MI Health Link. Enrollees may choose to continue to receive services through “out-of- network” Providers for 180 days. Behavioral Health providers will be given an opportunity to join the DWIHN MI Health Link provider network after completing the DWIHN credentialing and impaneling process. If the provider chooses not to become a DWIHN contracted provider, Members will be transitioned to an in-network MI Health Link provider after 180 days.

CASE COORDINATION FOLLOWING ENROLLMENT

Once enrolled, the enrollee is assigned an ICO Care Coordinator and receives initial screening. Within 45 days of initial screening, the ICO completes a Health Risk Assessment, also referred to as the Level I assessment. Should the enrollee identify a need for behavioral health services, he/she will be offered a referral for such services. Referrals are sent to the DWIHN Access Center to determine whether or not the person is already enrolled with DWIHN. If the individual is already receiving services at a DWIHN MI Health Link network provider, a request is made for the provider to submit the biopsychosocial assessment, diagnostically appropriate level of care (LOCUS/SIS/ASAM) assessment, and Consent to Share Information form via the MH WIN system. In this demonstration, the biopsychosocial assessment and level of care assessment are considered the Level II assessment for behavioral health.

For individuals without a current behavioral health provider, the DWIHN Access Center will schedule the Level II assessment with a Behavioral Health Provider that is a DWIHN MI Health Link Provider. This documentation must be completed within 15 days of completion of the Level I assessment by the ICO. The completed documents are uploaded and sent to the ICO via MHWIN. The PIHP Care Coordinator monitors and ensures that the assessments are completed in a timely manner and contacts responsible Providers as necessary. Additionally, the PIHP Care Coordinator engages enrollees and legal representatives, as needed, to ensure that the enrollee is linked to appropriate services. They will also help connect enrollees to other community-based social services to help them live as independently as possible. The PIHP Care Coordinator also maintains contact with the ICO Care Coordinator to provide updates that affect the enrollee's overall care plan.

Following completion of the Level II assessment, an Integrated Care Team (ICT) meeting is scheduled with the enrollee. The ICO Care Coordinator leads and coordinates this meeting. From this meeting, an Integrated Individualized Care and Supports Plan (IICSP) is developed. Ideally, ICT meetings should be mapped to the person- centered planning processes outlined in the Michigan Mental Health Code to reduce redundancy. The IICSP should incorporate the following:

1. Assessment results
2. Individual's Health needs
3. Individual's Preference for care
4. Supports and services needed to assist in individual's care Prioritized concerns, goal list, and strengths
5. Specific services with scope, frequency, duration, and amount identified
6. Strategies to address identified concerns and goals
7. Identified individuals who will carry out various portions of the plan the date of plan initiation as well as the reassessment date

SPECIALIZED RESIDENTIAL SERVICES FOR MI HEALTH LINK ENROLLEES

Specialized residential services are offered and authorized by the DWIHN. A referral for residential services is made by the behavioral health Provider to the Residential Services unit of DWIHN. The referral packet will include a biopsychosocial assessment, psychiatric evaluation, nursing assessment, and medication sheet.

The Residential Services unit will then complete a level of care assessment to determine appropriateness for specialized residential services. The level of care assessment includes individual choice with regard to residential options. If the individual is homeless, the behavioral health Provider can assist in identifying pre- placement/transitional housing until a more permanent option is identified. Once results of the assessment are available, the PIHP Care Coordinator shall notify the ICO Care Coordinator of the individual's transition in care plan,

if applicable and continue to collaborate with the ICO Care Coordinator on any care and service needs the individual may have.

MI HEALTH LINK CARE COORDINATION IN ACUTE CARE SETTINGS

The following steps shall be taken by DWIHN PIHP Care Coordinators (CC):

1. CC reviews DWIHN reports for notification of an inpatient admission or other acute care activity i.e. crisis residential, SUD residential, partial hospitalization
2. CC contacts the hospital and obtains vital information regarding enrollee's potential needs at discharge and coordinate transitions in care as applicable
3. CC notifies the ICO Care Coordinator of the admission and shares clinical information and discharge documents, as appropriate. If the enrollee has significant medical issues, the CC works with the ICO Care Coordinator to ensure that necessary supports are in place to address these concerns prior to discharge
4. CC identifies if the enrollee is engaged with a behavioral health provider and works with the hospital discharge planner and outpatient provider to ensure a smooth transition.

MI HEALTH LINK OMBUDSMAN

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

MI Health Link Ombudsman can be reached Monday – Friday, from 8:00am to 5:00pm by contacting: **Toll-Free:** 1- 888-746-6456

BEHAVIORAL HEALTH HOME / OPIOID HEALTH HOME

Behavioral Health Home and Opioid Health Home provides comprehensive care management and coordination services to Medicaid beneficiaries with specific diagnoses. These Health Homes attend to a beneficiary's complete health and social needs. **Participation is voluntary and enrolled beneficiaries may opt-out at any time.** Which health home is best for the member depends on diagnosis.

The Health Home functions as the central point of contact for directing patient-centered care across the broader health care system. Beneficiaries will work with an interdisciplinary team of providers to develop an individualized care plan to best manage their care.

These services include:

- Comprehensive Care Management
- Care Coordination
- Health Promotion
- Comprehensive Transitional Care
- Individual and Family Support (including authorized representatives)
- Referral to Community and Social Support Services

ELIGIBILITY

Adults and children who are Wayne County residents enrolled in Medicaid, the Healthy Michigan Plan, MIChild, Freedom to Work, or Full Fee-for-Service Healthy Kids - Expansion who have selected diagnoses are eligible to participate in either Behavioral Health Home or Opioid Health Home.

*People may only be enrolled in **ONE** Health Home, either BHH or OHH.

**Participation in the following program(s) disqualify health home eligibility:

- Health Home MI Care Team
- Integrated Care MI Health Link
- SED Waiver (**BHH only)
- Nursing Home
- Hospice
- Spend down

DIAGNOSTIC CRITERIA

Medicaid beneficiaries with a specific ICD-10 Code diagnosis, including the following. The qualifying Dx does not have to be primary:

BHH Diagnostic Criteria	OHH Diagnostic Criteria
• **F06** Other mental disorders due to known physiological condition • **F20** Schizophrenia • **F25** Schizoaffective disorders • **F31** Bipolar disorder • **F32** Major depressive disorder, single episode • F33 Major depressive disorder, recurrent • F43 Reaction to severe stress, and adjustment disorders • F41 Other anxiety disorders • F90 Attention-deficit hyperactivity disorders	**All F11 Opioid Use Codes (Including but not limited to):** • **F11.1** Opioid abuse • **F11.12** Opioid abuse with intoxication • **F11.14** Opioid abuse with opioid-induced mood disorder • **F11.15** Opioid abuse with opioid-induced psychotic disorder • **F11.18** Opioid abuse with other opioid induced disorder • **F11.2** Opioid dependence • **F11.9** Opioid use, unspecified

Refer to MDHHS program Handbooks for full program information:

- BHH Informational Page: https://bit.ly/3ClmeD4
- BHH Handbook (located in Provider Resources page): https://bit.ly/39fn3RE
- OHH Informational Page: https://bit.ly/3zv20qA
- OHH Handbook (located in Provider Resources page): https://bit.ly/3zqMZpq

Omnibus Reconciliation Act of 1987 (OBRA)

The OBRA/PASRR program was established as a result of the Omnibus Reconciliation Act of 1987 (OBRA) which enacted legislation to strengthen the protection of the rights of nursing home residents. Pre- admission/Annual Resident Review (PASRR) assessments assure all persons with a serious mental illness and/or intellectual/developmental disability seeking admission to a nursing facility are evaluated to determine whether the nursing facility is the most appropriate place for them to reside and if they require specialized mental health services. The PASRR assessment is required on an annual basis to assure that they continue to require nursing home placement and or specialized mental health services. Any individual pursuing nursing home admission in Wayne County must have a Level I, MDHHS 3877 form completed. This is usually done at the hospital, nursing home or by a community provider. The referral is completed via the MDHHS electronic site or by faxing the completed MDHHS 3877 form to Detroit Wayne Integrated Health Network at 313-484-2166 or email to OBRA@dwihn.org.

DCH-3877, PREADMISSION SCREENING (PAS)/ ANNUAL RESIDENT REVIEW (ARR)

(Mental Illness/Intellectual Developmental Disability/Related Conditions Identification)

Michigan Department of Health and Human Services

Level I Screening

(Revised 3-22)

SECTION 1 – LEVEL I SCREENING

☐ **PAS** ☐ **ARR** ☐ **Change in Condition** ☐ **Hospital Exempted Discharge**

SECTION 2 – PATIENT, LEGAL REPRESENTATIVE AND AGENCY INFORMATION

Patient Name (First, MI, Last) | Date of Birth (MM/DD/YY) | Gender ☐ Male ☐ Female

Address (number, street, apt., or lot #) | City | State | Zip Code

County of Residence | Social Security Number | Medicaid Beneficiary ID Number | Medicare ID Number

Does this patient have a court-appointed guardian or other legal representative? ☐ No ☐ Yes

If yes, give Name of Legal Representative

County in which the legal representative was appointed | Legal Representative Telephone Number | Address (number, street, apt., or lot #) | City | State | Zip Code

Referring Agency Name | Telephone Number | Admission Date (actual or proposed)

Nursing Facility Name (proposed or actual) | County Name

Nursing Facility Address (number and street) | City | State | Zip Code

Sections 3 and 4 of this form must be completed by a registered nurse, licensed bachelor, or master social worker, licensed professional counselor, psychologist, physician's assistant, nurse practitioner or a physician.

SECTION 3 – SCREENING CRITERIA (All 6 items must be completed.)

1. The person has a current diagnosis of ☐ **Mental Illness** or ☐ **Dementia** (Check one or both)
2. The person has received treatment for ☐ **Mental Illness** or ☐ **Dementia** (within the past 24 months) (Check one or both) ☐ No ☐ Yes ☐ No ☐ Yes
3. The person has routinely received one or more prescribed antipsychotic or antidepressant medications within the last 14 days. ☐ No ☐ Yes
4. There is presenting evidence of mental illness or dementia, including significant disturbances in thought, conduct,

emotions, or judgment. Presenting evidence may include, but is not limited to, suicidal ideations, hallucinations, delusions, serious difficulty completing tasks, or serious difficulty interacting with others.

☐ No ☐ Yes

5. The person has a diagnosis of an intellectual/developmental disability or arelated condition including, but not limited to, epilepsy, autism, or cerebral palsy and this diagnosis manifested before the age of 22. ☐ No ☐ Yes

6. There is presenting evidence of deficits in intellectual functioning or adaptive behavior which suggests that the person may have an intellectual/developmental disability or a related condition. These deficits appear to have manifested before the age of 22. ☐ No ☐ Yes

Note: If you checked "Yes" to items 1 and/or 2, checked the word "**Mental Illness**" and/or "**Dementia**." If yes, please explain

Note: The person screened shall be determined to require a comprehensive Level II OBRA evaluation if any of the above items are "Yes" UNLESS a physician, nurse practitioner or physician's assistant certifies on form DCH-3878 that the person meets at least one of the exemption criteria.

SECTION 4 - CLINICIAN'S STATEMENT: I certify to the best of my knowledge that the above information is accurate.

Clinician Signature	Date	Name (type or print) Degree/License
	Telephone Number	

The Michigan Department of Health and Human Services will not exclude from participation in, deny benefits of, or discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, partisan considerations, or a disability or genetic information that is unrelated to the person's eligibility.

AUTHORITY: Title XIX of the Social Security Act

COMPLETION: Is voluntary, however, if NOT completed, Medicaid will not reimburse the nursing facility.

DISTRIBUTION: If any answer to items 1 – 6 in SECTION 3 is "Yes", send ONE copy to the local Community Mental Health Services Program (CMHSP), **with a copy of form DCH-3878** if an exemption is requested. The nursing facility must retain the original in the patient record and provide a copy to the patient or legal representative.

PREADMISSION SCREENING (PAS)/ANNUAL RESIDENT REVIEW (ARR)

Mental Illness/Intellectual Developmental Disability/Related Conditions Identification

Instructions for Completing Level I Screening

This form is used to identify prospective and current nursing facility residents who meet the criteria for possible mental illness or intellectual/developmental disability, or a related condition and who may be in need of mental health services.

Sections II and III must be completed by a registered nurse, licensed bachelor, or master social worker, licensed professional counselor, psychologist, physician's assistant, nurse practitioner or physician.

Preadmission Screening or Hospital Exempted Discharge: The referral source completing the Level I Screening (DCH-3877), must complete and provide a copy to the proposed nursing facility **prior to admission. Check the appropriate box in the upper right-hand corner.**

Annual Resident Review or Change in Condition: This form must be completed by the nursing facility.
Check the appropriate box in the upper right-hand corner.

Section II – Screening Criteria – All 6 items in this section must be completed. The following provides additional explanation of the items.

1. **Mental Illness:** A current primary diagnosis of a mentaldisorder as defined in the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders.

   Current Diagnosis means that a clinician has established a diagnosis of a mental disorder within the past 24 months. Do NOT mark "Yes" for an individual cited as having a diagnosis "by history" only.

2. **Receipt of treatment for mental illness or dementia within the past 24 months** means any of the following: inpatient psychiatric hospitalization; outpatient services such as psychotherapy, day program, or mental health case management; or referral for psychiatric consultation, evaluation, or prescription of psychopharmacological medications.

3. **Antidepressant and antipsychotic medications** mean any currently prescribed medication classified as an antidepressant or antipsychotic, plus Lithium Carbonate and Lithium Citrate.

4. **Presenting evidence** means the individual currently manifests symptoms of mental illness or dementia, which suggests the need for further evaluation to establish causal factors, diagnosis, and treatment recommendations. Further evaluation may need to be completed if evidence of suicidal ideation, hallucinations, delusion, serious difficulty completing tasks or serious difficulty interacting with others.

5. **Intellectual/Developmental Disability/Related Condition:** An individual is considered to have a severe, chronic disability that meets ALL 4 of the following conditions:

   a. It is manifested before the person reaches **age 22**.

   b. It is likely to continue indefinitely.

   c. It results in substantial functional limitations in **3 or more** of the following areas of major life activity: self-care, understanding and use of language, learning, mobility, self-direction, and capacity for independent living.

   d. It is attributable to:

      - Intellectual/Developmental Disability such that the person has significant subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period;

      - cerebral palsy, epilepsy, autism; or

- any condition other than mental illness found to be closely related to Intellectual/ Developmental Disability because this condition results in impairment in general intellectual functioning OR adaptive behavior similar to that of persons with Intellectual/Developmental Disability and requires treatment or services similar to those required for these persons.

6. **Presenting evidence** means the individual manifests deficits in intellectual functioning or adaptive behavior, which suggests the need for further evaluation to determine the presence of a developmental disability, causal factors, and treatment recommendations. These deficits appear to have manifested before the age of 22.

Note: When there are one or more "Yes" answers to items 1 – 6 under SECTION II, complete form DCH-3878, Mental Illness/Intellectual/Developmental Disability/Related Condition Exemption Criteria Certification only if the referring agency is seeking to establish exemption criteria for a dementia, state of coma, or hospital exempted discharge.

SECTION 5: COMMUNICATIONS

DEPARTMENT OVERVIEW:

The Communications Department is responsible for internal and external communications to staff, Providers, people we serve, legislators, advocacy groups and other stakeholders. The department also manages community outreach, website content, media and blog stories, social media messaging, the myDWIHN mobile app and ensuring that DWIHN supports and services are shared throughout Wayne County. The department also manages Youth United which is a group of young mental health ambassadors who are advocacy and action focused, helping to spread positive mental health messaging throughout Detroit and Wayne County.

SHARING INFORMATION WITH MEMBERS

Providers, Board Members and Board Committee meetings related to its performance of the contractual agreement with DWIHN must be open to the public.
DWIHN must provide reasonable advance notice for such meetings and allow for input from Members, advocates, Providers, citizens, and the general public. Additionally, subcontractors should also be made award of these public meetings which are always posted on the home page of the DWIHN website, www.dwihn.org.

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

SHARING INFORMATION WITH SUBCONTRACTORS AND STAFF

Providers are also expected to communicate and train individuals as necessary on applicable policies, procedures, Medicaid regulations, DWIHN requirements/standards, and other relevant information that will assist the subcontractor and its staff in providing care and services to Members. It is particularly important that staff have all the information available to assist them in providing care. The DWIHN Communications team sends out communications almost on a daily basis to providers. Those memos are sent from the email address: info@dwihn-news.org.

MARKETING STANDARDS DEFINITION

Material that is intended primarily to attract or appeal to eligible Members and to promote membership retention by providing general information about the Providers and the services offered. Materials include written information, letters developed for mass mailing, and any other communication that is directed to more than 25 individuals.

REQUIREMENTS

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

- All printed materials and marketing merchandise distributed must contain the DWIHN logo
- DWIHN must be properly acknowledged on provider websites with the DWIHN logo
- All submitted materials must be "camera ready", i.e. ready for print or in final format before being submitted to DWIHN for review
- Providers are required to adhere to a specific format when developing communication materials and all must include DWIHN logo on provided materials
- Material readability must be at the 4th grade level
- Materials must be translated to a language alternative when an alternative language-related population comprises 5% of the eligible population including, at a minimum, Spanish, Chinese, Arabic, French, Italian, and Polish
- Materials in non-English languages or Braille must be submitted in the non-English or Braille format, "camera ready" version accompanied by an English translation of the communication along with a letterof attestation from the CEO that both documents convey the same information
- A professional translator must translate materials. The name and the translator's credentials must accompany any translated materials submitted to DWIHN
- Materials must be printed in 12-point or larger font size, preferably in the New Times Roman type
- All marketing conveyances (e.g., newspaper, radio, TV, brochures, etc.) are applicable to the marketing requirements and approval process
- Marketing material must clearly explain the concept of networks and subnetworks and the concept of choice
- Descriptions of the quality of the Provider Network must not be "embellished". For example, Providers cannot use superlatives (e.g., highest, best)
- Unsubstantiated comparisons with other Providers
- Direct negative statements about other Providers including individual statements from members
- Providers can use:
- Qualified superlatives (e.g., among the best, some of the highest)

- Superlatives (e.g., ranked number 1) if they can be substantiated by ratings, studies, or statistics; the source must be identified in the advertisement
- Survey data regarding own organization (but may not use it to make specific comparisons to others)
- Testimonials must comply with marketing material review guidelines and cannot use negative testimonials about other Providers
- Provider marketing materials or efforts cannot discriminate
- Marketing staff cannot be solely compensated on commission

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

SECTION 6: COMPLIANCE

DEPARTMENT OVERVIEW:

The Michigan Department of Health and Human Services (MDHHS) maintains a contractual relationship with the Community Mental Health Service Programs (CMHSPs) that emphasizes at the local level the obligation to understand and meet not only State requirements but also Federal regulations. The Compliance Division of the DWIHN was created to provide regulatory oversight, conduct trainings, and investigate complaints relating to fraud, waste, and abuse occurring in Medicaid/ Medicare funded services. This means the Compliance Division has a general review and oversight function regarding the investigations of violations of the major laws, regulations, rules, protocols, standards and contractual terms that govern DWIHN's activities directly and those of it Network Providers, its mechanisms for providing mental health services. DWIHN's Compliance Program includes the Compliance Plan, Standards of Conduct Policy, the Conflict of Interest Policy, the Investigations Policy and Fraud Waste and Abuse Policy, which can all be found at http://www.dwihn.org/documents.asps.

Each Network Provider is expected to maintain its own Compliance Plan, Standards of Conduct, and Conflict of Interest policies similar to DWIHN's. At a minimum, each Compliance Plan should incorporate the seven standards given in the federal Sentencing Guidelines as evidence of a health care provider's due diligence. (United States Sentencing Commission Guidelines 1991). The Compliance Division may request the compliance documentation from a Network Provider at any time for review. Moreover, each Network Provider's staff is responsible for completing web-based training developed by DWIHN (i.e., Detroit Wayne Connect (DWC)) pursuant to DWIHN's "Required Trainings Chart" (as amended).

DWIHN's Compliance Division, in coordination with the Quality Division, will monitor implementation of each Network Provider's Compliance Plan.

FRAUD AND ABUSE

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

Each Network Provider should also utilize annually a methodology for the verification of the provision of Medicare and Medicaid services.

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

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

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

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

DWIHN POLICIES

- **Compliance Plan** establishes the requirement of a Compliance Plan and a (Compliance) Program within DWIHN and its network.
- **Compliance Reporting Policy** provides a procedure to report compliance issues to the Compliance Division.
- **Conflict of Interest Policy** establishes the definition for the various conflicts and the reporting requirement for all DWIHN employees, including board members.

- **Fraud Waste and Abuse Policy** establishes the standards to prevent the abuse and misuse of Medicare and Medicaid funds.
- **Investigation Policy** establishes the process of how each compliance complaint will be investigated.
- **Standard of Conduct Policy** establishes the standards for the how business will be conducted by DWIHN staff and its provider network.

NOTE: The above references are not meant to be all-inclusive. All polices can be found at http://www.dwihn.org/documents.aspx.

HEALTH CARE COMPLIANCE RESOURCES:

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

CONTACT INFORMATION FOR COMPLIANCE

DWIHN Compliance Hotline (313-833-3502), for anonymous and confidential reporting to the extent provided by law.

In writing to the Corporate Compliance Officer: Attn: Corporate Compliance Officer

Detroit Wayne Integrated Health Network 707 W. Milwaukee, Detroit MI, 48202 EMAIL: compliance@dwihn.org

The state's Office of Inspector General:
Michigan Department of Health and Human Services Office of Inspector General
PO Box 30062
Lansing, MI 48909
Ph: 855-MI-Fraud (643-7283).

SECTION 7: CRISIS SERVICES

The Crisis Services Department ensures appropriate access to crisis management services. Crisis Services works in collaboration with other departments (Hospital Emergency Departments, Law Enforcement, Judicial System, Inpatient Psychiatric Hospitals-state and

local, homeless outreach groups, etc.) to ensure access to DWIHN's full array of services as

well as the Crisis Continuum Service System.

DWIHN Community Mental Health Service Programs provide 24/7 crisis emergency service and stabilization for persons experiencing acute emotional, social, or behavioral dysfunctions. There is never a cost to the beneficiary for emergency services provided by the PIHP and its CMHSP provider network. DWIHN must cover and pay for emergency services regardless of whether the provider that furnishes the services has a contract with the PIHP.

Upon crisis evaluation, the attending physician from the facility where the member is screened will determine medical clearance, and psychiatric clearance will be obtained in tandem with the attending physician from the facility and DWIHN screening entities.

Members are not held responsible for ongoing stabilization to maintain, improve, or resolve a member's stabilized condition.

The department manages the responsibilities for the initial authorizations for Inpatient psychiatric hospital stays and Crisis Residential Unit placement as well as authorizing Partial Hospitalization Services and transitions to other levels of care. These responsibilities are managed through the following contracted providers:

ADULT CRISIS SCREENING

1. Community Outreach for Psychiatric Emergencies (COPE) Facilitated via Hegira Health Inc.
    a. Crisis Stabilization Unit (CSU), Mobile Crisis Intervention and stabilization teams, and Crisis Residential Units.

CHILDREN'S' CRISIS SCREENING

1. The Children's Crisis Care Center

New Oakland Family Centers

a. Mobile Crisis Services The Guidance Center
b. Mobile Crisis Services

MOBILE CRISIS STABILIZATION TEAMS

1. Community Outreach for Psychiatric Emergencies (COPE) Facilitated via Hegira Health Inc.
    a. Adults only

New Oakland Family Services

b. Children only

CRISIS RESIDENTIAL UNITS

1. Adults Only:
    a. Hegira Health Inc. Oakdale House Children only:
    b. Safehaus

CRISIS RESPONSE LINE

- DWIHN Crisis Hotline: 1-800-241-4949

NOTIFICATIONS AND CRISIS ALERTS FOR PERSONS EXPERIENCING BEHAVIORAL HEALTH CRISIS

Crisis Providers need to coordinate with the individual's Clinically Responsible Service Provider (CRSP) when they show up in the emergency department or receive a crisis service.

NOTIFICATIONS

DWIHN needs a contact and/or email address to send notifications for individuals experiencing crisis. Notifications will document information on an individual being in the emergency department and seen by a Mobile Crisis Screening Provider, Crisis Stabilization Unit, Psychiatric Urgent Care, or calls to DWIHN's Crisis Line.

The contact information should include: a general email address or a minimum of two contact persons to follow up on any concerns. The information should include name, title, email, and telephone number. Each CRSP must also develop a process for how these notifications will be reviewed, addressed, and monitored

CRISIS ALERTS

The purpose of the alerts is to assist in coordination of care for the individual. The CRSP should provide information on the individual that may divert them from inpatient care if appropriate and plan for the best level of care. For individuals that may need to go inpatient, developing a discharge plan should occur at the time the disposition is made, which can assist in the individual being placed and/or shorten their inpatient stay.

As the CRSP, the expectation is to reach out and engage the individual, even though they may have never been to your facility or have previously been closed. All results and/or attempts must be documented in MH-WIN appointment section.

Staff should also enter alerts in MH-WIN's "Chart Notes and Health Warnings" section for individuals they have had difficulty locating in order to be called if the individual shows up in the ED or with a DWIHN Crisis provider in an effort to coordinate services.

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ADDRESSING MEMBERS EXPERIENCING BEHAVIORAL HEALTH CRISIS

- A Member displaying changes in behavior may indicate an impending crisis. See warning signs below for someone that may be experiencing a mental health crisis:

Inability to cope with daily tasks

- Not taking care of personal hygiene
- Not eating or eating too much Sleeps longer or refuses to get up

Can't sleep

Rapid mood swings Increased energy level Pacing

Suddenly depressed/withdrawn

Suddenly happy/calm after period of depression Talking very rapidly or non-stop

Medication changes may be a trigger with Members trying to adjust Confused thinking or irrational thoughts

Thinking everyone is out to get them or seeming to lose touch with reality If they are experiencing hallucinations or delusions

Making threats to others or themselves

Isolating themselves from friends and family, not coming out of their room Rapid weight loss or gain

Suicidal thoughts and statements such as "I want to die" or even possible vague statements such as "I don't want to be here anymore"

WHAT ARE MY OPTIONS?

1. Review Member's crisis plan:
    i. Begin to implement activities in the plan based on what has been documented.
    ii. Inform other staff in the home that Member's crisis plan needs to be executed and put everyone on alert.
    iii. If Member is unable to be stabilized based on crisis plan determine other actions as listed below.
    iv. The CMH provider should be called. If not available, the crisis services listed below are available as noted.
    v. If you have concerns about the Member and not sure who to call, contact the crisis line for assistance.
    vi. Revise current crisis plan (if not a new Member)
    vii. Be sure to document activities once crisis has ended and be sure to inform Members CMH Provider.

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2. Call the Crisis Line (1-800-241-4949):

    i. If the Member seems to be escalating into a crisis.
    ii. If the Member needs to or request to speak to a counselor
    iii. If Member refuses to get on the line, staff can speak with counselor for support on stabilizing crisis.

    The Crisis Line has master's level clinicians that will attempt to de-escalate the crisis. They may warm transfer a call from an AFC home to Community Outreach for Psychiatric Emergencies (COPE). The crisis line may also determine that they need to facilitate a call to 911. Be sure to document activities once crisis has ended and be sure to inform Members CMH Provider

3. Take Member to a Crisis Stabilization Unit (If safe to transport Member):

    i. If experiencing problems stabilizing Member
    ii. If Member needs a crisis assessment that may result in hospitalization
    iii. If Member has run out of medications and is at risk of demonstrating behavioral concerns as previously listed

- Hegira Health: COPE 24-hour Crisis Stabilization Unit – 844-296-COPE, Located at: 33505 Schoolcraft, Livonia, MI 48150

- Team Wellness Center: 24-hour Crisis Stabilization Unit – 313-331-3435, Located at: 6309 Mack, Detroit, MI 48207

- For AFC Homes - Call COPE (Adults Only) 1-844-296-COPE:
    a. If staff are unable to de-escalate Member via crisis plan or crisis line call
    b. If the Member has refused medications over the last 24-48 hours and may not be able to immediately see their outpatient provider.
    c. If the Member is having difficulty completing normal activities and it appears as if it may escalate to a crisis.
    d. If Member begins to display behaviors that previously resulted in a visit to the emergency department.
    e. If Member has been to the emergency department for behavioral health services within the last 30 days
    f. If Member has experienced a SUD episode
- COPE may dispatch a mobile crisis intervention team out to the home, direct the Member to be taken to a Crisis Stabilization Unit or facilitate a call to 911.

- For Children Only, Call the Crisis Options below:
    a. If Member cannot be de-escalated via crisis plan or crisis line
    b. If the Member has refused medications over the last 24-48 hours and may not be able to immediately see their outpatient provider.
    c. If the Member is having difficulty completing normal activities and it appears as if it may escalate to a crisis.

d. If Member begins to display behaviors that previously resulted in a visit to the emergency department

- The Children's Center – Children's Crisis Care Center: 313-324-8557. Monday – Friday from 8:00am to 8:00pm. Members can go or be taken to the facility during hours of operation.
- New Oakland Family Centers – 24-hour Crisis Stabilization: 877-800-1650. Services are designed to provide a short-term alternative to inpatient psychiatric services and are available for on-site clinical intervention and/or telephone consultation at all times.

4. Call 911:

i. If Member is experiencing a medical emergency
ii. If Member has attempted suicide
iii. If Member has made suicidal or homicidal threats
iv. If Member has destroyed property
v. If the Member is a behavioral threat

- Once crisis has ended be sure to complete an Incident Report and submit to DWMHA at 313-833-2086 and/or complete the e-Critical/Sentinel Event form in MH-WIN.

CRISIS PLAN

Members shall be offered the opportunity to develop a Crisis Plan. Providers shall ensure documentation of acceptance or decline of this opportunity is in the case record. If the Member declines development of a plan when initially offered, it must be revisited within 60 days of declining or within 14 days of a crisis occurring.

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

SECTION 8: CUSTOMER SERVICE

For DWIHN policies procedures, and documents, visit our website at www.dwihn.org.

DEPARTMENT OVERVIEW:

DWIHN's Customer Service is administratively responsible for the oversight and monitoring of the Customer Service mandated standards at DWIHN and contracted service providers that have the delegated function of Customer Service. The department is charged with ensuring that all members have choice opportunities, access to services and are oriented to available benefits and services. Customer Service is responsible for ensuring prompt
assistance in addressing and resolving member's complaints, grievances, appeals, State Fair Hearing and Local Dispute concerns. Through efficient oversite, monitoring and reporting on member's due process, improvement efforts are identified and addressed.

Customer Service also oversees the Family Subsidy program, Medical Record requests and the development of Members' educational materials (i.e. Member Handbook, Provider Directory, Member Newsletter, and DWIHN's brochures). The department is also responsible for Member Engagement initiatives, which involves the participation with member training, educational and outreach events that benefit Members, Providers, and the Community.
Member and Provider experience surveys are also conducted by Customer Service annually. The findings are an integral part of DWIHN's Member Experience efforts towards obtaining member/provider feedback and DWIHN's continuous quality improvement commitment.

DWIHN's Customer Service department is available Monday - Friday, 8:00 AM - 4:30 PM EST and is staffed by highly trained Customer Service Representatives. After normal business hours, calls are forwarded to the DWIHN Access Center for processing.

DWIHN's Customer Service mission is to exceed its customer's expectation. Through its courteous staff, the emphasis is placed on providing prompt and efficient service, while ensuring that everyone is treated with dignity and respect. Customer Service staff is sensitive to those customers that need special accommodations i.e., hearing and /or language assistance.

CUSTOMER SERVICE STANDARDS

Customer Service's commitment to continuous quality improvement is carried out by the daily monitoring of the Customer Service functions throughout DWIHN's service provider network. Monitoring, tracking, trending, and reporting on Customer Service standards of performance are key in maintaining compliance with all contractual and regulatory process improvement initiatives.

DWIHN's Customer Services responsible for ensuring the following standards are met:

6. Prompt response to enrollee/member inquiries. 7. Systems navigation services.
8. Prompt handling and resolution of member complaints, grievances and appeals processes, local dispute resolution, State Fair Hearings and Alternative Dispute Resolution.
9. Coordinate the maintenance of Provider Director listings of all Service Providers, with whom the Network has contracts. The Provider Directory listing is to include services, languages, independent facilitators and any specialties and ADA accommodations. Enrollees/Members are to be given this list at time of enrollment and annually thereafter.
10. Ensure availability of information about DWIHN including the annual report, current organizational chart, DWIHN's board member list, meeting schedule and minutes provided in a timely manner upon request.
11. Assist members with grievances, appeals, local dispute resolution, Fair Hearings, alternative dispute resolutions and coordinate records as appropriate with the Office of Recipient Rights.
12. Development and distribution of resource materials (i.e., Member Handbook and educational brochures).
13. Participation with members, community and advocacy groups in collaborative efforts and events for advancing the rights of individuals.
14. Development and implementation of structured customer service-related outreach, training and learning opportunities for staff, members, and service providers.
15. Continuous monitoring of the customer service function at DWIHN and service provider locations to meet compliance standards for customer service, member grievances, appeals and member rights.
16. Technical assistance to Service Providers to promote customer service quality assurance, improvement, and management.
17. Trending, tracking, and reporting on Customer Service-related activities (i.e. total call volume, abandonment rates, the average speed of answer, hold time, call types, etc.).
18. Coordinate monitoring activities and the development of tools to evaluate system-wide customer satisfaction.

PROVIDER RESPONSIBILITIES:

Delegated Customer Service Providers are to adhere to all mandated Customer Service standards, policies, procedures, and expectations:

19. Maintain an identifiable Customer Service unit staffed with qualified individuals knowledgeable in customer service protocols;
20. Customer Service unit shall be staffed with a minimum of one (1) full-time staff dedicated to customer services. Appropriate full-time equivalents (FTEs) shall be assigned to sufficiently meet the needs of the people in the service area;
21. All customer service staff hired at DWIHN and contracted service providers are to be trained on customer service standards within thirty (30) days of hiring and annually thereafter. 4.

Identify a customer service staff person as the contact person to serve as a provider liaison to DWIHN's Customer Service. Any changes to this assignment are to be made to DWIHN's Customer Service immediately;

22. There shall be a delegated toll-free customer service telephone line and access to a TTY (also known as a TDD Telephone Text device) number. Ensure that the customer services telephone line is answered by a live voice during business hours. Telephone menus are not acceptable;
23. Ensure prompt responses to all inquiries by:
    a. Providing systems navigation including services that are peer-delivered;
    b. Providing prompt identification, assistance, handling and resolution of grievance and appeals processes information, referrals, and follow-through.
    c. Distributing DWIHN's resource materials as indicated by DWIHN (i.e., DWIHN Member Handbook, brochures, directories, etc.);
    d. Reporting provider changes (i.e. address, phone number, closures, accepting new members, etc.) to your assigned Provider Network Manager via the Provider Change Form via www.dwihn.org;
    e. Promoting learning opportunities for members and their participation to enhance system design, delivery, assessment, and quality improvement;
    f. In compliance with a member's rights, providers are expected to:
        i. To provide quality behavioral health services;
        ii. To assess and evaluate behavioral health care requests in a timely manner;
        iii. To give members a choice of providers to the extent that is possible;
        iv. To offer members a second opinion if you request one;
        v. To provide members with information about your behavioral health services and your rights;
        vi. To provide members with a written Adverse Benefit Determination Notice, when advising a member of termination, reduction, denial, suspension or limit the authorization of services that the member has requested and/or have been receiving;
        vii. To provide members with information about your operations, organizational structure, annual reports, etc. upon request and to notify members annually that this information is available;
        viii. To protect the rights of individuals receiving services;
        ix. Required by law to maintain the privacy and security of members personal health information;
        x. Inform members promptly if a breach occurs that may have compromised the privacy or security of their information. To follow the duties and privacy practices described in the notice of Privacy Practices and give members a copy;
        xi. Do not use or share member's information other than as described in the Notice of Privacy Practices unless he/she tells you can in writing;

xii. Members can change their mind at any time about the sharing of information, but this request should be made in writing to ensure it is documented.
xiii. Provide members with a written notice of any significant State and Provider network changes at least 30 days before the intended effective date of change.
xiv. Give members written notice by the later of 30 calendar days prior to the effective date of a provider termination, or 15 calendar days after receipt or issuance of the termination notice.

Participating with members, community and advocacy groups in collaborative efforts and events for advancing the rights of individuals with disabilities.

Ensure that members participate in DWIHN's efforts to assess Member satisfaction with the system and services provided;

Provide information and assistance to member filing grievances, appeals and/or rights violations.

Conduct Member Orientation (see Member Orientation section below)

CUSTOMER SERVICE PROVIDER COMPLIANCE MONITORING

To ensure that customer service functions are being carried out in accordance with DWIHN, Federal and State requirements, DWIHN's Customer Service is responsible for monitoring provider compliance on an ongoing basis. This compliance monitoring includes:

1. Reviewing monthly performance reports and conducting periodic meetings with contractors to address compliance issues.
2. Conducting an annual site assessment by DWIHN's Customer Service to address compliance standards as indicated with a focus on the following:
    - Accommodations for Individuals with Visual & Mobility Impairments Communication Using Teletype Device & Michigan Relay Service or Other Communication Devices
    - Affordable Care Act, Section 1557
    - Americans with Disability Act (ADA)
    - Balanced Budget Act (BBA)
    - Customer Service Member Orientation
    - Customer Service Member Appeals
    - Customer Service Member Grievance
    - Customer Service Policy
    - DWIHN, MDHHS and Medicare contracts
    - Limited English Proficiency (LEP)
    - MDHHS Customer Service Standards
    - Member Rights and Responsibilities

- Member Experience
- Mental Health Code

3. Providing internal Customer Service oversight, performance measurement and monitoring of customer service functions.
4. Providing monthly performance monitoring, tracking and reporting to DWIHN's Customer Service assigned Performance Monitor as dictated by DWIHN which is inclusive of the following:

- Ensure members are provided with a DWIHN approved orientation that addresses services, benefits, member rights and responsibilities at time of enrollment and annually, thereafter;
- Provide documentation, monitoring and reporting on member enrollment to DWIHN's Customer Service department.

CUSTOMER SERVICE ANNUAL PROVIDER SITE ASSESSMENT

When conducting the Customer Service Annual Provider Site Assessment, monitoring tool are used that clearly identifies the specific standard that are to be reviewed. The tool includes the elements and criteria evidence that will be requested of the service provider in order to meet the standards.

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

CUSTOMER SERVICE FUNCTION STANDARD

Evidence of:

- Access to Services
- Call Center Standards
- Customer Service Identifiable functions
- Customer Service Policy
- Performance Standards of Excellence and Efficiency
- Cultural Sensitivity and Accommodations
- Delegation of Customer Service Function
- Welcoming Environment

GRIEVANCES & APPEALS STANDARD

Evidence of:

- Delegation
- Method for Filing
- Process for Handling Grievances & Appeals
- Recordkeeping

MEMBER RIGHTS STANDARD

Evidence of:

- Member Orientation Policy
- Member's Rights and Responsibilities Statement
- Right to be Treated with Dignity and Respect
- Right to Receive Information on Treatment Options
- Right to Request and Obtain Information

CUSTOMER SERVICE PERFORMANCE MEASUREMENTS

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

Examples of performance measurements are as follows:

- Percentage of grievances resolved within ninety (90) calendar days
- Percentage of enrollees/members who receive an orientation within fourteen (14) business days after enrollment
- Percentage of newly hired Customer Service staff receiving a Customer Service orientation within thirty (30) days of hire
- Percentage of Customer Service inquiries processed within twenty-four (24) hours
- Number of members informed of the estimated cost of services
- Dictated performance measurements are to be accurately tracked, recorded and reported to DWIHN on the Monthly Performance Measurement and Tracking Report.

If the Customer Service function is delegated to its Provider network, it is the responsibility of the Provider to report to DWIHN's CSO with the expectation that the following process will be implemented to accomplish the aforementioned:

- Assignment of a unit or department who will be responsible for the timely submission of customer service performance measurements.
- Utilization of an internal monitoring tool and system to address customer service activities, training, grievances, appeals, enrollment and orientation processes within its organization/ network.
- A system that will tabulate, document, and provide timelines to report information
- The areas that are to be tracked monthly and monitored includes: Number of Customer Service calls handled

- Number of Customer Service calls resolved within 24 hours Number of Customer Service Walk-ins
- Number of new member orientations
- Number of initial requests for Hearing Impaired and Limited English Proficiency assistance
- Number of Grievances handled, tracked, and monitored to determine the use of Grievances and Complaints as a source to identify network adequacy
- Number of Advance and Adequate notices generated Number of members re-engaged
- Number of members disenrolled
- The tracking of types of services rendered including teleservices, hearing impaired and LEP assisted services
- The tracking of continued education training of Customer Service staff

- Any Customer Service Satisfaction Surveys that may be conducted in coordination with DWIHN.
- Member education and training attendance
- Other activities as dictated by DWIHN

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

LIMITED ENGLISH PROFICIENCY (LEP)

DWIHN and service providers must take reasonable steps to provide members with limited English proficiency (LEP) meaningful access and opportunity to participate in DWIHN funded programs by doing the following:

- Develop policies and procedures that will assure language assistance to members with limited English proficiency
- Ensure all services, programs, or activities shall be available to enrollees/members with LEP.
- Provide adequate information to enable enrollee/members with LEP to understand the types of services and benefits available.
- Ensure meaningful access by enrollee/members with LEP to critical services while not imposing undue burdens on the entity. Applying the four-factor analysis might lead to the conclusion that different language assistance measures are sufficient for different

programs or activities. An individualized assessment that balances the following four factors should be conducted:

g. The number or proportion of LEP enrollees/members eligible to be served or likely to be encountered. (This may be obtained through an examination of the latest census data for the area served, data from school systems and community organizations.) The greater number or proportion, the more likely language services will be required.
h. The frequency with which LEP individuals come in contact with the program. The more frequent the contact with a particular language group, the more likely that enhanced language services will be needed (e.g., a program that encounters LEP Members on a daily basis may have a greater obligation than a program that encounters LEP Members sporadically.)
i. The nature, importance, and urgency of the program. The more essential and crucial the activity, the more likely that language services will be needed (e.g., the communication of rights to a person whose benefits are being terminated)
j. The resources that are available to provide effective language assistance. Reasonable steps may cease to be "reasonable" where costs substantially exceed benefits.

Provide a range of language assistance which may include:

- Using sign language interpreters for individuals with hearing impairments/limitations.
- Disseminating alternative formats such as large print or Braille for individuals with visual impairments/limitations.
- Providing bilingual employees that are trained and competent in interpreting.
- Testing identified bilingual staff to assure language proficiency.
- Contract with outside interpreter(s) to meet the language needs of enrollees/members served.
- Arrange for the services of trained and skilled voluntary community interpreter(s), which includes testing for an adequate level of fluency.
- Provide telephonic language interpreter service as needed. This may be used as a supplemental system or when other resources cannot accommodate the encountered language.
- Ensure that interpreters are familiar with the terminology used in to the provision of mental health and substance abuse services.
- Ensure that vital documents are available in language(s) other than English for each regularly encountered LEP group eligible to be served or likely to be affected by the program.

Ensure the member has the following:

- Use of language identification cards, which allow LEP enrollees/member to identify their language needs. A message on the card must invite the LEP person to identify the language he/she speaks.
- Identification of the member's language must be included in the individual's record.
- Posting signs in regularly encountered languages (in accordance with Federal Safe Harbor Threshold guidelines) other than English in waiting rooms, reception areas, and other initial points of entry. These signs must inform applicants and beneficiaries of their right to free language assistance services and invite them to identify themselves as enrollees/members needing services.
- Translation of applications, and instructional information, and other written materials into appropriate non-English languages by competent translators.
- Develop uniform procedures for timely and effective communication between staff and LEP individuals. This includes instructions for English speaking employees to obtain assistance from interpreters or bilingual staff when receiving calls from, or initiating calls, to LEP individuals.
- Include statements about services available and the right to free language assistance services, in applicable non-English languages in brochures, booklets, outreach, and recruitment information and other materials routinely disseminated to the public.
- Disseminate Limited English Proficiency policy to staff (i.e., through staff training, initial orientation, memoranda, etc.).
- Provide training to new employees and annually thereafter (or as new or existing regulations modify standards of business/clinical practice to ensure all professionals:
    i. Are knowledgeable and aware of LEP policy and procedures.
    ii. Are trained to work effectively with interpreters and
    iii. Ensure the understanding of the dynamics with interpretation between members and the interpreters.

Monitor the language assistance program periodically to assess:

- The current LEP makeup of its service area.
- The current communication needs of LEP applicants and members.
- Ensuring the existing assistance is meeting the needs of the applicant/member.
- Ensuring staff is knowledgeable about policies and methods of implementation.

H. MEMBER ORIENTATION

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

The Service Providers are responsible for orientating members via the Member Orientation Process as required by the State of Michigan.

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

DWIHN's Customer Service department is responsible for ensuring that Customer Service contracted Service Providers comply with the following orientation procedure:

24. Shortly after initial enrollment and or at the time of initial intake, all intended beneficiaries are to be made aware of their need for an orientation to behavioral health care service, benefits and how to access them within 3 – 7 business days;
25. Ensure the member receive an orientation packet which includes the following:
    - MDHHS Recipient Rights Handbook
    - DWIHN's Member Handbook
    - DWIHN's Provider Directory
    - DWIHN's Grievance and Appeals Bookmark
    - DWIHN's Customer Service Brochures
    - Information from Service Providers (i.e., information specific to their organization) 26. Ensure that members are provided detailed information regarding:
    - Benefits covered; cost sharing, if any;
    - Service area (i.e., Wayne County);
    - Names, locations, telephone numbers of current affiliated Providers with ability to communicate with non- English language enrollees/members;
    - Where and how to obtain counseling or referral services that are not covered because of moral or religious objections;
    - Notification to all members and potential beneficiaries of the availability of information in alternative formats, taking into consideration their special needs (e.g., visual, limited reading proficiency), and how to access those formats;
    - A mechanism to help members and potential beneficiaries understand the managed care program, and the requirements and benefits of the plan;
27. General information must be furnished to the member as follows:
    - Notification of any restrictions on the freedom of choice among network Notification of rights and protections;
    - The member is free to exercise his or her rights, and that the excision of those rights will not adversely affect the way DWIHN, or its Providers, or the Michigan Department of Health and Human Services (MDHHS) treat the beneficiary/person;
    - Notifications of their right to "Psychiatric Advance Directives;"
    - Information on the structure of DWIHN and the scope and process of accessing emergency services and post-emergency care including:
        i. Prior authorization not being required for emergency services,
        ii. The process and procedures for obtaining emergency services including the proper use of the local 911-telephone system,

iii. The locations of any emergency services at which Providers and hospitals furnish emergency services and post-stabilization services covered by DWIHN,
iv. The amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that member understand the benefits to which they are entitled, the estimated cost to DWIHN of each covered service and support that he/she is receiving, Procedures for obtaining benefits, including authorization requirements.

Identified Customer Service provider staff shall conduct the orientation by reviewing each document in the orientation packet and highlighting the entitled benefits, services, and process on how to access them. The member is to be provided an opportunity to ask questions.

Upon completion of this process, the member is to be given the applicable customer service phone numbers and advised where to call for questions.

The member shall be informed of DWIHN and Service Provider structure.

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

Upon completion of the orientation, the member is provided an Orientation Evaluation form to complete and return for filing in their medical record.

Copies of the New Member Orientation Log Sheets are to be tallied monthly and reported to the Customer Service Unit. A final orientation tally report is to be prepared and forward monthly to the DWIHN Customer Service Unit.

Upon request, original Orientation log sheets, signed evaluation forms and signed member orientation checklist are to be made available for DWIHN site reviews.

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

MEMBER RIGHTS

DWIHN is committed to maintaining a mutually respectful relationship with our members and providers. The DWIHN Members' Rights and Responsibilities statement is provided to assist members in understanding and exercising their rights while accessing behavioral health care services in Detroit-Wayne County. This statement helps to minimize potential misunderstandings and promote compliance with all applicable statutory and regulatory requirements. Understanding member rights and responsibilities will help members to make informed decisions about your healthcare. These include but are not limited to:

Members Have the Right To:

Be provided with information about member rights, responsibilities, and protections;
Be treated with respect and recognition of your dignity and right to privacy;
Receive information about providers services, practitioners and rights and responsibilities;
Be provided freedom of choice among network providers;
A candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage and to freely communicate with other providers and without restriction on any information regarding care;
Be informed of the availability of an independent, external review of the UM final determinations;
Receive information on available treatment options;
Participate in decisions regarding health care, the refusal of treatment and preferences for future treatment decisions;
Be made aware of those services that are not covered and may involve cost sharing, if any;
Request and receive an itemized statement for each covered service and support you received;
Track the status of your claim in the claims process and obtain information over the telephone in one attempt or contact;
Receive information on how to obtain benefits from out-of-network providers;
Receive information on advance directives;
Receive benefits, services and instructional materials in a manner that may be easily understood;
Receive information that describes the availability of supports and services and how to access them;
Receive information member requested and help in the language or format of their choice;
Receive interpreter services free-of-charge for non-English languages as needed;
Be provided with written materials in alternative formats and information on how to obtain them if you are visually and/or are hearing impaired or have limited reading proficiency;
Receive information within a reasonable time after enrollment;
Be provided with information on services that are not covered on moral /religious basis;
Receive information on how to access 911, emergency, and post-stabilization services as needed;
Receive information on how to obtain referrals for specialty care and other benefits that are not provided by the primary care provider;

Receive information on how and where to access benefits that are not covered under DWIHN Medicaid contract but may be available under the state health plan, including transportation;
Receive information on the grievance, appeal, and fair hearing processes;
Voice complaints and request appeals regarding care and services provided;
Timely written notice of any significant State and provider network-related changes;
Make recommendations regarding the DWIHN member rights and responsibilities.
Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in other Federal regulations on the use of restraints and seclusion.
To request and receive a copy of his/her medical records, and request that his/her record be amended or corrected.
A second opinion from a network provider, or arrange for members to obtain one outside the network, at no cost to them.
Obtain mediation to resolve a complaint or conflict.
Receive information on available treatment options and alternatives, presented in a manner appropriate to their condition and ability to understand.

MEMBER APPEALS AND GRIEVANCES

APPEALS:

For DWIHN policies, procedures, and documents, visit our website at www.dwihn.org.

When a request for a level of care requiring prior authorization is denied, an appeal of that decision is offered to the enrollee and Provider. Both the enrollee/member and Provider may request an appeal. DWIHN is responsible for distributing and assuring compliance with its policies for accessing the clinical appeal process.

Appeal: A review of an adverse benefit determination.

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

- Denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit;
- Reduction, suspension, or termination of a previously authorized service; Denial, in whole or in part, of payment for a service;
- Failure to make a standard authorization decision and provide notice about the decision within 14 calendar days from the date of receipt of a standard request for service;
- Failure to make an expedited authorization decision within 72 hours from the date of receipt of a request for expedited service authorization;

- Failure to provide services within 14 calendar days of the start date agreed upon during the person-centered planning and as authorized by DWIHN;
- Failure of DWIHN to act within 30 calendar days from the date of a request for a standard appeal; Failure of DWIHN to act within 72 hours from the date of a request for an expedited appeal and/or Failure of DWIHN to provide disposition and notice of a local grievance/complaint within 90 calendar days of the date of the request.

ADVANCE NOTICE

Whenever services are denied, suspended, reduced, or terminated (e.g., services will not be provided as specified in the IPOS), the individual, parent, authorized representative, or his or her legal guardian shall receive the *Advance Notice of Adverse Benefit Determination Form*, and a *Local Request Form*.

The written notice is required regardless of the reason of reduction, termination, suspension, or denial of services (e.g., the person moves out of state or the country, or the person indicates they no longer want services). The advance notice must be mailed at least 10 calendar days before the intended action takes effect for Medicaid enrollees and 30 calendar days prior for underinsured and uninsured.

ADEQUATE NOTICE

Whenever requested services are denied or partially denied, or delayed, the individual and his or her guardian shall receive an Adequate Notice of Adverse Benefit Determination form and a Local Appeal Request form, A copy of the signed form shall be placed in the enrollee's case record.

Adequate Notice of Adverse Benefit Determination shall be provided to each Medicaid or Uninsured/Underinsured beneficiary at the time of the denial, partial denial, or delay. These individuals will also be provided with a request and instructions on how to process a Local Appeal/Local Dispute Resolution.

NOTICE OF DENIAL OF MEDICAL COVERAGE

For the enrollees that participate in the MI Health Link program through the 5 contracted Integrated Care Organizations (ICOs) which include (Aetna, AmeriHealth, HAP Empowered, Meridian and Molina), if a service that is being requested is denied/partially denied or an ongoing service is being reduced, suspended, or terminated, a Notice of Denial of Medical Coverage is issued to the member and/or the provider. The Notice is provided to the member ten (10) calendar days prior to the action being taken for ongoing services. For requested services, the notice should be provided at the time of the action.

LOCAL APPEAL PROCESS

Federal regulations provide a Medicaid beneficiary the right to a local level appeal of an action (adverse benefit determination). PIHP appeals, like those for fair hearings, are
initiated by an "action" (adverse benefit determination). The beneficiary may request a local appeal under the following circumstances: The beneficiary has sixty (60) calendar days from the date of the Adverse Benefit Determination to request a local appeal. Participants in the MI Health program or Providers attempting to appeal an adverse decision also have 60 calendar days after the receipt of the Notice of Appeal Decision to request a Local Appeal.

An oral request for a local appeal of an adverse benefit determination is treated as an appeal to establish the earliest possible filing date for appeal.

The beneficiary may file an appeal with the PIHP organizational unit approved and administratively responsible for facilitating local appeals.

If the beneficiary or representative requests a local appeal, not more than 10 calendar days from the date of the notice of action, the PIHP must reinstate the Medicaid services until the disposition of the hearing. The PIHP, or Service Provider is responsible for providing reasonable assistance to the beneficiary to complete the forms and to take other procedural steps. This includes but not limited to providing interpreter services, toll free numbers that have adequate TTY and interpreter capability.

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

EXPEDITED APPEALS

An expedited appeal is available when it is determined that following the standard
timeframe could seriously jeopardize the beneficiary's life, health, or ability to attain, maintain or regain maximum function. Medicaid beneficiaries must be given instructions for accessing the expedited local appeal process, which can be filed in writing or orally. These appeals are to be resolved within 72 hours. The following information can be utilized for written or faxed appeal requests:

DWIHN Customer Service Address: 707 West Milwaukee St., Detroit, Michigan 48202

Toll Free Phone: 1-888-490-9698

Local Phone: 313-833-3232
TTY: 1-800-630-1044

Fax: 313-833-2217

STATE FAIR HEARING APPEAL PROCESS FOR MEDICAID SERVICES (STATE FAIR HEARING PROCESS)

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

A Medicaid beneficiary or a MI Health Link participant has the right to request a State Fair Hearing when the PIHP has upheld the decision to deny, reduce, suspend, or terminate a service or a grievance request is not acted upon within 90 calendar days. The beneficiary must exhaust the local appeals process before he/she can request a State Fair Hearing.

The Network may not limit or interfere with the beneficiary's freedom to request a State Fair Hearing after the conclusion of a Local Appeal.

The parties to the State Fair Hearing include the PIHP, the beneficiary, his or her representative, guardian, or the representative of a deceased beneficiary's estate.

The beneficiaries are given 120 calendar days from the date of the Notice of Appeal Denial to request a State Fair Hearing.

If the beneficiary or representative requests a fair hearing not more than 10 calendar days from the date of the notice, the PIHP must reinstate Medicaid services until disposition by the Administrative Law Judge as long as the criteria for receiving such services is met.

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

MICHIGAN OFFICE OF ADMINISTRATIVE HEARING AND RULES FOR THE DEPARTMENT OF HEALTH AND HUMAN SERVICES ADMINISTRATIVE TRIBUNAL

P.O. BOX 30763 LANSING, MI 48909-9951

MEDIATION

An individual receiving services from DWIHN has the right to request a mediation related to their behavioral health services, planning services, and DWIHN supports. DWIHN is required to share with the individual their right to mediation when they initially receive services and then annually after that. DWIHN is also required to share with the individual their right to mediation when local dispute resolution process, local appeals process, or State Fair Hearing is requested.
If mediation is requested, DWIHN (and the identified CRSP or Service Provider) must participate.
Cases that cannot be mediated include: assisted outpatient treatment plans, Recipient Rights investigations, medical necessity, State Fair Hearings, or the role of CMH/PIHP staff as experts.

Individuals interested in the mediation process (or their legal representative) can contact 1-844-3-MEDIATE to start the process.

GRIEVANCES:

A member has the right to say that they're unhappy with the services or supports or the staff who provide them, by filing a "grievance." A member can file a Medicaid grievance any time by calling, visiting, or writing to DWIHN, or Service Provider's Customer Service unit. A MI Health Link member has 60 calendar days from the date of the incident to file a grievance. Assistance is available in the filing process by contacting the Grievance Coordinator or a CS Representative. The member will be given detailed information about grievance and appeal processes when they first start services and then again annually. MI Health Link grievances are processed solely by DWIHN.

You may ask for this information at any time by contacting DWIHN, or the Service Provider CS unit.

DWIHN and Service Providers will:

- Assure that all employees are trained on the grievance and appeal process within 30 days of hire and annually thereafter.
- Assure that the enrollee is provided information on the grievance and appeal process upon enrollment, at the time the IPOS is developed, annually thereafter, and as requested by the enrollee/member.
- Prominently display grievance and appeal forms, posters, and brochures in public areas of the service Provider locations.
- Not substitute the grievance or appeal process for filing a recipient rights complaint.

- Ensure persons who file a grievance or appeal shall not be subject to discrimination or retaliation. Ensure staff that participates in the review or resolution of a grievance, or an appeal shall not be subject to discrimination or retaliation.
- Ensure that the grievance and appeal process is timely, objective, and fair to all parties.
- Ensure that a grievance or appeal will be expedited when it is determined that following the standard timeframe could seriously jeopardize the enrollee/member's life or health or ability to attain, maintain, or regain maximum function.
- Ensure that the grievance and appeal process is accessible and understandable to the member/enrollee/legal representative and service Provider.
- Ensure that documentation of grievance and appeal records and logs are maintained in MHWIN.

The enrollee/member or legal representative shall be:

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

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

DWIHN Customer Service Address: 707 West Milwaukee St., Detroit, Michigan 48202

Toll Free Phone: 1-888.490.9698

Local Phone: 313-833-3232

TTY/TDD: 1(800) 630-1044

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

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

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

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

VIOLATION OF CUSTOMER SERVICE- SANCTIONS

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

- Any impediment to a member's access to the grievance and appeals processes;
- Any impediment to monitoring by staff employed by DWIHN or
- Any harassment or retaliation against any individual seeking to report, pursue a grievance or appeal or failure to cooperate with the resolution of a grievance or an appeal.
- Appropriate prompt action against a contracted entity in the event of any violation of the aforementioned provisions may be imposed based on the severity of the findings. Such actions may include, but are not limited to, the following:
    i. Removal of a staff from a service site or stop further referrals to the Contracted Provider;
    ii. Removal of the offending Contracted Provider from its network;
    iii. Withholding all or a portion of contractual payments to offending Contracted Provider;
    iv. Assessing monetary sanctions reflecting the severity of the violation; and/or terminating the Agreement.

SELF-MANAGEMENT TOOL MYSTRENGTH

DWIHN provides an evidence-based self-management tool, myStrengthTM, which is available to our provider network to help members and staff manage their health, stay
healthy and reduce risk. myStrength's proven web and mobile resources can help strengthen mind, body, and spirit. This wellness self-management tool offers personalized resources to improve depression or anxiety and help overcome the challenges of stress, drug and alcohol use, pain management and insomnia. To enroll, see the "Member" tab at **www.dwihn.org**.

COORDINATION OF BENEFITS

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

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

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

- Verify the Person's eligibility for other benefit coverage
- Bill the other coverage as primary payer Notify DWIHN of such coverage
- Notify DWIHN of changes in insurance or other coverage status
- The Contracted Provider must assist Members in applying for and maintaining their eligibility and enrollment with entitlements as appropriate.

For instructions on how to enroll in CHAMPS, log on to https://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_42542_42543_42546_85441---,00.html

COVERED SERVICES

ENROLLEE COVERED SERVICES AND BENEFITS

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

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

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

FAMILY SUBSIDY

Michigan's Family Support Program was established with the passing of Public Act #249 of 1983, the Family Support Subsidy Act. The Program is designed to provide financial help for families who are caring for their children, 17 years of age and younger, with severe disabilities in the family home. Monthly stipends are equivalent to the monthly maximum supplemental security income payment available in Michigan for an adult recipient living in the household of another. Increases are determined annually by legislative appropriation. DWIHN's Family Subsidy Office may be contacted at 313-833-4150.

MEMBERISM

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

DWIHN must establish a person/stakeholder advisory body composed of Members, family members, and advocates. The

advisory body is responsible for advising the Executive Director and Board of Directors on all aspects of implementing Memberism including:

- Choice
- Member-run services
- Member involvement in the design, implementation, delivery, and evaluation of the network and network operations.
- Given the critical need it is expected that this body meets no less than monthly. However, once the body is fully constituted and all functions are implemented, it may choose to meet less frequently, but no less often than quarterly.
- DWIHN must include representation of primary and secondary Members on their Board of Directors. Refer to the Governance section for additional details.

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

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

DWIHN must establish Member recognition and awards for special achievements through employment, public service, sports, education, and other areas of accomplishments. DWIHN

should take every opportunity to recognize Member's contributions at board meetings, proactively seek media exposure for Member-run services and activities, and create forums for Members to receive public recognition for accomplishments.

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

DWIHN policies and procedures must:

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

CULTURAL COMPETENCE/LIMITED ENGLISH PROFICIENCY

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

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

- Method of assessment that reflects community demographics
- Method to ensure organizational cultural competency is achieved and maintained (includes DWIHN and their sub-contractors)
- Plan to identify, remedy, and otherwise improve cultural competency
- Policies and procedures for ensuring cultural needs are comprehensive and available to all staff, and Training is provided to all staff that effectively instills cultural competency.
- All providers of behavioral health services must ensure that they can access language services that comply with federal guidelines when a Member requires/requests them.

MEANINGFUL ACCESS ACCOMMODATIONS:

Each DWIHN contractor must comply with all Americans with Disability Act (ADA) requirements including Title VI of the Civil Rights Act of 1964, and Title II and III of the Americans with Disability Act of 1990(PL 101336). The contractors must establish and implement policies and procedures that include:

Individuals with visual, mobility or communication limitations/impairments shall be assured full participation and maximum benefit from services offered and involvement in governance functions Services, programs, board meetings, and other governance functions must be accessible to and usable by individuals with disabilities. This includes, but is not limited to:

a. Provision of language assistance services. Accommodations for service animals
b. Ensure that elevators are available in multi-story buildings.
c. Ensure that parking lots have sufficient designated parking for vehicles with handicap permits. Provision of alternate methods to facilitate communication.
d. Communication aids and alternative communication methods, including a qualified sign language interpreter or augmentative communication specialist, must be provided for Members, family members, and others who are involved in the provision of services and treatment.
e. Accommodation shall be made at expense of the other DWIHN contractor. Accommodations must afford accessibility to the building, work site, and any areas used by Members to enable individuals to perform all essential program functions. Arrangements for the provision of accommodations shall not depend on a request by the Member or others involved in treatment.
f. Staff shall receive annual training on resources and technology available for individuals with visual, mobility, or communications limitations/impairments. Documentation of these training sessions must be made available to DWIHN upon request.

PEER SUPPORT

Peer support services are an evidence-based model of care which consists of utilizing qualified peer support specialists in assisting individuals with their recovery from mental illness and substance use disorders. Peer Support Specialists provide individuals with support, mentoring and assistance in achieving community inclusion, participation, independence, recovery, and resiliency.

Peer Support Specialists may participate as a team member in the PCP process based upon Member choice and preference.

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

CONTACT INFORMATION FOR CUSTOMER SERVICE

To reach Customer Service with any questions please call the following: 313-833-2500 or 1-888-490-9698

SECTION 9: INFORMATION TECHNOLOGY

DEPARTMENT OVERVIEW:

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

1. The information system for the Providers must include the following qualifications:
2. Ability to import and manage enrollment information;
3. Ability to store and report member-specific socio-economic information;
4. Ability to store and report other sources of benefit coverage (COB) information; Ability to store and accurately reflect the subcontractor's structure;
5. Ability to capture, store, and report utilization data for all levels or care/services; Capability of adjudicating claims and encounters;
6. Ability to store, manage, and report member rights issues; Ability to support clinical and business analysis;
7. Compliance with HIPAA standards as required by federal and state laws; and
8. Ability to transfer and receive data between DWIHN using ANSI Standard, HIPAA compliant transaction formats.

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

1. Monthly downloads of Medicaid eligible information; Person registration and demographic information; Provider enrollment;
2. Third party liability activity;
3. Claims payment system and tracking; Grievance tracking;
4. Tracking and analyzing services and costs by population group, and special needs categories asspecified by the MDHHS;
5. Encounter and demographic data reporting; Performance indicator reporting;
6. HIPAA compliance; 837 submission;
7. UBP (Uniform Billing Project) compliance; and • User access and satisfaction.

MH-WIN

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

The direct contracted provider must have Internet access in order to use MH-WIN. This cost of internet access will not be incurred by DWIHN.

Encounters

Direct contracted providers must submit encounters directly to the DWIHN MH-WIN system weekly.

Funding

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

Membership Lookups

All direct contracted providers may review membership eligibility in MH-WIN. The Provider's may request access to MH-WIN by completing DWIHN's Provider Data Sheet. See the Provider Data Sheet in the Forms section of the Manual.

Provider Information Systems Requirements

The Provider's Management Information System must have full Electronic Medical Record (EMR) capability. This includes the ability to track Member, clinical and administrative, transactions performed within the Provider organization. The system should be designed specifically to support Community Mental Health functions as determined by DWIHN. It must be able to support managed care capabilities including the management of service authorizations wherever appropriate. Administrative capabilities include:

1. The detailed tracking of costs and reimbursement for services performed by the organization.
2. The ability to track the eligibility and benefits of individuals served within the provider organization and accurately apply this information to the processing of claims and reporting from the Provider systems. The tracking across time of demographic, socio-economic, and Quality Improvement (QI) data attributable to the Members served by the Provider.
3. The ability to receive and send clinical and administrative data to the various trading partners within the PIHP. This includes the movement of data between the funding providers and DWIHN. The Provider systems must be able to support standard methods for movement of data between these trading partner systems.
4. The data maintained in the Providers EMR must follow all recognized industry standards for documenting clinical and support services.
5. The system must be able to track various funding methods in support of services to the Members.
6. The Provider and their system must provide the appropriate safeguards for "protected health information (PHI) in accordance with HIPAA, the Michigan Mental Health Code, 42-CFR – Part-2 as well as other regulatory requirements that apply to the Provider and our network.
7. The Provider's system and administration must be able to support various audits as prescribed by DWIHN, and the State of Michigan.
8. The Provider system must be at a level that supports any accreditation and certification requirements. The Provider's system must be scalable to accommodate the current and potential size of the population served within its organization.
9. The Provider's system must be configured and managed in such a way so that it isolates the business of DWIHN and not co-mingle data with other business endeavors.
10. The system must support a fully functional claims and encounter management system that includes the functionality identified in the Claims Section of this manual.
11. The Provider's system must be able to support DWIHN administrative requirements to support Member rights and outreach range down into the providers organization including but not limited to grievances and appeals, fair hearing, incident reporting, Critical Events, etc.
12. The Provider systems must support the administrative tracking and reporting of the State of Michigan Performance Indicators.

MH-WIN

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

Encounters

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

Membership Lookups

All Providers may review membership eligibility in MH-WIN. The Providers may request access to MH-WIN by completing DWIHN's Provider Data Sheet, this can be located in the Forms section of the Manual.

Claim and Encounter Submission

DWIHN will receive, process, and pay clean claims as described in its Claims Processes Policy for covered services as described per DWIHN Utilization Guidelines and per contract. Please also see the "Information Systems" section of this manual. Information to include on a Claim/Encounter Form

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

1. Include a valid member identification number, indicate patient's name, address, birth date.
2. Indicate the day, month, and year the service was provided.
3. Be submitted within 60 days of the date of service for professional claims and 90 days for Facility claims (or discharge date for a facility); for resubmission claims, claims must be submitted within 180 days of service date and secondary claims must be submitted with 365 days of the date on the primary payor's EOB.
4. Include all relevant provider information including: Provider name...
5. National Provider Identifier (NPI) location of service
6. Provider identification number (if different from NPI).
7. Include a description of the covered service using DWIHN accepted codes stated in the contract, CPT codes, or other codes required by the State of Michigan.
8. Include a valid diagnosis code.
9. Only be submitted for services covered.
10. Have all fields necessary for accurate payment completed.
11. DWIHN, or any organization paying Medicaid claims must pay 95% of clean claims within 30 days and 90% of Medicare claims within 30 days of receipt of the clean claim.

Web-Based Encounter Submission

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

SECTION 10: MANAGED CARE OPERATIONS

DEPARTMENT OVERVIEW

The Managed Care Operations Department is focused on developing, maintaining, and continually evaluating DWIHN providers. With over 400 providers in the network, consisting of SUD, Autism, MI-Health Link, IDD/SMI, Self-Determination and Grant Funded programs, DWIHN ensures network adequacy to provide quality services to individuals within the Detroit Wayne system. Additionally, we provide oversight of provider contracts as it relates to performance, outcomes and regulatory compliance to enrollees and fulfill obligations of our MDHHS contract. There are 11 Provider Network Managers overseeing 400 provider contracts, serving over 123,000 members in Detroit and Wayne County.

DWIHN's five (5) key components to maintaining a strong network of providers are:

1. Building a partnership/relationship with providers.
2. Ensuring the Standardized Rate is competitive and adequate.
3. Ensure provider compliance with their contractual obligations with DWIHN.
4. Training and guiding providers on changes within the system and any changes that come from MDHHS ensuring providers are well trained.
5. Monitor the performance of the provider throughout the year to certify their eligibility for contract renewal.

DWIHN has assigned a (Provider Network Manager (PNM)/Contract Manager), to support each Direct Contract Provider organization (DCP). The PNM is responsible for:

1. Receiving and responding to operational requests and inquiries of the DCP; such as program and/ or closures. Refer to our Network Monitoring and Management Policy.
2. Assisting the DCP in resolving inter-network programmatic issues;
3. Providing and/or arranging for technical assistance, training, resource materials, and other supports to assist the DCP in complying with the terms and conditions of the Contract;
4. Advising the DCP of changes, revisions, and/or corrections to instructions, policies, procedures, guidelines, and protocols applicable to the Contract; and
5. Assuring that the direct contract providers comply with DWIHN's contract performance expectations.

DWIHN expects the key leaders and staff of the DCP to meet with its Provider Network Manager/ Contract Manager on a quarterly basis.

Management of Services

DWIHN ensures a comprehensive service array is available for Members/Enrollees via a large network of DCP. The management of a comprehensive service array for Medicare/Medicaid Enrollees (MME) is the responsibility of DWIHN. The DCPs have the responsibility to ensure that services are accessible, are appropriate to meet the Member's needs, and are provided in the least restrictive environment. DWIHN maintains a list of providers credentialed to participate in the network, including the MI Health Link program for MME. That list includes at a minimum:

1. Complete business or individual contact information
2. Subcontractor's name and address
3. Telephone Number
4. Contact person
5. NPI number of individual or business
6. Website of the Provider
7. Type of Service
8. A column indicating that the provider is/is not accepting new members

Any delegated services or responsibilities must be reported to DWIHN which include:

1. Claims management
2. Community Benefit
3. Complaint, Grievance, Appeals processes
4. Credentialing and Privileging
5. Customer service
6. Financial management
7. Financial operations and risk management
8. Information services
9. Information systems management
10. Level of care assessment and service support
11. Managing Review processes
12. Network development
13. Network policy development
14. Performance measurement
15. Provider education and training
16. Provider network management
17. Quality management
18. Regulatory management or Corporate Compliance
19. Service authorization
20. Standards setting
21. Utilization management
22. Utilization Review

Network Access Standards

The following are the access standards that must be adopted and demonstrated within the DWIHN Quality Management Program under MDHHS Network Adequacy Standards 42 CFR, 438.68 and 457.1218 for adult and pediatric populations:

1. 30 Miles/30 Minutes: Members must have reasonable access to all types of covered services. Members receiving services have a choice to seek out providers that are greater than 30 minutes/ 30 miles to receive services. DWIHN is obligated to keep an adequate network so Members don't have to travel more than 30 miles/30 minutes to be served.
    a. When services cannot be provided within the 30 miles/ 30 minutes access standard, (e.g., a child in foster care outside Wayne County), the DWIHN in collaboration with the service provider will execute a single case agreement or an out of network agreement to provide services in the local area in which the person is residing.
2. 10 Miles /20 Minutes: MI-Health Link Members must have reasonable access to all types of covered services. Members receiving services must not be required to travel greater than 10 miles/20 minutes to receive services.
    a. Out of Network providers for the MI Health Link program are providers that do not have contracts with DWIHN but provide behavioral health services to the MME. They have an option to contract with DWIHN within 90 days of determining that a Member is an MME. A member from DWIHN will contact the provider(s). If provider has questions they should contact the Integrated Care unit at: pihpcarecoordination@dwihn.org or Provider Network Management at pihpprovidernetwork@dwihn.org Please review MI Health Link Non-Contracted Provider Procedure at https://www.dwihn.org/policies
3. Emergent: Must be seen immediately by a provider for a face-to-face evaluation by a mental health professional.
4. **Urgent:** Must be seen by a mental health professional for a face-to-face evaluation within 24 hours of the request for services (including transfer between levels of care during a chemical dependency episode).
5. **Routine:** Must be seen by a mental health professional for a face-to-face intake/evaluation within 14 calendar days of the request for service.

If it is determined that DWIHN's network has any gaps in providers and/or services to meet the needs of members, DWIHN's Access Committee will immediately review and follow procedures to get the network back in a sufficient state utilizing a Request for Information (RFI) or Request for Proposal (RFP) process to meet the MDHHS network adequacy standards (42 CFR 438.68 and 457.1218).

DWIHN and its contracted providers must ensure that costs to the beneficiary shall be no greater than they would be if the services were furnished within the network. MCO is responsible for communicating this protocol in writing to all out of network providers utilizing the standardized rate sheet.

Contract Management

All vendors wanting to become a DCP must go through the onboarding and credentialing process utilized by DWIHN to ensure that there is an adequate network of providers that can meet the behavioral health and SUD needs of individuals residing in Wayne County. To initiate this process, a new provider must review the Medicaid standards/requirement and complete the online provider inquiry form on DWIHN website at: https://www.dwihn.org/for-providers

The DCP must designate individual(s) as point(s) of contact for the Provider Network Manager.

The DCP staff/contact person is responsible for:

1. Responding to all inquiries from DWIHN in a timely manner,
2. Assisting the PNM/Contract Manager in resolving inter and intra network issues, coordinating participation in DWIHN offered or sponsored trainings,
3. Advising the appropriate parties within the DCP network of changes, revisions, and/or corrections to DWIHN instructions, policies, procedures, guidelines, and protocols applicable to the Contract. The DCP must implement the required policies, procedures and/or DWIHN instructions, upon any changes.
4. DCP will maintain adequate professional and general liability coverage as prescribed in each provider's contract with DWIHN as well all licenses, certifications, accreditations, and practice privileges required by law. Providers will furnish proof of such credentials upon DWIHNs request or upon expiration. Providers will fully comply with applicable DWIHN credentialing requirements and will immediately notify DWIHN of any material changes in the provider's licensure, certification, licensed staff changes, program or staff deficiencies accreditation or practice privileges. Providers will furnish covered services in accordance with each provider's legal qualifications and professional capabilities in a manner consistent with professionally recognized standards of health care.
5. Providers must provide all identifying information (phone numbers, group affiliations, National Provider Identifier, tax identification number, billing address, etc.). When that information changes, providers must update the information at least 60 days in advance of the change, when possible. This also applies to other types of changes. Note: All Changes should be communicated to your assigned PNM and must submit the DWIHN Existing Provider Change Form, located on our website under the Provider Tab: Provider Close Out Plan and Required Change Forms
6. Providers will look solely to DWIHN for payment of covered services and will accept payment in full for all covered services. The only exception is that providers will pursue payments from other responsible payers when appropriate.
7. Providers will comply with all obligations outlined in their provider contracts and in the amendments to those contracts.

Staffing Standards

All direct contracted providers must have sufficient staffing standards, policies, and procedures, and hiring practices that ensure appropriate; qualified staff are providing services to Members and in accordance with the member(s) Individual Plan of Service (IPOS). The DWIHN providers must ensure that they conduct criminal background checks on all professional and nonprofessional individuals hired in accordance to DWIHN policies and the State's guidelines for health care workers. DCPs must ensure that no Members with criminal histories are hired at any direct care level within the organization or network. DCPs must review evidence of criminal background check on all employees responsible for delivery of direct care services to Members. For additional information, refer to the Credentialing section of this manual.

How to add a location/site or service/program(s)

Providers wanting to add a location, site or service/program must contact the assigned Provider Network Manager. While there is no guarantee that the service or location will be granted approval. All requests must go through our credentialing process to determine the appropriate credentialing for said site or service. Please complete the Existing Provider Change Request Form on our website at: https://www.dwihn.org/Provider-Close-Out-Plan-and-Required-Change-Forms.id.2119.htm

Providers that are not contracted with DWIHN and would like to find more information on how to become part of the network, please visit our website and complete the link

"Interested in becoming a Provider in our Network" at: https://www.dwihn.org/for-providers

Provider(s) will be contacted by the DWIHN Network Management department to complete the process once the request has been reviewed.

Provider Service/Program or Location Closure or Contract Termination

If a provider is terminating services, closing a location, or is terminated from the Network, please follow below requirements.

Service or Location closure

For any program and or location closures, refer to the Network Monitoring and Management Policy located on the website at: https://www.dwihn.org/policies or find forms at; https://www.dwihn.org/Provider-Close-Out-Plan-and-Required-Change-Forms.id.2119.htm

Contract Termination

DWIHN notifies members when a provider's contract has been terminated or when a DCP stops affiliating with DWIHN for any reason, DWIHN will provide timely written notice of the provider's termination to all members within 14 days of the date of termination notification.

Providers wishing to terminate must notify DWIHN and its serving members as required under the DWIHN policy. Complete forms located on website at: https://www.dwihn.org/Provider-Close-Out-Plan- and-Required-Change-Forms.id.2119.htm

The DCP must provide written notification 30 days in advance to DWIHN when they wish to terminate their contract or a program. Providers must terminate their DWIHN contract in accordance with the terms and conditions of their contract and continue to provide covered services to members until a new provider has been selected.

Providers should refer to their contract for the proper notification time period and any additional requirements for termination. Timely notification of provider termination assures proper payment to providers and assures continuity of care for the members.

Providers are reminded that timely notification to the members is facilitated by the notification that providers must give to DWIHN. Members receive additional information from DWIHN to assist them in the transition.

Termination notices should be submitted in accordance with the notice requirements of the policy.

All providers are assigned to a PNM or Contract Manager, see contract assignment list at https://www.dwihn.org/providers-mco-contract-assignments, for SUD provider: https://www.dwihn.org/providers-sud-contract-manager-list.pdf

Provider Directory

DWIHN must produce, maintain, and distribute a current directory of its direct contracted providers (DCP) to Members upon request. The directory must include: provider name, address, phone number, hours of operation, company website, provider accreditation, type of practice, emergency contact numbers, 24-hour screening centers numbers and locations, and other professional services offered and applicable practice restrictions.

All contracted providers must maintain and keep accurate staff records in DWIHN's MH-WIN system to ensure DWIHN's online directory is up to date and current. All new information from the provider will be updated in the online directory within 30 calendar days of receipt of the new information from the provider.

Cultural and Linguistic Services

All contracted providers and its subcontracts must provide Cultural and Linguistic Cover Services whenever a member who needs culturally appropriate covered services. Service provider shall provide access to interpreters for members to access covered services either through telephone, sign language or interpreters.

DWIHN Delegated Functions as of 23/24

Medicaid Managed Care Functions	Mobile Crisis Stabilizations Team, Crisis Service Units (CSU)
Utilization Management	
Access &Eligibility Determination	DWIHN Access Center
Level of Care Assessments & Service/support selection	DWIHN Access Center, Direct Contract Provider (DCP), Mobile Crisis Stabilization Team, CSU
Service Authorization	DWIHN Access Center, Mobile Crisis Intervention
Utilization Review	DWIHN Staff, Direct Contract Provider (DCP)-MPRO
Credentialing /Re-Credentialing	
Credentialing and Privileging	DWIHN Credentialing Unit, Direct Contract Provider (Medversant)

Credentialing

For DWIHN policies, procedures, and documents, visit our website at https://www.dwihn.org/

DWIHN Credentialing

The DWIHN credentialing process is applicable to Direct Contract Providers. The credentialing process must include primary source verification of the following:

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

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

DWIHN/CVO requires that organizations and individuals directly or contractually employed meet all applicable licensing scopes of practice, contractual, Medicaid Medicare requirements for appropriate credentialing and re-credentialing. The Credentialing/Re-Credentialing process is required to verify that qualifications of practitioners are consistent with national credentialing standards and applicable laws.
DWIHN's Credentialing Committee shall provide oversight of the Credentialing and Re-Credentialing Process which includes the following activities:

- Development and update of credentialing criteria as needed, consistent with DWIHN, federal, and other State requirements and relevant professional standards,
- Review and final decision making for appeals of adverse credentialing decisions made by contracted providers with the network,
- Ensuring adherence to timely appeal standards for adverse credentialing decisions which include reconsideration of appeal decisions in writing within 30 calendar days of receipt of an appeal request, and referral to DWIHN's Credentialing Committee for final appeal decisions,
- Developing and monitoring adherence to established timelines for the credentialing process,
- Determining, as needed, the utilization of participating providers to ensure all relevant information is incorporated in credentialing/re-credentialing decisions,
- Maintaining oversight of the CVO, and the contracted provider network's implementation of the credentialing, and re-credentialing process, which includes the right to approve, suspend, or terminate contracted providers and
- Granting temporary or provisional credentials, based upon a specific community/consumer need.

Individual Practitioners

Direct Contract Providers (including SUD treatment and prevention providers) must develop policies and procedures for credentialing and re-credentialing individual practitioners which shall include at least the following:

- Physicians (MDs and D.O.'s)
- Physicians Assistants (PA)
- Psychologist (licensed, Limited License, and Temporary License) (TLLP, LLP, PsyD)
- Licensed Master's Social Workers (LMSW)

- Licensed Bachelor's Social Workers (LBSW)
- Limited License Social Workers (Masters and Bachelors) and Registered Social Service Therapist (LLMSW, LLBSW, RSST)
- Licensed Marriage and Family Therapists, and Limited Licensed Marriage and Family Therapists (LMFT, LLMFT)
- Licensed Professional Counselors, Limited License Professional Counselors (LPC, LLPC)
- Nurse Practitioners, Registered Nurses and Licensed Practical Nurses (NP, RN, LPN)
- Occupational Therapists and Occupational Therapist Assistants (Ot and OTA)
- Physical Therapists and Physical Therapist Assistants (PT, PTA)
- Certified Therapeutic Recreational Specialists and Recreational Therapists (CTRS, RT)
- Speech and Language Pathologists (SLP)
- Autism Spectrum Disorders Benefit Behaviorists – Qualified Behavior Health Professionals (BCBA, BCaBA, and QBHP)
- Substance Abuse Treatment Specialists (SATS)
- Substance Abuse Certified Prevention Specialists (SAPS)
- Certified Peer Recovery Mentor/Coach (CPRM)

Primary Source Verification

Primary Source Verification is comprised of:

- Licensure or certification
- Board Certification, or highest level of credentials attained if applicable, or completion of any required internships/residency programs, or other postgraduate training.
- Documentation or graduation from an accredited school
- National Practitioner Databank (NPDB)/Healthcare Integrity and Protection Databank (HIPDB) query or, in lieu of the NPDB/HIPDB query, all of the following must be verified:
- Minimum five-year history of professional liability claims resulting in a judgment or settlement;
- Disciplinary status with regulatory board or agency;
- Medicare/Medicaid sanctions.
- If the individual practitioner undergoing credentialing is a physician, then physician profile information obtained from the American Medical Association or American Osteopathic Association may be used to satisfy the primary source requirements.

Credentialing and Re-Credentialing Process

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

- Health Care Professionals shall not be the subject of discrimination solely on the basis of license, registration or certification; or as a result of serving a high-risk population who specialize in the treatment of conditions that require costly treatment.
- All findings from the Quality Assessment Performance Improvement Program are submitted to the chair of DWIHN's decisions.
- Maintenance of complete individual credentialing/re-credentialing files for all credentialed providers which include: the initial credentialing and all subsequent re-credentialing applications; information gained through primary source verification; and all other pertinent information used in determining

whether or not the provider met the PIHP's credentialing and re-credentialing standards.

- Inform the applicant in writing of the reasons for any adverse credentialing/re-credentialing decision to deny, suspend, terminate the contract for any reason other than lack of need, and their right to appeal the process (consistent with state and federal regulations).
- Upon notification of substantially varied information obtained from other sources, the practitioner has the right to correct any erroneous information. The following procedures must be followed:
  - The practitioner must complete a request in writing within 7 days of notification that information is incorrect.
  - Practitioners have 30 days to correct any erroneous information.
  - Written documentation of corrections must be submitted to the Credentialing Committee Chair within 10 days of receipt of corrected information, DWIHN will verify corrections and notify practitioner of the status of their application.

CVO Credentialing Responsibilities

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

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

Initial Credentialing Process

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

- Lack of present illegal drug use.
- Any history of loss of license, registration, or certification, and/or felony convictions.
- Any history of loss or limitation of privileges or disciplinary action.
- State sanctions or limitations on licensure and limitations on scope of practice.
- Any history of Medicare/Medicaid sanctions, including the Preclusions database for MI Health Link Practitioners.
- Reasons for inability to perform the essential functions of the position.
- Current malpractice insurance coverage.
- A summary of the practitioner's work history for the prior five years. Recent college graduates may use their internships as experience when submitting their initial credentialing application after graduation.
- Attestation by the applicant of the correctness and completeness of the application.

Temporary/Provisional Credentialing of Individual Practitioners

The Credentialing and Re-Credentialing process ensures provisions for granting temporary or provisional credentials. Temporary or provisional credentialing shall not exceed 60 days.

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

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

Re-Credentialing Individual Practitioners

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

- Re-Credentialing at least every two years,
- Practitioner must update information in the Re-credentialing file,
- A review of any sanctions, complaints, and quality issues pertaining to the practitioner which must include, at minimum, a review of:
    - Medicare/Medicaid sanctions
    - State sanctions or limitations on licensure, registration or certification, and
    - Concerns/issues pertaining to grievances (complaints), quality of care issues and appeals
    - Continuing education credits must cover the two years from initial credentialing until the re-credentialing cycle

Reporting Improper Conduct

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

DWIHN Credentialing Committee

The DWIHN Credentialing Committee is comprised of the Chief Medical Officer or their Physician Designee, staff from DWIHN departments and representatives from the behavioral health and substance use disorder networks. This committee approves all clean provider and practitioner files verified by the CVO. The members also review complaints against clinicians and review all adverse decisions.

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

Organizational Credentialing /Recredentialing of Providers

Each organization that has a contract with DWIHN must be credentialed to determine if they meet minimal standards to provide the behavioral health or substance use disorder services. This process occurs every two years. Providers must complete the application and provide supporting documentation. They are reviewed by the CVO, presented to the Credentialing Committee for approval. If an organization seeks to add additional locations or services they must contact the Credentialing unit at pihpcredentialing@dwihn.org.

Practitioner Rights

Practitioners have the following rights:

1. If a practitioner receives an adverse credentialing decision, they have the right to appeal.
2. The letter sent regarding an adverse decision will have an appeal document attached that must be returned within 30 calendar days of the decision in order to get a review by the Appeals Committee.

a. Failure to send a valid request for appeal within 30 calendar days allotted shall constitute waiver by the practitioner of any right to appeal.

3. The applicant has the right and will receive a decision within 7 business days of the final disposition.
4. The right to review information submitted to support the credentialing application
5. The applicant has the right to review information obtained by the CVO to evaluate their credentialing application, attestation or Curriculum Vitae (CV).

a. The applicant must send a request in writing to the CVO.

Required Training Associated With Credentials

1. Minimum standards for continuing education credits by credential complies with Michigan Department of Health and Human Services staff requirements:

   a. Minimum standards require at least 24-hours per year of SED Child and Adolescent specific training and continued education for Child Mental Health Professionals (CMHP) .
   b. Minimum standards for SMI require at least five (5) CE hours per year specific training and continued education for Qualified Mental Health Professionals (QMHP).
   c. Minimum standards for I/DD require at least five (5) CE hours per year specific training and continued education in intellectual/developmental disabilities for Qualified Intellectual Disabilities Professional (QIDP).
   d. Minimum standards for MI Health Link providers require annual Medicare Fraud, Waste and Abuse training within 30 days of hire and annually thereafter.
   e. Minimum standards for BCBA, BCaBA Autism providers are required to obtain 32 continuing education units (CEUs) within each 2-year recertification cycle, including 4 CEUs in ethics and 3 CEUs in supervision (for supervisors) and continued education for Qualified Behavioral Health Professional (QBHP).
   f. Minimum standards for Substance Abuse Treatment Specialist require at least twenty (20) CE hours per year specific training and continued education in Substance Use Disorders and Certified Alcohol and Drug Counselor or state approved development plan.
   g. Minimum standards for Substance Abuse Certified Prevention Specialist and Certified Peer recovery Mentor require at least twenty (20) CE hours per year specific training with 6 hours must be ethics.

2. Training may be counted toward more than one credential type.

   a. If a training's title and content reflect that it addresses mental health issues for Children and Adults, it may be counted toward CMHP and QMHP credentials.
   b. Likewise, if a training's title reflects that it addresses I/DD issues in Children, it may be counted toward CMHP and QIDP credentials.
   c. If clinicians must be credentialed as CMHP, QIDP, and QMHP simultaneously and the 24 hours of Child-specific training they completed includes titles which reflected I/DD and SMI (Adults with Severe Mental Illness) topics, training may be counted toward each of the relevant credentials. In other words, a person could realistically satisfy all three credentials with 24 hours of training if all 24 of the hours reflected Child-specific topics and at least 5 of them additionally reflected I/DD topics for a Children's population and another 5 of them reflected topics related to Adults with Severe Mental Illness.

3. For staff currently pursuing a graduate degree, the college course credit can be used as a source for CE hours in the credentialing process. The current degree classes must be included on the staff transcript as completed and credit(s) earned and the training must meet the criteria of credential population requirements.
4. For practitioners hired within 6 months of graduation, classes specific to the credential they are seeking can be used as continuing education units.
5. Maintenance of all credentialing material for practitioners in files with the following documentation that supports the specific activity or population group for which practitioners are being credentialed:
    a. A resume dated by month and year that provides evidence of supervised experience in working with the relevant population. In lieu of a resume, a descriptive statement on letterhead of a previous employer will be accepted.
    b. Evidence of primary source verification of the following:
        i. Licensure or certification.
        ii. Board Certification or highest level of credentials attained if applicable,
        iii. Valid DEA or CDS certificate for all prescribers.
        iv. Medicare and Medicaid sanctions.
        v. Degree from an accredited school.
        vi. Current competence:

5. Documentation of certification to provide special assessments, services or processes (e.g., Child & Adolescent Functioning Assessment Scale (CAFAS), electroconvulsive therapy (ECT), and neuropsychological testing, etc.).
6. Practitioners must be qualified by training and experience to provide services, support, treatment, and UR/UM activities, as clinically indicated.
7. For Qualified Behavioral Health Professional, transcripts must identify the completion of 3 of the 6 Board Certified Behavior Analyst required master level courses.

SECTION 11: QUALITY IMPROVEMENT

OVERVIEW OF THE QUALITY IMPROVEMENT UNIT:

The Quality Improvement Unit has the overall responsibility for monitoring DWIHN's Behavioral Health Care Network. The key functions of the QI unit include but are not limited to Monitoring, Performance, and Measurement. The Quality Assurance Performance Improvement Plan (QAPIP) provides the structure and governance to guide the processes for evaluating and improving the quality and appropriateness of healthcare services and the health status of the population we serve. DWIHN's QAPIP aligns with NCQA requirements and the MDHHS contractual requirements.

QUALITY ASSURANCE PERFORMANCE IMPROVEMENT PLAN (QAPIP)

The Contacted Service Provider shall at all times provide a written quality improvement plan (the "QI Plan") approved by DWIHN that addresses all services provided by the Contracted Service Provider. The Service Provider that provides Case Management or Supports Coordination shall submit their QAPIP Plan to DWIHN for its approval at least annually, and incorporate all revisions requested by DWIHN. The QAPIP Plan shall satisfy all applicable DWIHN, MDHHS, state, and federal requirements including, but not limited to the Balanced Budget Act of 1997 ("BBA") requirements, and the Centers for Medicare and Medicaid Services ("CMS").

PERFORMANCE IMPROVEMENT PROJECTS

The Contracted Service Providers shall cooperate with DWIHN on any Performance Improvement Projects ("PIP") that DWIHN is involved in conducting. Failure to comply with this section may result in monetary sanctions against Service Providers.

PROVIDER/PROGRAM MONITORING

The Provider and Program monitoring process is geared to improve quality and measure our performance in the delivery of service and compliance with required standards. Continuous self-monitoring of your operations is a responsibility that accompanies accepting Medicaid funds for the services you provide. It is the expectation of DWIHN's to ensure providers deliver Medicaid and Medicare services consistent with applicable sections of the Social Security Act; the Code of Federal Regulations (CFR); Center for Medicare and Medicaid (CMS) Medicaid & State Operations Manuals; Michigan's Medicaid State Plan and its Michigan Medicaid Provider Manual: Behavioral Health and Developmental Disability Supports and Services (formerly called Mental Health-Substance Abuse Section); Provider agreement; DWIHN Policy and Procedures and the Home and Community Based Setting Final Rule.

DWIHN has developed a multilevel monitoring approach using standardized tools. Those tools can be found in DWIHN's MH-WIN system. The provider self-monitoring review process begins at the service provider level and cascades up to DWIHN's Quality Improvement Team. The procedures for the provider self-monitoring and DWIHN validation process can be found in the Quality Improvement Oversight and Monitoring Policy. DWIHN also conducts Environmental Health and Safety reviews to ensure compliance with regulatory requirements. On-going provider reviews will identify trends, areas for continuous quality improvement, and corrective action plans as needed.

MEDICAID CLAIMS VERIFICATION REVIEW PROCESS

As part of DWIHN's contractual obligation with MDHHS, DWIHN conducts Medicaid Claims verification reviews throughout the provider network. The purpose is to review Medicaid/Healthy Michigan claims/encounters data against services provided to beneficiaries under contract. The sampling universe shall be in a fiscal year period for Medicaid/Healthy Michigan claims/encounters only; it does not apply to Substance Use Disorder (SUD) Block Grant and P.A. 2 funded services. Providers are selected utilizing a statistically sound sampling methodology in accordance with OIG standards. The process occurs twice a year beginning in March of each year. The standards for the review process can be found in the Medicaid Claims Verification Policy and Procedure.

BEHAVIOR TREATMENT PLAN REVIEW COMMITTEE REQUIREMENTS

The Contracted Service Providers who provide Behavior Treatment Services are required to submit behavior treatment data on MDHHS spreadsheets every quarter to Quality Improvement (QI) unit. The due dates for Behavior Treatment Plan Review Committees
("BTPRC") data spreadsheets and BTPRC meeting minutes are January 15th, April 15th, July
15th, and October 15th. The providers with BTPRC are required to adhere to MDHHS
Technical Requirements for BTPRC and DWIHN's current Behavior Treatment policy and forms posted on DWIHN's website at: https://www.dwihn.org/ The standards for Behavior Treatment Plans can be found in the Policy Use of Behavior Treatment in Community Mental Health Settings.

DWIHN Clinically Responsible Service Providers (Mental Health CRSP) are required to have a BTPRC to review and approve or disapprove any BTP that proposes to use Restrictive and Intrusive interventions. Each BTPRC will keep track and analyze the use of all physical management and involvement of law enforcement for emergencies, as well as the use of intrusive and restrictive techniques for each individual receiving the interventions. Assigned Clinical Staff at each agency is required to document a summary and follow up on the five (5) reportable categories: Suicide, Non-suicide death, Emergency Medical Treatment due to Injury or Medication Error, Hospitalization due to Injury or Medication Error, and Arrest of Member (misdemeanor/felony) for the members on BTPs.

CRITICAL/SENTINEL EVENTS AND INCIDENT REPORTING AND PROCESS

It is the expectation that the CRSP staff report, review, and enter critical events, sentinel events, and member deaths into the MH-WIN Critical Event/Sentinel Event Module. CRSP staff are required to attend the Critical/Sentinel Event face-to face training prior to being authorized access to the Critical/Sentinel module. This training is required annually thereafter. CRSPs are to report events for members actively receiving services funded through the DWIHN within 24 hours of knowledge of the event). The standards for critical incident reporting and timeframes can be found in the Critical Sentinel Events Policy and Procedure. Failure to report Sentinel Events may result in sanctions as described in the contract.

SECTION 12 RESIDENTIAL SERVICES

DEPARTMENT OVERVIEW:

Under the DWIHN system transformation effective October 1, 2018, the goal for the Residential Department was to bring specialized residential services under one umbrella throughout Wayne County. The purpose is to standardize and manage services provided to DWIHN Members receiving Adults with Mental Illness (AMI) and Intellectual/Developmentally Disabled (IDD), IDD Community Living Support and Personal Care Services in various residential settings. The Residential Department conducts assessments in inpatient hospital settings, nursing homes, correctional settings, agencies, and Department of Health and Human Services settings. All cases are reviewed and assessed by licensed social workers and counselors known as Residential Care Specialists. The staff bring a wide range of experience in community mental health and are trained in the use of the Residential Assessment. The Residential Care Coordinators are licensed social workers and are responsible for what is known as "brokering," in which cases are reviewed for placement in the community. In addition to conducting assessments and brokering, the Residential Department is responsible for overseeing and monitoring specialized residential settings and other settings. The authorization team is composed of Residential Care Specialists who are licensed, social workers and counselors.

Authorizations are reviewed in conjunction with the Individual Plan of Service and additional documentation. The Residential Department is responsible for making presentations to the network providers to help them understand the authorization process and the assessment process. Training gives the service providers the most up-to-date information that will enable them to submit information correctly to DWIHN.

DWIHN RESIDENTIAL SERVICES

RESIDENTIAL DEPARTMENT REFERRAL PROCESS

Referrals can be made by Referral Agents:

1. CRSP
2. Community Hospital Inpatient
3. Skilled Nursing Homes / Rehabilitation Facilities
4. Member/Guardian

Clinical packets are submitted: by EMAIL: residentialreferral@dwihn.org or by FAX: (313) 989- 9525

Referral Agent must submit the clinical packet with completed Referral Checklist with all clinical documents. The Referral Checklist can be found on the DWIHN website at: https://www.dwihn.org/providers-residential-forms-docs

Within 24 hours/next business day (after 2 PM) of submission the Residential Care Specialist (RCS) is assigned and contacts Referral Agent to introduce themselves and schedule assessment appointment:

Referral from CRSP: Coordinates Member's availability providing 2-3 available dates & times for assessment appointment at CRSP facility

Referral from Hospital/Emergency Department: RCS contacts Referral Agent to confirm date & time for face-to-face assessment appointment with Member/Guardian or Family Support

All housing options and services are explained to Member/Guardian:

1. Location Preference
2. Type of Placement Settings

Residential Care Specialists (RCS) complete the Residential Assessment tool to determine criteria has been met for specialized residential services.

Residential Care Coordinators (RCC) receive completed assessment and clinical packet from RCS to begin placement process.

Works with Member/Guardian or family support to locate preferred placement. Responsible for notifying all parties of confirmed placement location and acceptance date.

AUTHORIZATIONS

The Residential Authorization Team reviews and approves authorization submitted to MHWIN by the CRSP for consideration. The Residential authorizations are for services rendered within a Licensed or Unlicensed residential setting within the community. Authorization can also be submitted internally by the Residential Care Coordinators and Specialists in the Residential Department. The Residential Authorization Team works daily to ensure that all related authorizations for each member are appropriately entered, assigned to correct contracted residential facilities, and continue to report identified errors and barriers. The Residential Authorization Team has set standards for review/to the approval of authorization within established timeframes.

Residential Authorization Team will ensure the authorization is submitted with the correct Provider ID# based on the Member's assigned home address. The Residential Authorization Team will check the capacity of the home to ensure the Member is properly assigned. All
vacancies must be reported in a timely manner to DWIHN's Residential Department by following the Vacancy Reporting Process.

Residential Authorization Team monitors/manages the following MH-WIN queues for residential authorizations:

- Approve Authorizations (Residential Rate Setting)
- Approve Residential Authorizations (UM)

The Residential Authorization Team reviews incoming authorization requests by completing the following steps:

1. The Residential Authorization Team will review authorizations in the order they are received. The Team has up to 14 days to review the authorization for approval/return of authorizations submitted to MH-WIN by the CRSP. If an authorization is returned to a requester, the requester (CRSP) has 48-72 hours to make updates and resubmit.

2. Member's chart will be reviewed for the following clinical documentation:

Clinical Documentation	Licensed Settings	Unlicensed Settings
Primary Designation	X	X
BH CRSP	X	X
SIS Assessment (IDD only)	X	X
LOCUS (AMI only)	X	X
Medicaid Eligibility/Insurance	X	X
HAB Waiver (IDD only)	X	X
Home Help		X
Behavior Treatment Plan	X	X
Biopsychosocial	X	X
Residential Progress Note	X	X
Treatment Plan	X	X
Medical Necessity	X	X

MEDICAL NECESSITY DOCUMENTATION:

Medical Necessity is reviewed based on how it is defined in the Medicaid Provider Manual:

Medical Necessity - *Determination that a specific service is medically (clinically) appropriate, necessary to meet needs, consistent with the person's diagnosis, symptomatology, and*

functional impairments, is the most cost-effective option in the least restrictive environment and is consistent with clinical standards of care. Medical necessity of a service shall be documented in the individual plan of services.

ACTIVE TREATMENT PLAN:

All members must have an active Treatment Plan in the MH-WIN system for an authorization to be approved. If a member does not have an active Treatment Plan, this may cause a lapse in services. The authorization will be returned to the requestor with a request for an Interim IPOS or an updated IPOS to be completed by the CRSP

RESIDENTIAL ASSESSMENT:

Residential Assessment is reviewed for completion, accuracy and assessed hours. The Team will ensure the authorization is submitted with the correct Provider ID# based on the Member's assigned home address and will check the capacity of the home to ensure the Member is properly assigned. All vacancies must be reported in a timely manner to DWIHN's Residential Department by following the Vacancy Reporting Process.

AUTHORIZATION PROCESS FLOW

1. Identify and confirm the Member ID.
2. Confirm the Disability Designation – AMI or IDD.
3. Verify the most recent Individual Plan of Service is active.
4. Verify date of the Treatment Plan Meeting is effective for time of authorization being requested.
5. Confirm Effective Date/Expiration Date
6. If there is a gap in service dates, an Interim IPOS will need to be created and uploaded.
7. Review the most recent Residential Assessment to determine assessed hours for member in the home.
8. Note any exceptions to be removed from the totals
    a. a. Home Help/Expanded Home Help
    b. b. HAB Waivers
9. Creating the Authorization:
    a. Select Authorizations from Member's Home Page in MH-WIN under Clinical Services
    b. Select Click here to add DWIHN CMH Service Authorization
    c. Select Provider
    d. Click on lookup to ensure that the entire section will populate
    e. Select the current IPOS
    f. Enter the Authorization Effective Date and Expiration Date;

g. Authorization Effective Date must be the day after the Expiration Date of the previous authorization. No overlapping in services is approved.
h. Complete the Provider Notes
i. Provider Notes should include:
    i. Hours Assessed
    ii. Any discrepancies
    iii. Name of Requester

10. Click on Add Service
11. Enter correct CPT code in box “CPT code or part of CPT description”
12. Click on “Program” Programs: AMI Residential or IDD Residential
13. Click Search
14. Select appropriate CPT code After selecting the Fee Schedule, this screen will appear:
15. Enter the blank fields following examples below:
16. Units per Period: Enter From 1 To Total Number of Units
17. Frequency: Select Per Week
18. Click on Calculate
19. Click Save
20. Click Save again and that will process the request

ENTERING THE AUTHORIZATION FOR A SPECIALIZED RESIDENTIAL SETTING:

1. Select the fee schedule
2. Enter the blank fields following examples below:
3. Example: Units per Period: Enter From 1 to 1 Example:
4. Frequency: Select Per Day
5. Click on Calculate and click Save

GUIDELINES FOR CREATING THE IDD AUTHORIZATION:

1. Check if the Member is on a HAB Waiver and review the HAB Waiver Goals
2. If Overnight Health and Safety Supports (T2X27/H2X15) is being considered, the following must be applicable:
    a. Be Medicaid eligible
    b. Be enrolled in one of the following waiver programs; CWP, HSW, or SEDW;
    c. Be living in a community-based setting (not in a hospital, intermediate Care Facility for Individuals with IDD or ICF/IID, nursing facility, licensed foster care, correctional facility or child caring institution
    d. Require supervision overnight to ensure and maintain the health and safety of an individual living independently; and
3. The need for OHSS must be reviewed and established through the PCP process with the beneficiary's specific needs identified that outline health and safety concerns and a history of behavior or action that have placed the beneficiary at risk of obtaining or maintaining their independent living arrangement.
4. Usual sleep hours and sleep schedule must be documented in IPOS and Residential Assessment.

AUTHORIZATION REQUEST TIMELINE

1. Authorizations can be submitted 60 days before the expiration of the previous authorization and no later than 30 days after the expiration of the previous authorization or further action is required from the requester.
2. All submitted requests are reviewed and processed in the order received.
3. Residential Auth Team has 14 days to review/approve/return authorizations submitted to MH-WIN.
4. If Authorization is returned to requester, they must resubmit the authorization for review within 48-72hr of authorization being returned, a new 14-day timeframe starts once authorization is updated and returned for review/approval.
5. Upon completion of the review; email notification through MH-WIN advising the approval(s) for billing, unless additional information is needed from the designated CRSP.

6. If Large Gap in Service Dates:
    a. Explanation for the delay in request is required.
    b. Explanation for the delay will be reviewed by the Residential Department to determine exception.
7. After review and approval, the Residential Provider will need to complete the claims appeal process to receive payment.
8. For additional information, review the Authorization Process Flow Refresher Training on the DWIHN web site
9. Residential Authorization Team email residentialauthorizations@dwihn.org

RESIDENTIAL SETTINGS

SPECIALIZED ADULT FOSTER CARE (AFC) HOME PROVIDERS (LICENSED BY THE STATE OF MICHIGAN) Specialized Adult Foster Care Homes are licensed, community -based, congregate settings with an occupancy of 6-12 individuals. The Direct Care Workers (DCW) provide skill- building and 24-hour monitoring in Personal Care services and Community Living Supports (CLS). DWIHN must ensure that residential placement is provided to eligible Members fairly and equitably. DWIHN cannot establish waiting lists that disadvantage or prevent eligible Members from timely residential placement. DWIHN must establish policies and procedures to guide residential placement decisions. DWIHN recognizes there are varying levels of care provided in the residential environment. In those instances where the needs of two or more individuals can similarly be met in a residence, the individual first requesting placement must have priority. The Residential Department tracks the date of request for placement along with the requesting referral source information. All referral packets are housed in a database after assignment to a Residential Care Specialist or Residential Care Coordinator who in turn, documents all efforts to secure suitable placement.

PERSONAL CARE SERVICES INCLUDE ASSISTING THE BENEFICIARY TO PERFORM THE FOLLOWING: Assistance with food preparation, clothing and laundry, and housekeeping beyond the level required by facility licensure, (e.g., a beneficiary requires special dietary needs such as pureed food).

- Eating/feeding
- Toileting
- Bathing
- Grooming
- Dressing
- Transferring (between bed, chair, wheelchair, and/or stretcher);
- Ambulation; and
- Assistance with self-administered medications.

"Assisting" means staff performs the personal care tasks for the individual; or performs the tasks along with the individual (i.e., some hands-on); or otherwise assists them to perform the

tasks themselves by prompting, reminding, or by being in attendance while the beneficiary performs the task(s).

CLS are used to increase or maintain personal self-sufficiency, facilitating an individual's achievement of his goals of community inclusion and participation, independence or productivity. The supports may be provided in the participant's residence or in community settings (including, but not limited to, libraries, city pools, camps, etc.).

COVERAGE INCLUDES:

Assisting (that exceeds state plan for adults), prompting, reminding, cueing, observing, guiding and/or training in the following activities:

- Meal preparation
- Laundry
- Shopping for food and other necessities of daily living
- Money management
- Socialization and relationship building

CLS may be provided in a licensed, specialized residential setting as a complement to, and in conjunction with, state plan coverage Personal Care in Specialized Residential Settings. These services are assessed during the completion of the Residential Assessment that is completed by the Residential Care Specialist. All services must be authorized by DWIHN and indicated in IPOS to be completed by the CRSP.

CASE MANAGEMENT / SUPPORTS COORDINATOR MONTHLY MONITORING NOTE

The Case Management/ Supports Coordinator Monthly Monitoring Note is designed to monitor all services provided to the individual in a specialized setting. Billable Medicaid services must be monitored to ensure that the individual is receiving services identified in the IPOS. In addition, monitoring includes the linking and coordinating of services coordinated by the case manager/support coordinator. Coordination helps the individual gain access to medical, social, educational, and waivers for members with intellectual developmental disabilities. Locate form at https://www.dwihn.org/providers-residential-forms-docs

SEMI-INDEPENDENT LIVING (SIL) PROVIDERS AMI POPULATION

Provides CLS services and all services indicated in the IPOS.

Providers are responsible for monitoring and providing services to adults in independent settings. Members are assessed for CLS domains that will promote increased skills and independence. Providers are responsible for the lease agreements, collection of monthly rent and turning to the courts in the event of eviction. All direct services are captured on the Standardized Progress Note. Personal Care services are not provided in a semi-independent living setting.

SUPPORTED INDEPENDENT LIVING PROGRAM (SILP) PROVIDERS IDD POPULATION

Provides CLS services and all services indicated in the IPOS.

People can live in a home of their own in a variety of settings or in their home and receive needed supports and services in their own homes. Most often this involves either owning or renting a place to live in the individual's own name. Housing can vary from apartments to condos or single-family homes. Sometimes individuals share a home or apartment with other persons to share costs. These settings are commonly referred to as "S.I.P.'s," which stands for Supported Independence Program settings. People who are living independently can still receive the level of supports and services they need. CLS staffing agencies are reviewed and selected by the member as their service provider. Once the provider is selected, services are provided based on the IPOS/PCP.

PRE-PLACEMENT FACILITIES

The length of stay at these facilities is up to 14 days however, each member's situation is evaluated by the RCS to determine if additional days are required. These facilities also accept referrals after hours, holidays and weekends from other community agencies such as COPE (Community Outreach for Psychiatric Emergencies). All services must be coordinated and authorized by DWIHN.

- Akwaaba - Detroit
- Stallworth – Detroit
- Georgia's Care – Detroit
- Glenwood - Inkster
- Lewis Manor - Detroit
- Detroit Family Home – Southfield
- Kinloch- Infinity Care – Redford

INTERNAL TRANSFER PROCESS IN A SPECIALIZED RESIDENTIAL SETTING

This outlines the process of relocating a resident between specialized residential settings of licensed or unlicensed facilities.

MEMBER/GUARDIAN NOTIFICATION

1. Request for relocation will be submitted via Residential Internal Relocation Request form and will be forwarded to DWIHN Residential Unit via fax line (313) 989-9525 or email to the residentialreferral@dwihn.org
2. Request for relocation will be submitted via Residential Internal Relocation Request form and will be forwarded to the assigned CRSP Case Manager/Supports Coordinator.

3. The new location must be a contracted facility with DWIHN. Failure to adhere to this will result in a lack of payment as no authorization will be entered.
4. Member and Guardian will receive notification of the intent to relocate member to a Specialized Licensed/Unlicensed and contracted facility. Member/Guardian must document consent to the move in writing (must be signed and dated). The Residential Internal Relocation Request Form can be found on the DWIHN website under the Provider tab: https://www.dwihn.org/providers-residential-forms-docs.
5. The following must be completed on the form:
    a. Reason for relocation
    b. Name, address and phone number of the contracted facility
    c. Provider ID Number
    d. Member ID Number
    e. Date of Birth
    f. Guardian name and phone number
    g. Assigned Clinically Responsible Service Provider

CLINICALLY RESPONSIBLE SERVICE PROVIDER

1. Case Manager/Supports Coordinator will acknowledge receipt of the notification via email residentialreferral@dwihn.org to provider and DWIHN.
2. Case Manager/Supports Coordinator will obtain the new address and verify that the home is contracted with DWIHN. If not, contact DWIHN immediately prior to the move.
3. Case Manager/Supports Coordinator will update the clinical record and the IPOS as needed by Addendum.
4. Case Manager/Supports Coordinator will notify DWIHN via email residentialauthorizations@dwihn.org when the member is to be transferred to the new facility.

EMERGENCY TRANSFER PROCESS IN A LICENSED OR UNLICENSED SETTING

This process addresses emergent/ urgent situations in a specialized residential facility. Providers will follow this process in the event of extreme emergencies, urgent housing, or staff issues.

MEMBER/GUARDIAN NOTIFICATION

1. Member and Guardian will receive an immediate notification of the intent to relocate members to a temporary Specialized, Licensed, and Contracted facility due to a staffing shortage in the current facility. Written notification on company letterhead will be forwarded to DWIHN Residential Unit via fax line (313) 989-9525 or sends an email to the residentialservices@DWIHN.org.

2. The provider will provide written notification to the assigned CRSP Case Manager/ Supports Coordinator via fax or email.

SPECIALIZED RESIDENTIAL PROVIDER NOTIFICATION

1. A written request will indicate the reason for the emergency relocation. The request will include the following information:
2. Reason for emergency relocation
3. Number of staffing shortage and which shift (morning, afternoon, midnight)
4. Expected timeframe for return to original facility
5. Name, address and phone number of the contracted facility
6. Member ID Number
7. Date of Birth
8. Guardian name and phone number
9. Admission date to the emergency facility

CLINICALLY RESPONSIBLE SERVICE PROVIDER

1. Case Manager/ Supports Coordinator will acknowledge receipt of the notification via email to provider and DWIHN.
2. Case Manager / Supports Coordinator will contact the home to discuss additional needs of the consumer.

DWIHN RESIDENTIAL DEPARTMENT/UNIT DIRECTOR OR MANAGER

1. Residential Department Manager or Unit Director reviews the request and assigns the case to Residential Care Specialist or Care Coordinator to oversee relocation process

RESIDENTIAL CARE SPECIALIST / RESIDENTIAL CARE COORDINATOR (IF MEMBER REMAINS IN THE FACILITY FOR OVER 24 HOURS)

1. RCS or RCC will review emergency location in MH-WIN assuring it is a DWIHN facility.
2. Follows up with email notification with address to guardian and CRSP.
3. Contact the Specialized Residential Provider via email or phone to advise of case assignment.
4. Document case assignment and phone call to Residential Provider in MH-WIN chart notes.
5. Notify the Guardian and CRSP when member is placed in the emergency facility. An internal authorization request will be sent to the authorization specialist to generate a new authorization.

AUTHORIZATION PROCESS

1. The address of the facility will be verified prior to entering the authorization.
2. The current authorization is end dated in MH-WIN.
3. Admission date to the emergency facility is verified.
4. New authorization is entered for the new facility.
5. Updates consumer assignment in MH-WIN.

SPECIALIZED RESIDENTIAL PROVIDER RETURN NOTIFICATION

1. The provider will notify DWIHN Residential Unit when shifts have returned to full capacity.
2. The provider will provide a staffing roster to DWIHN Residential unit to verify staffing.
3. The provider will submit a return to facility notification on company letterhead to DWIHN Residential Unit via fax (313) 989-9525 or email residentialreferral@dwihn.org

RESIDENTIAL 30-DAY / EMERGENCY DISCHARGE GUIDELINES

30-DAY DISCHARGE FROM RESIDENTIAL PROVIDER TO THE MEMBER

In accordance with the State of Michigan's DHHS Licensing Rules for Adult Foster Care Large Group Homes Ordinance R400.14302(3), a residential provider shall provide a Member with a 30-day discharge notice in the event the residential provider has determined and documented the Member is not appropriate for the current placement setting; establishing the Member is in substantial risk due to:

1. The inability of the home staff to meet the Member's immediate needs, and/or appropriate care
2. The inability to assure the safety and well-being of the Member and/or other Members of the home.
3. The Member is considered to be a substantial risk, or has had an occurrence of self- destructive behavior; serious physical assault (to themselves, other Members, and/or home staff); the destruction of property.

DWIHN requires the residential provider to provide a 30-day notice as a written and/or typed statement stating the reasons for discharge; to be signed and dated on the provider's company letterhead; and immediately issued to the:

1. Member
2. Guardian (if applicable)
3. Designated CRSP; and
4. DWIHN Residential Services

30-DAY DISCHARGE FROM MEMBER/GUARDIAN TO RESIDENTIAL PROVIDER

A Member (or their guardian) can also issue a 30-day discharge notice following the same process of submitting a statement (in writing, signed, and dated) and reason to their residential provider, and their designated CRSP. The CRSP and guardian are to assure the notice is also issued to DWIHN Residential Services.

SIL EXCLUSION

1. Semi-independent living (SIL/SIP) discharges must adhere to lease agreement, also informing the CRSP Case manager/Supports Coordinator of the eviction. Prior to SIL eviction, CRSP must submit a complete referral packet to DWIHN Residential Services.
2. If needed, CRSP Case Manager/Supports Coordinator can also make a referral to one of the pre-placement facilities while Residential Services proceeds with brokering the Members' relocation into another DWIHN contracted facility.

EMERGENCY DISCHARGE POLICY

An emergency discharge can be issued by the residential provider upon approval and in conjunction with the designated in the form of a written statement indicating the Member is not appropriate for the current placement setting. The CRSP designee can then have the Member transferred to an (accepting) pre-placement facility until an alternate, more appropriate residential location can be confirmed, not to exceed the DWIHN pre-placement agreement guidelines up to 14 days.

HOUSING PRACTICE GUIDELINE

The MDHHS recognizes housing to be a basic need and affirms the right of all Members of public mental health services to pursue housing options of their choice. Just as Members living in licensed dependent settings may require many different types of services and supports, persons living in their own homes or sharing their household with another may have similar service needs. The Behavioral Health Home (or holder of the IPOS) shall foster the provision of services and supports independent of where the Member resides. The Behavioral Health Home (or holder of the IPOS) shall educate Members about housing options and supports available, and assist them in locating habitable, safe, and affordable housing. The process of locating
suitable housing shall be directed by the Member's interests, involvement, and informed choice, Independent housing arrangements in which the cost of housing is subsidized by the Behavioral Health Home (or holder of the IPOS) are to be secured with a lease or deed in the Member's name. This policy is not intended to subvert or prohibit occupancy in the participation with community-based treatment settings such as an adult foster care home when needed by an individual recipient.

EQUITABLE RESIDENTIAL PLACEMENT

DWIHN must ensure that residential placement is provided to eligible Members fairly and equitably. DWIHN cannot establish waiting lists that disadvantage or prevent eligible Members from timely residential placement. DWIHN must establish policies and procedures to guide residential placement decisions. DWIHN recognizes there are varying levels of care provided in the residential environment. In those instances where the needs of two or more individuals can similarly be met in a residence, the individual first requesting placement must have priority. The

Residential Department tracks the date of request for placement along with the requesting referral source information. All referral packets are housed in a database after assignment to a Residential Care Specialist or Residential Care Coordinator who in turn documents all efforts to secure suitable placement.

DISCHARGE PLANNING

Discharge planning begins at the time of admission and is an ongoing process throughout the course of treatment for all levels of hospital-based care. Appropriate discharge and aftercare planning are important to the successful management of behavioral health care services. The direct contracted providers are expected to actively plan for discharge of Members in inpatient settings. The specialized housing needs are paramount as the Member should be afforded safe housing and reduce recidivism. The hospital social worker is responsible for submitting a comprehensive packet to the DWIHN Residential Department for review. The Plan should include

1. Involvement of the Member and the family in plan development,
2. Brief summary of the diagnosis and course of treatment,
3. Identification and confirmation of available natural supports and community resources,
4. Recommendations for the next level of care as Member moves to a less restrictive environment,
5. Initial aftercare appointment, and
6. Description of course of treatment, restrictions, if any and planned final disposition. **Note**: A psychiatrist must see a Member within seven (7) days following an inpatient stay or partial hospitalization. According to Michigan's Mission-Based Performance Indicators, the percent of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days is 95%.

OUT-OF-COUNTY REQUESTS

The CRSP will forward a clinical packet to the DWIHN Residential Department via email or fax (313) 989-9525. The clinical packet will include the following:

1. Reason for placing the Member out of the county. Is it medically necessary?
2. Have other options been explored with the guardian/Member/family?
3. List other options
4. Is this the first placement for this Member?
5. Is the requested provider contracted with DWIHN?
6. If this is an out of network provider, do you have program materials related to programming and rates?

Understand that DWIHN is the payer of services. DWIHN reserves the right to review, approve, or not approve all out of county requests for placement. The request will be reviewed with all relevant departments within DWIHN to determine if the request will be approved. The determination will be provided to the CRSP in writing within one week of the request.

SECTION 13: OFFICE OF RECIPIENT RIGHTS

MISSION STATEMENT OF THE OFFICE OF RECIPIENT RIGHTS

To ensure that recipients of mental health services through the DWIHN system of care receive individualized treatment services suited to their condition as identified in their IPOS, that is developed in the PCP process, and receives services in a safe, sanitary, and humane environment where they are treated with dignity and respect, free from abuse and neglect.

OVERVIEW OF THE OFFICE OF RECIPIENT RIGHTS

The Office of Recipient Rights (ORR) is the unit within DWIHN that is responsible for providing or coordinating the protection of Recipient Rights throughout the DWIHN service provider network. To safeguard and protect the rights guaranteed to recipients receiving services through DWIHN and its contracted service provider network, DWIHN ORR takes actions that are appropriate and necessary as mandated by Federal statutes, the Michigan Mental Health Code (MHC), the Michigan Administrative Rules, the MDHHS contract, and DWIHN policies. The ORR accepts complaints via mail, telephone (hotline), fax. 313 833-2043 and 1-888-399-5595. In case a provider's office is not equipped with a fax machine, please email us at orrcomplaints@dwihn.org. However, **all** Incident Reports must be faxed over.

OFFICE OF RECIPIENT RIGHTS RESPONSIBILITIES

DWIHN ORR has four primary responsibilities in the protection of recipient rights:

1. PREVENTION of recipient rights violations;
2. EDUCATION of recipient rights;
3. MONITORING for recipient rights compliance;
4. COMPLAINT RESOLUTION by investigating recipient rights complaints and recommending appropriate remedial action.

CONTRACTOR AND SUBCONTRACTOR RESPONSIBILITIES

DWIHN ORR expects all Contractors and Sub-Contracted Service Providers to protect the rights of all recipients of service and ensure that there is unimpeded access to DWIHN ORR and the recipient rights system.

Contractors and Sub-Contractors will ensure the rights of recipients are protected by:

1. Ensuring that "You Have Rights" Posters, complete with the telephone number, fax number, and address of the DWIHN ORR, are conspicuously posted throughout all service locations.
2. Ensuring there is ample supply of "YOUR RIGHTS" booklets (also known as the Blue Book) available and easily accessible.

3. Ensuring there is ample supply of Recipient Rights complaint forms available and easily accessible.
4. Ensuring the "Reporting Requirements for Abuse and Neglect" poster is conspicuously
5. posted at all service locations.
6. Ensuring that recipients, parents of minor recipients, and guardians or other legal representatives are notified of the rights guaranteed by chapter 7 and 7a of the Michigan Mental Health Code, in an understandable manner, both at the time services are initiated and annually thereafter, during the time services are provided to the recipient.
7. Ensuring all Contractor and Sub-Contractor Staff, within 30 days of being newly hired, receive New Hire Recipient Rights training (NHRRT) from DWIHN ORR or that the newly hired staff has verification that they have recently received NHRRT from another MDHHS- ORR certified trainer who uses an MDHHS ORR compliant curriculum.
8. Ensuring, following completion of NHRRT, all Contractor and Sub-Contractor Staff continue to receive Recipient Rights Training, annually thereafter.
9. Ensuring inclusion of DWIHN ORR staff in all Behavior Treatment Committees, as ex-officio members.
10. Ensuring that all incident reports involving recipients of services are faxed or mailed to DWIHN ORR within 24 hours of occurrence, in accordance with the DWIHN Incident Reporting Policy and Procedures.
11. Ensuring that all deaths of recipients of services are reported to DWIHN ORR within 24 hours of when the Contractor or Sub-contractor becomes aware of the death, in accordance with DWIHN Death Reporting Policy and Procedures.
12. Ensuring DWIHN ORR has unimpeded access to all programs and services operated by the Contractor and Sub-Contracted Provider; all staff, volunteers, and agents of the Contractor and Sub-Contracted Provider; and all evidence necessary to conduct a thorough investigation or to fulfill its monitoring function.
13. Ensure current and approved ORR contract language is included in all Sub-contracts for services.
14. Ensure Contractor staff are available to respond to recipients and others who have questions regarding Recipient Rights and referring them (or making the contact on their behalf) to DWIHN ORR. This includes conducting the necessary follow-through to ensure access to the rights protection system.
15. Ensuring a timely response and appropriate remedial actions if it has been determined through investigation that a right has been violated. Ensuring that the remedial actions taken meet all of the following criteria:
16. Corrects or provides a remedy for the rights violations;
17. Is implemented in a timely manner;
18. Attempts to prevent a recurrence of the rights violation;

19. Ensuring Complainants, recipients, staff of the office of recipient rights, and any staff acting on behalf of a recipient will be protected from harassment or retaliation resulting from recipient rights activities and that appropriate disciplinary action will be taken if there is evidence of harassment or retaliation.
20. Ensuring required disciplinary action is taken for substantiated Abuse, Neglect and Retaliation/Harassment complaints, that meets or includes the following action types:
21. Written Counseling
    - Written Reprimand
    - Demotion
    - Suspension
    - Reassignment
    - Termination
22. Ensuring timely and appropriate responses to all corrective actions recommended or required by DWIHN ORR as a result of announced or unannounced site visits. (Service provider shall abide by all determinations made by DWIHN ORR and shall promptly implement any remedial action or corrective action required by DWIHN ORR.)

RECIPIENT RIGHTS POLICIES AND PROCEDURES

DWIHN Contractors and Sub-contracted service providers shall adopt, adhere to and implement all, DWIHN ORR rules, policies and procedures, as included in DWIHN's Provider Manual and its Service Providers Agreement (Contract) with DWIHN.

Please refer to the most recent version of DWIHN policies, procedures, and documents, by visiting our website at https://www.dwihn.org/for-providers.

DWIHN ORR Specific Policies:

1. Abuse and Neglect
2. Change in Type of Treatment
3. Communication and Visits
4. Comprehensive Examinations
5. Consent to Treatment And Services
6. Disclosure of Confidential or Privileged Information
7. Family Planning
8. Fingerprinting, Photographing, Audio Taping and Use of One-Way Glass
9. Freedom of Movement
10. Incident Reporting Policy
11. Personal Property and Search
12. Qualifications and Training For ORR Staff
13. Recipient Rights Appeals

14. Recipient Rights Complaint Resolution
15. Resident Funds
16. Resident Labor
17. Restraint
18. Right to Entertainment Materials
19. Seclusion
20. Services Suited to Condition In The Least Restrictive Setting
21. Treatment by Spiritual Means
22. Treatment with Dignity And Respect
23. Use of Psychotropic Drugs

Section 14: SUBSTANCE USE DISORDER

DEPARTMENT OVERVIEW:

DWIHN has direct contracts with 56 substance use disorder (SUD) providers to ensure an adequate and sufficient network of providers through various services. Our continuum of care consists of prevention, treatment, and recovery services. Our prevention programs address the reduction in childhood and underage drinking, reducing prescription and over- the-counter drug abuse/misuse, reducing youth access to tobacco, and reducing illicit drug use. Our traditional treatment consists of Outpatient, Intensive Outpatient, Withdrawal Management, and Residential, as well as innovative modes of treatment such as Early Intervention, Medication-Assisted Treatment, Women's Specialty Services, Relapse Recovery, Peer Recovery Coaches, Case Management, Screening Brief Intervention Referral to Treatment (SBIRT), Acupuncture, Opioid Health Homes, Faith-Based Services, Returning Citizens, Obesity and Health Programs, Drug Courts, Recovery Homes, Recovery Activities, and Intensive Wraparound services.

Substance Use Disorder
Substance Use Disorder services for Wayne County residents are accessed through Detroit Wayne Integrated Health Network.

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

- Screening, Diagnosis, Placement, and Referral
- Outpatient Services:
  - Individual Therapy
  - Family Therapy
  - Group Therapy
- Intensive Outpatient Services:
  - With Domicile

- Withdrawal Management
- Residential Services
- Methadone, Suboxone or Vivitrol Treatment is defined as chemotherapy using drugs or other such prescribed medication as an adjunct to any type of therapy provided to opiate dependent clients. Such services can be performed only under the care of a licensed physician in programs approved by the Food and Drug Administration (FDA) and the Drug Enforcement Administration (DEA).

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

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

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

- Call the region's Toll-Free Access Center Line-Adults and adolescents – 1-800-241-4949.

Providers are expected to adhere to all standards, requirements and legal obligations contained in the referenced guidance below.
Key references for SUD services include:

- DWIHN SUD Prevention contract
- DWIHN Treatment contract
- DWIHN SUD Policy Manual
- LARA Licensing Regulations
- MDHHS Provider Qualification Chart/ MCBAP Requirements
- Medicaid Provider Manual
- MDHHS Provider Qualification Chart
- Medicaid Services Administration (MSA) Bulletins

Managing Co-Occurring Substance Use Disorders (SUDs)

The Direct Contract Providers (DCP) are responsible for providing and ensuring that needed substance abuse treatment services are available to Consumers. Direct Contract Providers must have staff who are capable of treating individuals with SED, SMI, and I/DD who also have co- occurring substance use disorders (SUDs). The DCPs must also have the capability to treat

consumers with co-occurring SUDs. Traditionally, these individuals are not best served in programs whose sole focus is the treatment of substance use disorders. It is expected that the DCP develop integrated programs where mental health and substance abuse treatment occur in the same treatment setting.

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

SECTION 15: UTILIZATION MANAGEMENT

DEPARTMENT OVERVIEW

Utilization Management (UM) functions are driven by DWIHNs commitment to the provision of effective, consistent, and quality behavioral health care services that are efficient and effective. The UM program description reflects the expectations and standards of MDHHS and the Centers for Medicare and Medicaid Services (CMS).

PERSON CENTERED PLANNING PROCESS AND APPROVAL

DWIHN Direct Contracted Providers shall ensure implementation of the Person/Family- Centered Planning process for all individuals. Each CRSP shall ensure implementation of DWIHN's standardized PCP documents: pre-planning, psychosocial assessment for adults and children, and the IPOS/person/youth/family centered plan. SUD providers shall adhere to all MDHHS requirements regarding development of a Master Treatment Plan.

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

The DWIHN contractors must ensure that all Covered Services provided by the contractor or its subcontractors are in keeping with the Michigan Mental Health Code, DWIHN Policies and Benefit Plan, MDHHS, current, clinical guidelines, and the service utilization guidelines.
DWIHN must provide PCP training to its subcontractors/providers, staff, families/guardians, and other stakeholders. For additional information, reference DWIHN Policy and Procedure Manual.

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

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

UM STAFF AND PROGRAM STRUCTURE

DWIHN requires all staff performing pre-admission reviews and/or UM functions including initial/continuous reviews, appeals, and denials to be credentialed and re-credentialed. The UM staff are expected to be highly skilled, experienced professionals and participate in regularly scheduled case consultations with the DWIHN Chief Medical Officer. DWIHN is committed to increasing competency and the quality of services through continuous staff development activities. Individuals who do not maintain appropriate licensing, training and scope of practice shall be immediately removed from the role of a preadmission review screener and/or utilization management decision makers.

PRIOR AUTHORIZATION REVIEW /PREADMISSION REVIEW (PAR) SCREENING:

DWIHN uses a prior authorization review screening process which is a systematic assessment of clinical information about an individual referred or recommended for services and should be based on meeting the needs of the eligible person. The purpose of a PAR is to determine eligibility, benefit coverage and/or establish the presence or absence of medical necessity so that a decision can be made regarding the request for services. Prior authorization review is designed to promote the appropriate utilization of medically necessary services, to prevent unanticipated denials of coverage and to ensure that all services are provided at the appropriate level of care for the member's needs in a timely manner.

Prior Authorization is required for all inpatient treatment, partial hospitalization, crisis residential services, SUD services and state hospitalizations. A PAR screening is conducted by the DWIHN Crisis Service Vendor(s) or delegated providers. The source of information for the prior authorization comes from the screening centers, requesting facility(hospitals) or outpatient provider. It is expected that the requestor is familiar with each case as a result of a face-to-face meeting with the member, telephonic screening, or as a result of an informed review of the clinical/medical record.

The DWIHN Crisis Service Vendor(s) operate twenty-four (24) hours a day, seven (7) days a week. Providers can contact the Crisis Service Vendor at 1-844-296-2673 or TYY 248-424- 4800 from 8am-5pm Monday- Friday and 248-995-5055 after business hours for the hearing impaired. Providers can contact the Children's Crisis Service Vendor via the Access Center at 1-800-241-4949.

CONTINUED STAY REVIEW:

For the seriously mentally ill (SMI), Intellectually Developmentally Disabled (IDD), seriously emotionally disturbed (SED) and individuals with SUD populations, including the MI Health Link population, DWIHN is responsible for authorization and continued stay reviews for all levels of care including acute inpatient treatment, partial hospitalization, crisis residential services, SUD services, outpatient services and state hospitalizations. Care reviews are completed at an interval dictated by clinical severity of the case, service utilization guidelines and conducted prior to the end of the authorized period.

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

EMERGENCY CARE RESULTING IN ADMISSIONS:

DWIHN ensures that coverage is provided to members if they require emergency or urgently needed services. Prior authorization is not required for emergency room services or any emergent services needed to stabilize the emergent or urgent condition. After members receive emergency behavioral health care and their condition is under control, they should promptly receive follow-up care with a behavioral health provider to make sure the condition continues to stabilize and improve. Post-stabilization care is inclusive of inpatient services following emergency services. Consistent with 42 CFR,438.114 emergent and/or urgent care should be rendered as needed with notification of any admission to the DWIHN Crisis Service Vendor within forty- eight (48) hours of the admission, or as soon as possible. The Crisis Service Vendor will review emergent and/or urgent admissions within one (1) calendar day of request for services.

DWIHN may not limit what constitutes an emergency medical condition with reference to 42 CFR, 438.114 on the basis of lists of diagnosis or symptoms; and may not refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member's primary care provider, PIHP, or MDHHS of the member's screening and treatment within 10 calendar days of presenting for emergency services. The PIHP must cover and pay for emergency services regardless of whether the provider that furnished the service has a contract with the PIHP. In the event the provider is out-of- network, the procedure for completing a single case agreement should be completed.

Medical Necessity

DWIHN has adopted nationally developed and published Behavior Health guidelines from MCG Health, which is part of the Hearst Health Network. The MCG Behavioral Health Medical Necessity Guidelines describe best practice care for mental health and substance related disorder diagnoses, covering major diagnostic groups with graded evidence from published resources. The diagnosis-based guidelines plus level of care guideline's content, covers adult, child and adolescent populations, members with unknown diagnosis and members with SUD. These criteria then serve as a decision support tool to help define the most appropriate treatment setting and help assure consistency of care for each individual. The MCG Behavioral Health Medical Necessity Guidelines are available to contracted providers/practitioners within MH-WIN and are located within the Pre-admission Review Form. Due to the proprietary nature of the guidelines, access to an encyclopedic/static online version are also made available by calling the DWIHN UM Department for protected log in information. Members and providers can also request a copy of the medical necessity criteria in relation to a specific requested service or procedure, free of charge, by contacting DWIHN's UM Department.

DWIHN is utilizing the most current edition of the MCG Behavioral Health Guidelines. DWIHN and their UM delegated entities complete the Indicia software within MH-WIN to screen for the behavioral health services of inpatient, crisis residential, and partial hospitalization. The MCG criteria and the Medicaid Provider Manual further define medical necessity for outpatient services. Industry accepted assessment tools such as the LOCUS, SIS, CAFAS, PECFAS, and DECA coupled with Service Utilization Guidelines further support the UM function and PCP philosophy. For the MI Health Link member, the National Coverage Determination (NCD) criteria developed by the Centers for Medicare & Medicaid Services (CMS) is utilized. If no NCD guidance has been issued, or an NCD requires further

clarification, a Local Coverage Determination (LCD) will be utilized. LCD's are developed by the Medicare Administrative Contractor for the geographic service area; (Michigan is in jurisdiction 8) and either supplement or explain when an item or service will be covered if there is no NCD. In addition, the CMS Coverage Manual, or other CMS-based resources such as the Medicare Program Integrity and Medicare Benefit manuals are used to determine coverage provisions for this population. In coverage situations where there is no NCD or LCD guidance on coverage in original Medicare manuals, DWIHN may make its own coverage determination utilizing the MCG criteria or send out to an Independent Review entity. The NCD and LCD criteria are available to contracted providers/practitioners through a URL link, by mail, email, or fax. Members and non-contracted providers can obtain a copy of specific criteria related to their case by contacting the DWIHN UM Department by phone or in- person.

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

American Society of Addiction Medicine 4601 North Park Ave Upper Arcade Suite 101 Chevy Chase, MD 20815

Telephone: 301-656-3920 Fax: 301-656-3815

Email: email@asam.org

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

INTER-RATER RELIABILITY:

Review of consistency of Behavioral Health UM decision making and Inter-Rater reliability testing is administered for all new hires and annually for UM reviewers and psychiatrists involved in UM decision making. DWIHN utilizes the MCG web-based Learning Management System and Inter-Rater Reliability module which tests the selection and proper use of MCG guidelines with clinician-developed case studies. The case studies and testing evaluate an individual's ability to find and apply the appropriate guideline based on a specific clinical scenario. DWIHN has a benchmark standard of scoring 90% or greater. Any staff making UM decisions or physician reviewer(s) with an Inter-Rater reliability score less than 90% will be required to retest within 30 days of the initial administration. If upon re-testing, the staff person does not achieve 90% or greater, they will be placed on a corrective action plan (CAP) which can involve such activities as face to face supervision, coaching and/or education, training, or re-training. During the time period of the CAP, random samples of the staff member's current cases may be subject to supervisory audit. Annual education and training on updates to the criteria is provided for all staff performing UM activities.

MCG also has web-based on-demand training modules that are available 24/7. The results of the Inter-Rater reliability case reviews are also used to identify areas of variation among decision makers and/or types of decisions. The results help to identify opportunities for improvement as well as further training needs. MCG and the Learning Management Software can be queried to provide reports that indicate modules or trainings completed by each UM reviewer/front end user.

DENIAL OF AUTHORIZATION FOR CARE:

DWIHN only allows physicians (MD or DO) to render behavioral health care and pharmaceutical medical necessity denials. DWIHN ensures that practitioners have the opportunity to discuss any UM denial decision with a physician reviewer. The physician reviewer must discuss the clinical merits of the request with the physician/provider prior to issuing a denial.

All pertinent clinical information must be obtained and reviewed as part of this process. When a denial is issued, the Provider is notified verbally and in writing, and the member is notified in writing. The notification must inform the Provider and member of clear information regarding the reasons for the denial and the availability of the UM appeal and dispute resolution processes. At the time that the provider/practitioner is notified of the denial, the opportunity to discuss the medical necessity denial is also discussed. Services may not be denied solely based on preset limits of the cost, amount, scope and/or duration.

Instead, determination of the need for services shall be conducted on an individualized basis. Physicians nor any other UM staff are not rewarded for issuing denials of coverage or service or reducing the provision of care which is deemed medically necessary.

AFFIRMATIVE STATEMENT:

All DWIHN, Crisis Service Vendors, and practitioners and employees who make UM decisions understand the importance of ensuring that all Members receive clinically appropriate, humane, and compassionate services of the same quality that one would expect for their child, parent, or spouse by affirming the following:

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

UM/PROVIDER APPEALS AND ALTERNATIVE DISPUTE RESOLUTION:

DWIHN has established appeals and dispute resolution policies and processes that afford fair, efficient, consistent and timely review of a UM decision for providers. An appeal or dispute can be initiated by telephone or in writing and must be done within prescribed time frames depending on the funding stream of the service(s).

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

1. **Administrative** - an appeal or dispute review involving a benefit determination decision that was not based on medical necessity. Administrative appeals involve failure to meet contractual requirements, UM issues such as denials resulting from not obtaining a prior authorization and/or continued authorization for some or all types and dates of services within a timely manner.
2. **Medical Necessity** - an appeal or dispute review involving a decision that a service does not meet MDHHS MCG,CD, LCD, or other medical necessity criteria. The medical necessity appeal is reviewed by a DWIHN or an independent review organization physician with the same or similar credentials as would usually treat the condition which is being appealed.
   The physician reviewing the appeal is not involved in the initial denial.

The following describe time-frames for appeals:

1. **Expedited/Urgent** - a request to review a decision concerning eligibility, screening, admission, continued/concurrent stay, or other behavioral healthcare services for an enrollee/member who has received urgent services but has not been discharged from a facility, or when a delay in decision-making might seriously jeopardize a member's life, health, or ability to attain, maintain, or regain maximum function.
2. **Standard** - is a request to review a decision concerning eligibility, screening, admission, continued/concurrent stay, or other behavioral healthcare services for a member who has received services or is currently receiving services but a delay in decision-making does not jeopardize a member's life, health, or ability to attain, maintain, or regain maximum function.

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

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

1. Monitoring trends and patterns of key UM indicators for under and over utilization and appropriateness of care;
2. Member and Provider satisfaction with the UM process;
3. Compliance with UM decision-making timeframes;
4. Compliance with certification, non-certification, and appeal resolution timeframes;
5. Consistency of UM decisions and application of medical necessity criteria by UM decision- makers;

6. Evaluation of UM process complaints and assessment of complaint trends;
7. Quality improvement activities;
8. Denial and Appeal category analysis;
9. Selection and application of Medical Necessity Criteria used for UM decisions;
10. New Technology Recommendations

SELF-DETERMINATION AND SELF-DIRECTING SERVICES

Self-Determination (SD) is the right of all people to have the power to make decisions for themselves; to have free will. On an individual basis, the goals of SD are to promote full inclusion in community life, to feel important and increase belonging while reducing the isolation and segregation of people who receive services. The principles of SD are autonomy, competence and relatedness which are the building blocks of psychological wellbeing. Self- Direction is an alternative method of service delivery which moves away from professionally managed models of supports and services. It is the act of selecting, directing, and managing one's services and supports. With support as needed, members who self-direct their services can decide how to use their authorized CMH funds. Self-Directed arrangements allow a member the flexibility over their authorized funds which are detailed in an individual budget. Flexibility allows the member to determine how to best use funds to meet the needs and outcomes identified in their IPOS.

SD and the option to Self-direct services must be explained to each member during their Pre- Plan. If a member decides they would like to Self-Direct their services, the Support Coordinator or Case Manager will assist them by coordinating the set-up with the DWIHN SD Team. DWIHN has the infrastructure to set up a Self-Directed arrangement for any member who receive services. DWIHN offers training on SD and Self-Directed arrangements to its members, providers, staff, families/guardians, and other stakeholders. Details of the roles and responsibilities for a Self-Directed arrangement are in a written agreement and paid for through a Financial Management Service. Members may choose who they want to provide the service to meet the needs identified in their IPOS and although the provider does not have to be contracted with DWIHN, all providers must meet Medicaid guidelines and adhere to DWIHN monitoring/credentialing criteria.

INDEPENDENT FACILITATION

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

An independent facilitator helps an individual create a vision for their future. It's a process rooted in relationship and can facilitate many objectives: exploring passions and interests, finding paid or volunteer work, developing new roles in community, nurturing new

friendships, and exploring options for home are just some of the aims that an individual may focus on through Independent Facilitation.

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

Direct Contracted Providers must ensure that individuals providing the independent facilitation services meet the following criteria:

Free of any conflict of interest (i.e., not employed at the organization he/she is providing the service)
11. Have had criminal background checks that demonstrate no history of criminal activity, 12. Have received training in the Independent facilitation process,
13. Are knowledgeable of the PCP process,
14. Are skilled facilitators

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

All DWIHN contractors must ensure that Members and family members are given the opportunity to evaluate independent facilitation services through Member satisfaction surveys immediately following the PCP meeting. Quality Improvement measures should be initiated, as necessary, based upon the results of the feedback from the survey process.

Families and family-run organizations engage in peer support activities to reduce isolation, gather, and disseminate accurate information, and strengthen the family voice.
Families and family-run organizations provide direction for decisions that impact funding for services,treatments, and supports and advocate for families and youth to have choices.
Providers take the initiative to change policy and practice from provider-driven to family-driven and youth-guided.
Administrators allocate staff, training, support, and resources to make family driven and youth-guided practice work at the point where services and supports are delivered to children, youth, and families. Community attitude change efforts focus on removing barriers and discrimination created by stigma. Communities and public and private agencies embrace, value, and celebrate the diverse cultures of their children, youth, and families and work to eliminate mental health disparities.

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

CONTACT INFORMATION FOR SELF DETERMINATION

For any questions pertaining to Self-Directing services, please email the SD Team at the following: Selfdetermination@dwihn.org

SECTION 16: WORKFORCE TRAINING AND PROGRAM DEVELOPMENT

DEPARTMENT OVERVIEW:

The ***mission*** of the Workforce Training and Program Development Department is to lead the organization in innovation by providing effective and efficient workforce development needs to the provider network. We strive to provide continuous support to the community through educational outreach and engagement while placing an emphasis on recovery and supporting resilience. This also includes a Veteran Navigator which helps Wayne County Vets and families in the Wayne County area.

Responsibilities for this team also include providing ongoing consultation to other departments and external organizations assisting in the development and implementation of emerging and promising practices. Our team is designed to help organizations shape program ideas, find grant resources, and provide support letters for grant proposals.

This team maintains the Detroit Wayne Connect (DWC) website, a continuing education platform for stakeholders of the behavioral health workforce. They strive to provide a variety of live and online courses for those serving adults with SMI, IDD, children with serious emotional disturbances and people with SUD. The Workforce Training and Program Development team coordinates conferences, workshops, and seminars throughout the system of care.

EMPLOYMENT OF MEMBERS RECEIVING SERVICES

DWIHN must:

1. Involve Members in the design, delivery, monitoring, and evaluation of covered services.
2. Use their best effort to ensure that at least 10% of the aggregate of its contracted Provider Network are:
3. Members who are in paid positions of at least ten (10) hours per week.
4. Increase their commitment and that of their contracted Provider Network to employ Members including making provisions for recruitment, placement, and development of pay scales, benefits, and training.

5. Establish programs specifically dedicated to Persons' interests, staffed by Members and/or family members.
6. Demonstrate improvements in performance in employment of Members.
7. Solicit and ensure Persons' input and involvement in the Provider Network, its community, and populations, needs assessment, and service planning activities.

ADULT JAIL DIVERSION

Best practices conclude that the needs of people with serious mental illness, serious emotional disturbance or developmental disability, the community, and the criminal justice system, are better served when those with SMI who commit crimes, are safely diverted into effectual community based mental health treatment, rather than enter into the criminal justice system. It is recognized that many people with serious mental illness have a co- occurring substance disorder, and upon entering the criminal justice system, have identifiable complex needs

The Sequential Intercept Model (SIM) should be used as a strategic planning tool to develop a complete guide of what services and programs are being engaged at each of the six intercept points, and conversely, what services are lacking at each intercept point: (0) Community Services, (1) Law Enforcement, (2) Initial Detention and Initial Court Hearings, (3) Jails and Courts, (4) Reentry, and (5) Community Corrections.

This practice guideline reflects a commitment to this principle and conveys MDHHS jail diversion policy and resources for Community Mental Health Services Programs (CMHSPs). The guideline is provided as required under DWIHN of the Michigan Mental Health Code, PA 258 of 1974, Sec. 330.1207-Diversion from jail incarceration (Add. 1995, Act 290, Effective March 28, 1996).

Section 207 of the Code states:

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

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

Jail diversion programs are intended for individuals charged with a misdemeanor crime, or non-violent felony, who voluntarily agree to participate in the diversion program.

REQUIRED TRAINING

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

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

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

Customer Service
888-490-9698 / 313-833-3232
Recipient Rights
888-339-5595
Services for Deaf Individuals
TTY/TDD: 800-630-1044
24-Hour Crisis Helpline
800-241-4949

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