MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
Behavioral Health and Developmental Disabilities Administration

CUSTOMER SERVICES STANDARDS

Preamble

It is the function of the Customer Services to be the front door of the Prepaid Inpatient Health Plan (PIHP) and convey an atmosphere that is welcoming, helpful, and informative. These standards apply to the PIHP and any entity to which the PIHP has delegated the Customer Services function, including affiliate Community Mental Health Service Providers (CMHSPs), or provider network.

Functions

a. Welcome and orient individuals to services and benefits available as well as the provider network.

b. Provide information about how to access behavioral health, primary health, and other community services.

c. Provide information about how to access the various rights processes.

d. Help individuals with problems and inquiries regarding benefits.

e. Assist people with and oversee local complaint and grievance processes.

f. Track and report patterns of problem areas for the organization.

Standards

1. There shall be a designated unit called “Customer Services.”

2. There shall be at the PIHP a minimum of one Full Time Equivalent (FTE) performing the Customer Services functions whether within Customer Services or elsewhere within the PIHP. If the function is delegated, affiliate CMHSPs and network providers, as applicable, shall have additional FTEs (or fractions thereof) as appropriate to sufficiently meet the needs of the people in Customer Services.

3. There shall be a designated toll-free Customer Services telephone line with access to alternative telephonic communication methods (such as Relays, TTY, etc.). The Customer Services telephone numbers shall be displayed in agency brochures and public informational material.

4. Telephone calls to Customer Services shall be answered by a live voice during business hours. Telephone menus are not acceptable. A variety of alternatives may be employed to triage high volumes of calls if there is response to each call within one business day.

5. The hours of Customer Services operations and the process for accessing information from Customer Services outside those hours shall be publicized. **It is expected that Customer Services will operate minimally eight hours daily, Monday through Friday, except for holidays.**

6. The Customer Services Handbook shall contain the State-required topics, and the PIHP will use the State-developed notice forms. (See Customer Services Handbook)

7. The Medicaid coverage name and the State's description of each service shall be printed in the Customer Services Handbook.

8. The Customer Services Handbook shall contain a date of publication and date of revision(s).

9. The PIHP or delegate entity must provide each customer a Customer Services Handbook within a reasonable time after receiving notice of the beneficiary's enrollment. This may be provided by:

    a. mailing a printed copy to the customer's mailing address,

    b. emailing a copy after obtaining the customer's agreement to receive information by email,

    c. posting the information on the website and advising the customer in paper or electronic form that the information is available on the website, provided that individuals with disabilities who cannot access the information online are provided auxiliary aids and services, upon request, at no cost, or

    d. the information is provided by any other method that can reasonably be expected to result in the customer receiving the information.

10. Information about how to contact the Medicaid Health Plans or Medicaid fee-for-service programs in the PIHP service area, including plan or program name, locations, and telephone numbers, shall be provided in the Customer Services Handbook.

11. The PIHP or delegate unit shall maintain a current listing of all providers, practitioners, organizations, and any group affiliation with whom the PIHP has contracts, street address(es), telephone number(s), website URL (if appropriate), the services they provide, cultural and linguistic capabilities (if they have completed cultural competency training), any non-English languages they speak (including American Sign Language), any specialty for which they are known, whether the provider's office/facility has accommodations for people with physical disabilities, and whether they are accepting new patients. This list must include independent person-centered planning (PCP) facilitators. The PIHP must make this available in paper form, upon request, and electronic form, such as the PIHP, CMHSP, or network provider's website, as applicable. Beneficiaries shall be given this list annually unless the beneficiary has expressly informed the PIHP that accessing the listing through an available website or customer services line is acceptable.

12. The provider directory must be made available in paper form, upon request, as well as electronic form. The provider directory must also be made available in a prominent, readily accessible location on the PIHPs website in a machine-readable file and format.

13. The paper provider directory must be updated at least monthly, and electronic provider directories must be updated no later than 30 calendar days after the PIHP receives updated provider information.

14. If the PIHP provides any required information electronically:

    a. It must be in a form that is readily accessible,

    b. It must be on the PIHPs Web site in a location that is prominent and readily accessible,

    c. It must be in electronic form which can be electronically retained and printed,

    d. The PIHP must inform the customer that the information is available in paper form, without charge, and provide it, upon request, within five (5) business days.

15. Customer Services shall have access to information about the PIHP including each CMHSPs annual report, current organizational chart, board member list, meeting schedule, and minutes. Customer Services will provide this information in a timely manner to individuals upon request.

16. Customer Services shall assist beneficiaries with filing grievances and appeals, accessing local dispute resolution processes, and coordinate, as appropriate, with Fair Hearing Officers and the local Office of Recipient Rights, upon request.

17. Customer Services staff shall be trained to welcome people to the public behavioral health system and to possess current working knowledge, or know where in the organization detailed information can be obtained, in at least the following:

    a. *The populations served (serious mental illness, serious emotional disturbance (SED), substance use disorder (SUD), and developmental disability) and eligibility criteria for various benefit plans (e.g., Medicaid, Healthy Michigan Plan, MIChild)

    b. *Service array (including substance abuse treatment services), medical necessity requirements, and eligibility for and referral to specialty services

    c. PCP

    d. Self-determination

    e. Recovery and Resiliency

    f. Peer Specialists

g. *Appeals and grievances, Fair Hearings, local dispute resolution processes, and Recipient Rights

h. Limited English Proficiency and cultural competency

i. *Information and referral about Medicaid-covered services within the PIHP as well as outside to Medicaid Health Plans, Fee-for-Services practitioners, and DHHS

j. The organization of the Public Behavioral Health System

k. The Balanced Budget Act (BBA) relative to Customer Services functions and beneficiary rights and protections

l. Community resources (e.g., advocacy organizations, housing options, schools, public health agencies)

m. Public Health Code (for substance abuse treatment recipients if not delegated to the PIHP)

*Must have a working knowledge of these areas, as required by the BBA.

PIHP CUSTOMER SERVICES HANDBOOK
REQUIRED STANDARD TOPICS

Each Prepaid Inpatient Health Plan (PIHP) must have a Customer Services Handbook that is provided to Medicaid beneficiaries when they first come to service. Thereafter, PIHPs shall offer the most current version of the Handbook annually at the time of person-centered planning (PCP), or sooner if substantial changes have been made to the Handbook. The list below contains the topics that shall be in each PIHPs Customer Services Handbook. The PIHP may determine the order of the topics as they appear in the Handbook and may add more topics. In order that beneficiaries receive the same information no matter where they go in Michigan, the topics with asterisks (*) below must use the standard language templates contained in this requirement. PIHPs should tailor the contact information in the brackets to reflect their local operations and may add local or additional information to the templates. Information in the Customer Services Handbook should be easily understood, and accommodations available for helping beneficiaries understand the information. The information must be available in the prevalent non-English language(s) spoken in the PIHPs service area.

The PIHP shall have written policies guaranteeing each enrollee's right to request and receive a copy of his/her medical records, and to request that they be amended or corrected.

The PIHP is required to utilize the model enrollee Customer Services Handbook and notices that describe the transition of care policies for enrollees and potential enrollees. The PIHP will implement a transition of care policy that is consistent with federal requirements and at least meets the state defined transition of care policy.

Per direction from the federal Centers for Medicare and Medicaid Services (CMS), the Michigan Department of Health and Human Services (MDHHS) must approve all Customer Services Handbooks to assure compliance with the Balanced Budget Act (BBA). After initial approval, it is necessary to seek MDHHS approval only when a PIHP makes significant changes (i.e., beyond new address or new providers) to the Customer Services Handbook.

PIHPs are required to produce supplemental materials (inserts, stickers) to their handbooks if/when MDHHS contractual requirements are updated so that a previously approved Customer Services Handbook continues to meet requirements. Supplemental materials must be provided to enrollees with their copy of the Customer Services Handbook.

*Must use boilerplate language in templates (attached)

<u>Topics Requiring Template Language (not necessarily in this order):</u>
*Confidentiality and family access to information
*Coordination of care
*Emergency and after-hours access to services
*Glossary
*Grievance and appeal
*Language accessibility/accommodation
*Payment for services
*Person-centered planning
*Recipient rights

*Recovery
*Service array, eligibility, medical necessity, and choice of providers in network
*Service authorization
*Non-Discrimination Tag Lines

Other Required Topics (not necessarily in this order):
Access process
Access to out-of-network services
Affiliate (for Detroit Wayne, the MCPNs) names, addresses, and phone numbers of the following personnel:

- Executive director
- Medical director
- Recipient rights officer
- Customer services
- Emergency

Community resource list (and advocacy organizations) Index
Right to information about PIHP operations (e.g., organizational chart, annual report) Services not covered under contract
Welcome to PIHP
What is Customer Services?
What can Customer Services do for the individual?
Hours of operation and the process for obtaining customer assistance after hours

Other Suggested Topics:
Customer Services telephone number in the footer of each page
Safety information
Web address

Contact the PHIP and MDHHS Office of Inspector General (OIG) at [addresses and toll-free telephone numbers] for reporting fraud, waste, or abuse to both the PIHP and the MDHHS-OIG. The reporting of fraud, waste, or abuse may be made anonymously.

Template #1: Confidentiality and Family Access to Information

You have the right to have information about your behavioral health treatment kept private. You also have the right to look at your own clinical records or to request and receive a copy of your records. You have the right to ask us to amend or correct your clinical record if there is something with which you do not agree. Please remember, though, your clinical records can only change as allowed by applicable law. Generally, information about you can only be given to others with your permission. However, there are times when your information is shared to coordinate your treatment or when it is required by law.

Family members have the right to provide information to [Contractor] about you. However, without a Release of Information signed by you, the [Contractor] may not give information about you to a family member. For minor children under the age of 18 years, parents/guardians are provided information about their child and must sign a release of information before information can be shared with others.

If you receive substance abuse services, you have rights related to confidentiality specific to substance abuse services.

Under the Health Insurance Portability and Accountability Act (HIPAA), you will be provided with an official Notice of Privacy Practices from your CMH. This notice will tell you all the ways that information about you can be used or disclosed. It will also include a listing of your rights provided under HIPAA and how you can file a complaint if you feel your right to privacy has been violated.

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

[Note to Contractor: you may add additional information to this template]

The Contractor should tailor the contact information in the brackets to reflect their local operations and may add local or additional information to the templates.

Template #2: Coordination of Care

To improve the quality of services, [Contractor] wants to coordinate your care with the medical provider who cares for your physical health. If you are receiving substance abuse services, your mental health care should be coordinated with those services as well.

Being able to coordinate with all providers involved in treating you improves your chances for recovery, relief of symptoms, and improved functioning. Therefore, you are encouraged to sign a “Release of Information” so that information can be shared. If you do not have a medical doctor and need one, contact [Customer Services], and staff will assist you in getting a medical provider.

[Note to Contractor: you may add additional information to this template]

The Contractor should tailor the contact information in the brackets to reflect their local operations and may add local or additional information to the templates.

Template #3: Emergency and After-Hours Access to Services

A “behavioral health emergency” is when an individual is experiencing symptoms and behaviors that can reasonably be expected in the near future to lead him/her to harm himself/herself or another; or because of his/her inability to meet his/her basic needs; he/she is at risk of harm; or the individual’s judgment is so impaired that he/she is unable to understand the need for treatment and that his/her condition is expected to result in harm to himself/herself or another individual in the near future. You have the right to receive emergency services at any time, 24 hours a day, seven days a week, without prior authorization for payment of care.

If you have a behavioral health emergency, you should seek help right away. At any time during the day or night call:

[Contractor insert local emergency telephone numbers and place(s) to go for help]

Please note: if you utilize a hospital emergency room, there may be health-care services provided to you as part of the hospital treatment that you receive for which you may receive a bill and may be responsible for depending on your insurance status. These services may not be part of the Contractor emergency services you receive. Customer Services can answer questions about such bills.

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

The Contractor should tailor the contact information in the brackets to reflect their local operations and may add local or additional information to the templates.

Template #4: Definition of Terms

Access: The entry point to the Contractor, sometimes called an "access center," where Medicaid beneficiaries call or go to request behavioral health services.

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 PCP and as authorized by the Contractor.
- Failure of the Contractor to act within **30 calendar days** from the date of a request for a standard appeal.
- Failure of the Contractor to act within **72 hours** from the date of a request for an expedited appeal.
- Failure of the Contractor to provide disposition and notice of a local grievance/complaint within **90 calendar days** of the date of the request.

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

Appeal: A review of an adverse benefit determination.

Behavioral Health: Includes not only ways of promoting well-being by preventing or intervening in mental illness such as depression or anxiety, but also has as an aim preventing or intervening in substance abuse or other addictions. For the purposes of this Customer Services Handbook, behavioral health will include intellectual/developmental disabilities, mental illness in both adults and children, and substance use disorders (SUD).

Beneficiary: An individual who is eligible for and enrolled in the Medicaid program in Michigan.

CMHSP: An acronym for Community Mental Health Services Program. There are 46 CMHSPs in Michigan that provide services in their local areas to people with mental illness and developmental disabilities. May also be referred to as CMH.

Cultural Competency: Is an acceptance and respect for difference, a continuing self-assessment regarding culture, a regard for and attention to the dynamics of difference, engagement in ongoing development of cultural knowledge, and resources and flexibility within service models to work toward better meeting the needs of minority populations.

Customer: Customer includes all Medicaid eligible individuals located in the defined service area who are receiving or may potentially receive covered services and supports. The following terms may be used within this definition: clients, recipients, beneficiaries, consumers, individuals, individuals served, and Medicaid Eligible.

Deductible (or Spend-Down): A term used when individuals qualify for Medicaid coverage even though their countable incomes are higher than the usual Medicaid income standard. Under this process, the medical expenses that an individual incurs during a month are subtracted from the individual's income during that month. Once the individual's income has been reduced to a State-specified level, the individual qualifies for Medicaid benefits for the remainder of the month. Medicaid applications and deductible determinations are managed by the MDHHS – independent of the Contractor's service system.

Durable Medical Equipment (DME): Any equipment that provides therapeutic benefits to an individual in need because of certain medical conditions and/or illnesses. DME consists of items which:

- are primarily and customarily used to serve a medical purpose,
- are not useful to an individual in the absence of illness, disability, or injury,
- are ordered or prescribed by a physician,
- are reusable,
- can stand repeated use, and
- are appropriate for use in the home.

Emergency Services/Care: Covered services that are given by a provider trained to give emergency services and needed to treat a medical/behavioral emergency.

Excluded Services: Health care services that your health insurance or plan does not pay for or cover.

Flint 1115 Demonstration Waiver: The demonstration waiver expands coverage to children up to age 21 years and to pregnant women with incomes up to and including 400 percent of the federal poverty level (FPL) who were served by the Flint water system from April 2014 through a State-specified date. This demonstration is approved in accordance with section 1115(a) of the Social Security Act and is effective as of March 3, 2016, the date of the signed approval, through February 28, 2021. Medicaid-eligible children and pregnant women who were served by the Flint water system during the specified period will be eligible for all services covered under the state plan. All such individuals will have access to targeted case management services under a fee-for-service contract between the State and Genesee Health Systems (GHS). The fee-for-service contract must provide the targeted case management services in accordance with the requirements outlined in the Special Terms and Conditions for the Flint Section 1115 Demonstration Waiver, the Michigan Medicaid State Plan, and Medicaid Policy.

Grievance: Expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships, such as rudeness, a provider, an employee, or failure to respect beneficiary's rights regardless of whether remedial action is requested. Grievance includes a beneficiary's right to dispute an extension of time proposed by the Contractor to make an authorization decision.

Grievance and Appeal System: The processes the Contractor implements to handle the appeals of an adverse benefit determination and grievances as well as the processes to collect and track information about them.

Habilitation Services and Devices: Health care services and devices that help an individual keep, learn, or improve skills and functioning for daily living.

Health Insurance: Coverage that provides for the payments of benefits because of sickness or injury. It includes insurance for losses from accident, medical expense, disability, or accidental death and dismemberment.

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

Healthy Michigan Plan: An 1115 Demonstration project that provides health care benefits to individuals who are aged 19-64 years, have income at or below 133% of the federal poverty level under the Modified Adjusted Gross Income methodology, do not qualify or are not enrolled in Medicare or Medicaid, are not pregnant at the time of application, and are residents of the State of Michigan. Individuals meeting Health Michigan Plan eligibility requirements may also be eligible for behavioral health services. The Michigan Medicaid Provider Manual (MPM) contains complete definitions of the available services as well as eligibility criteria and provider qualifications. The Manual may be accessed at:
http://www.michigan.gov/mdhhs/0,4612,7-132-2945_42542_42543_42546_42553-87572--,00.html

Customer Services staff can help you access the manual and/or information from it.

Home Health Care: Is supportive care provided in the home. Care may be provided by licensed healthcare professionals who provide medical treatment needs or by professional caregivers who provide daily assistance to ensure the activities of daily living (ADL) are met.

Hospice Services: Care designed to give supportive care to people in the final phase of a terminal illness and focus on comfort and quality of life rather than cure. The goal is to enable patients to be comfortable and free of pain so that they live each day as fully as possible.

Hospitalization: A term used when formally admitted to the hospital for skilled behavioral services. If not formally admitted, it might still be considered an outpatient instead of an inpatient even if an overnight stay is involved.

Hospital Outpatient Care: Is any type of care performed at a hospital when it is not expected there will be an overnight hospital stay.

Intellectual/Developmental Disability: Is defined by the Michigan Mental Health code as either of the following: (a) If applied to an individual older than five years, a severe chronic condition that is attributable to a mental or physical impairment, or both, and is manifested before the age of 22 years; is likely to continue indefinitely; and results in substantial functional limitations in three or more areas of the following major life activities: self-care, receptive and expressive

language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency; and reflects the need for a combination and sequence of special, interdisciplinary, or generic care, treatment or other services that are of lifelong or extended duration; (b) If applied to a minor from birth to age five, a substantial developmental delay or a specific congenital or acquired condition with a high probability of resulting in a developmental disability.

Individuals with Limited English Proficiency (LEP): Individuals who cannot speak, write, read, or understand the English language at a level that permits them to interact effectively with health care providers and social service agencies.

Limited English Proficient (LEP): Means potential beneficiaries and beneficiaries who do not speak English as their primary language and who have a limited ability to read, write, or understand English may be LEP. The beneficiary may be eligible to receive language assistance for a particular service, benefit, or encounter.

MDHHS: An acronym for Michigan Department of Health and Human Services. This State department, located in Lansing, oversees public-funded services provided in local communities and State facilities to people with mental illness, developmental disabilities, and SUD.

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

Michigan Mental Health Code: The State law that governs public mental health services provided to adults and children with mental illness, SED, and developmental disabilities by local CMHSPs and in-state facilities.

MIChild: A health care program for children who are under age 19 administered by the MDHHS. It is for the low-income uninsured children of Michigan's working families. MIChild has a higher income limit than U-19 Medicaid. There is only an income test. There is a $10 per family monthly premium for MIChild. The $10 monthly premium is for all the children in one family. The child must be enrolled in a MIChild health and dental plan to receive services. Beneficiaries receive a comprehensive package of health care benefits including vision, dental, and mental health services. Contact [Customer Services] for more information.

Network: Is a list of the doctors, other health care providers, and hospitals that a plan has contracted with to provide medical care/services to its members.

Non-Participating Provider: A provider or facility that is not employed, owned, or operated by the PHIP/CMHSP and is not under contract to provide covered services to members.

Participating Provider: Is the general term used for doctors, nurses, and other people who give you services and care. The term also includes hospitals, home health agencies, clinics, and other places that provide health care services, medical equipment, mental health, SUD, intellectual/developmental disability, and long-term supports and services. They are licensed or

certified to provide health care services. They agree to work with the Health Plan, accept payment, and not charge beneficiaries an extra amount. Participating providers are also called network providers.

Physician Services: Refers to the services provided by an individual licensed under State law to practice medicine or osteopathy.

PIHP: An acronym for Prepaid Inpatient Health Plan. A PIHP is an organization that manages the Medicaid mental health, developmental disabilities, and substance abuse services in their geographic area under contract with the State. There are 10 PIHPs in Michigan, and each one is organized as a Regional Entity or a CMHSP, according to the Mental Health Code.

Post-stabilization Care Services: As defined in 42 CFR 438.114(a), covered specialty services specified in the Contract that are related to an emergency medical condition and are provided after a beneficiary is stabilized in order to maintain the stabilized condition, or, under the circumstances described in 42 CFR 438.114(e), to improve or resolve the beneficiary's condition.

Preauthorization: Approval needed before certain services or drugs can be provided. Some network medical services are covered only if the doctor or other network provider gets prior authorization. Also called Prior Authorization.

Premium: An amount to be paid for an insurance policy or a sum added to an ordinary price or charge.

Prescription Drugs: Is a pharmaceutical drug that legally requires a medical prescription to be dispensed. In contrast, over-the-counter drugs can be obtained without a prescription**.**

Prescription Drug Coverage: Is a stand-alone insurance plan covering only prescription drugs.

Primary Care Physician: A doctor who provides both the first contact for an individual with an undiagnosed health concern as well as continuing care of varied medical conditions, not limited by cause, organ system, or diagnosis.

Primary Care Provider: A health care professional (usually a physician) who is responsible for monitoring an individual’s overall health care needs.

Provider: Is a term used for health professionals who provide health care services. Sometimes, the term refers only to physicians. Often, however, the term also refers to other health care professionals such as hospitals, nurse practitioners, chiropractors, physical therapists, and others offering specialized health care services.

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

Rehabilitation Services and Devices: Health care services that help an individual keep, get back, or improve skills and functioning for daily living that have been lost or impaired because an individual was sick, hurt, or disabled. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Resiliency: The ability to "bounce back." This is a characteristic important to nurture in children with SED and their families. It refers to the individual's ability to become successful despite challenges they may face throughout their life.

Specialty Supports and Services: A term that means Medicaid-funded mental health, developmental disabilities, and substance abuse supports and services that are managed by the PIHPs.

SED: An acronym for Serious Emotional Disturbance, and as defined by the Michigan Mental Health Code, means a diagnosable mental, behavioral, or emotional disorder affecting a child that exists, or has existed, during the past year, for a period of time sufficient to meet diagnostic criteria specified in the most recent Diagnostic and Statistical Manual of Mental Disorders (DSM) and has resulted in functional impairment that substantially interferes with or limits the child's role or functioning in family, school, or community activities.

Serious Mental Illness: Is defined by the Michigan Mental Health Code to mean a diagnosable mental, behavioral, or emotional disorder affecting an adult that exists, or has existed, within the past year, for a period of time sufficient to meet diagnostic criteria specified in the most recent DSM and has resulted in functional impairment that substantially interferes with or limits one or more major life activities.

Skilled Nursing Care: Skilled nursing care and rehabilitation services provided on a continuous, daily basis in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous (IV) injections that a registered nurse or a doctor can give.

Specialist: A health care professional whose practice is limited to a particular area, such as a branch of medicine, surgery, or nursing especially one, who by virtue of advanced training, is certified by a specialty board as being qualified to so limit his/her practice.

State Fair Hearing: A State level review of beneficiaries' disagreements with a CMHSP or Contractor denial, reduction, suspension, or termination of Medicaid services. State administrative law judges, who are independent of the MDHHS, perform the reviews.

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

Urgent Care: Care for a sudden illness, injury, or condition that is not an emergency but needs care right away. Urgently needed care can be obtained from out-of-network providers when network providers are unavailable.

[Note to Contractor: you may add additional information to this template]

The Contractor should tailor the contact information in the brackets to reflect their local operations and may add local or additional information to the templates

Template #5: Grievance and Appeals Processes

Grievances

You have the right to say that you are unhappy with your services or supports, or the staff who provide them, by filing a "grievance." You can file a grievance *any time* by calling, visiting, or writing to [Customer Services.] Assistance is available in the filing process by contacting _____. In most cases, your grievance will be resolved within **90 calendar days** from the date the Contractor receives your grievance. You will be given detailed information about grievance and appeal processes when you first start services and then again annually. You may ask for this information at any time by contacting [Customer Services].*

Appeals

You will be given notice when a decision is made that denies your request for services or reduces, suspends, or terminates the services you already receive. This notice is called an "Adverse Benefit Determination". You have the right to file an "appeal" when you do not agree with such a decision. If you would like to ask for an appeal, you will have to do so within **60 calendar days** from the date on the Adverse Benefit Determination.

You may ask for a "Local Appeal" by contacting _____ at _____.

You will have the chance to provide information in support of your appeal and have someone speak for you regarding the appeal if you would like.

In most cases, your appeal will be completed in **30 calendar days** or less. If you request and meet the requirements for an "expedited appeal," your appeal will be decided within **72 hours** after we receive your request. In all cases, the Contractor may extend the time for resolving your appeal by **14 calendar days** if you request an extension, or if the Contractor can show that additional information is needed and the delay is in your best interest.

You may ask for assistance from [Customer Services] to file an appeal.

State Fair Hearing

You must complete a local appeal before you can file a State Fair Hearing. However, if the Contractor fails to adhere to the notice and timing requirements, you will be deemed to have exhausted the local appeal process. You may request a State Fair Hearing at that time.

You can ask for a State Fair Hearing only after receiving notice that the service decision you appealed has been upheld. You can also ask for a State Fair Hearing if you were not provided your notice and decision regarding your appeal in the timeframe required. There are time limits on when you can file an appeal once you receive a decision about your local appeal.

Benefit continuation

If you are receiving a Michigan Medicaid service that is reduced, terminated, or suspended before your current service authorization, and you file your appeal within **10 calendar days** (as instructed on the Notice of Adverse Benefit Determination), you may continue to receive your same level of services while your internal appeal is pending. You will need to state in your appeal request that you are asking for your services to continue.

If your benefits are continued and your appeal is denied, you will also have the right to ask for your benefits to continue while a State Fair Hearing is pending, if you ask for one within **10 calendar days**. You will need to state in your State Fair Hearing request that you are asking for your services to continue.

If your benefits are continued, you can keep getting the services until one of the following happens: 1) you withdraw the appeal or State Fair Hearing request; or 2) all entities that got your appeal decide “no” to your request.

NOTE: If your benefits are continued because you used this process, you may be required to repay the cost of any services that you received while your appeal was pending, if the final resolution upholds the denial of your request for coverage or payment of a service. State policy will determine if you will be required to repay the cost of any continued benefits.

*[Note to Contractor: you may add detailed information about grievance and appeals to this template.]

The Contractor should tailor the contact information in the brackets to reflect their local operations and may add local or additional information to the templates.

Template #6: Accessibility and Accommodations

Language Assistance

If you are an individual who does not speak English as your primary language, and/or who has a limited ability to read, speak, or understand English, you may be eligible to receive language assistance.

If you are an individual who is deaf or hard of hearing, you can utilize the Michigan Relay Center (MRC) to reach your PIHP Contractor, CMHSP, or service provider. Please call 711 and ask MRC to connect you to the number you are trying to reach. If you prefer to use a TTY, please contact [Customer Services] at the following TTY telephone phone number: [telephone number].

If you need a sign language interpreter, contact [Customer Services] at [telephone number] as soon as possible so that one will be made available. Sign language interpreters are available at no cost to you.

If you do not speak English, contact [Customer Services] at [telephone number] so that arrangements can be made for an interpreter for you. Language interpreters are available at no cost to you.

[Note to Contractor: you should add in the Customer Services Handbook any other language assistance available.]

Accessibility and Accommodations

In accordance with Federal and State laws, all buildings and programs of the [Contractor] are required to be physically accessible to individuals with all qualifying disabilities. Any individual who receives emotional, visual, or mobility support from a qualified/trained and identified service animal such as a dog, will be given access, along with the service animal, to all buildings and programs of the [Contractor]. If you need more information, or if you have questions about accessibility or service/support animals, contact [Customer Services] at [telephone number].

If you need to request an accommodation on behalf of yourself, a family member, or a friend, you can contact [Customer Services] at [telephone number]. You will be told how to request an accommodation (this can be done over the phone, in person, and/or in writing,) and you will be told who at the agency is responsible for handling accommodation requests.

[Note to Contractor: you may add additional information to this template. To accommodate multiple affiliates or provider networks, it is acceptable to format names and numbers in the most logical way]

The Contractor should tailor the contact information in the brackets to reflect their local operations and may add local or additional information to the templates.

Template #7: Payment for Services

If you are enrolled in Medicaid and meet the criteria for the specialty behavioral health services, the total cost of your authorized behavioral health treatment will be covered. No fees will be charged to you.

Some members will be responsible for “cost-sharing”. This refers to money that a member needs to pay when services or drugs are received. You might also hear terms like “deductible, spend-down, copayment, or coinsurance,” which are all forms of “cost-sharing”. Your Medicaid benefit level will determine if you will have to pay any cost-sharing responsibilities. If you are a Medicaid beneficiary with a deductible (“spend-down”), as determined by the State, you may be responsible for the cost of a portion of your services.

Should you lose your Medicaid coverage, your PIHP Contractor/provider may need to re-evaluate your eligibility for services. A different set of criteria may be applied to services that are covered by another funding source such as General Fund, Block Grant, or a third-party payer.

If Medicare is your primary payer, your Contractor will cover all Medicare cost-sharing consistent with coordination of benefit rules.

[Note to Contractor: you may add additional information to this template]

The Contractor should tailor the contact information in the brackets to reflect their local operations and may add local or additional information to the templates.

Template #8: Person-Centered Planning

The process used to design your individual plan of behavioral health supports, services, or treatment is called “Person-Centered Planning (PCP).” PCP is your right protected by the Michigan Mental Health Code.

The process begins when you determine whom, beside yourself, you would like at the PCP meetings, such as family members or friends, and what staff from [Contractor] you would like to attend. You will also decide when and where the PCP meetings will be held. Finally, you will decide what assistance you might need to help you participate in and understand the meetings.

During the PCP meetings, you will be asked “What are your hopes and dreams?” and will be helped to develop goals or outcomes you want to achieve. The people attending the meetings will help you decide what supports, services, or treatment you need; who you would like to provide the services; how often you need the services; and where the services will be provided. You have the right, under federal and state laws, to a choice of providers.

After you begin receiving services, you will be asked from time to time how you feel about the supports, services, or treatment you are receiving and whether changes need to be made. You have the right to ask at any time for a new PCP meeting if you want to talk about changing your IPOS.

You have the right to “independent facilitation” of the PCP process. This means that you may request that someone other than [Contractor] staff conduct your PCP meetings. You have the right to choose from available independent facilitators.

Children under the age of 18 with developmental disabilities or SED also have the right to PCP. However, PCP must recognize the importance of the family and the fact supports and services impact the entire family. The parent(s) or guardian(s) of the children will be involved in pre-planning and PCP using “family-centered practice” in the delivery of supports, services, and treatment to their children.

Topics Covered during PCP

During PCP, you will be told about psychiatric advance directives, a crisis plan, and self-determination (see the descriptions below). You have the right to choose to develop any, all, or none of these.

Psychiatric Advance Directive

Adults have the right, under Michigan law, to a **“**Psychiatric Advance Directive.**”** A Psychiatric Advance Directive is a tool for making decisions before a crisis in which you may become unable to make a decision about the kind of treatment you want and the kind of treatment you do not want. This lets other people, including family, friends, and service providers know what you want when you cannot speak for yourself.

If you do not believe you have received appropriate information regarding Psychiatric Advance Directives from your PIHP Contractor, please contact [Customer Services] at [telephone number] to file a grievance.

Crisis Plan
You also have the right to develop a "crisis plan." A crisis plan is intended to give direct care if you begin to have problems in managing your life, or you become unable to make decisions and care for yourself. The crisis plan would give information and direction to others about what you would like done in the time of crisis. Examples are friends or relatives to be called, preferred medicines, or care of children, pets, or bills.

Self-determination
Self-determination is an option for payment of medically necessary services you might request if you are an adult beneficiary receiving behavioral health services in Michigan. It is a process that would help you to design and exercise control over your own life by directing a fixed amount of dollars that will be spent on your authorized supports and services, often referred to as an "individual budget." You would also be supported in your management of providers, if you choose such control.

[Note to Contractor: you may add additional information to this template]

The Contractor should tailor the contact information in the brackets to reflect their local operations and may add local or additional information to the templates.

Template #9: Recipient Rights

Every individual who receives public behavioral health services has certain rights. The Michigan Mental Health Code protects some rights. Some of your rights include:

- The right to be free from abuse and neglect
- The right to confidentiality
- The right to be treated with dignity and respect
- The right to treatment suited to conditions

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

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

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

You may contact your local CMHSP to talk with a Recipient Rights Officer with any questions you may have about your rights or to get help to make a complaint. Customer Services can also help you make a complaint. You can contact the Office or Recipient Rights (ORR) at [telephone number] or Customer Services at [telephone number].

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

[Note to Contractor: you may add additional information to this template]

The Contractor should tailor the contact information in the brackets to reflect their local operations and may add local or additional information to the templates.

Template #10: Recovery and Resiliency

Recovery is a journey of healing and transformation enabling an individual with a mental health or substance abuse problem to live a meaningful life in a community of his/her choice while striving to achieve his/her potential.

Recovery is an individual journey that follows different paths and leads to different locations. Recovery is a process that we enter in to and is a lifelong attitude. Recovery is unique to each individual and can truly only be defined by the individual themselves. What might be recovery for one individual may be only part of the process for another.

Recovery may also be defined as wellness. Behavioral health supports and services help people with a mental illness or SUD in their recovery journey. The PCP process is used to identify the supports needed for individual recovery.

In recovery, there may be relapses. A relapse is not a failure, rather a challenge. If a relapse is prepared for, and the tools and skills that have been learned throughout the recovery journey are used, an individual can overcome and come out a stronger individual. It takes time and is why recovery is a process that will lead to a future that holds days of pleasure and the energy to persevere through the trials of life.

Resiliency and development are the guiding principles for children with SED. Resiliency is the ability to “bounce back” and is a characteristic important to nurture in children with SED and their families. It refers to the individual’s ability to become successful despite challenges they may face throughout their life.

[Note to Contractor: you may add additional information to this template]

The Contractor should tailor the contact information in the brackets to reflect their local operations and may add local or additional information to the templates.

Template #11: Service Array

MEDICAID SPECIALTY SUPPORTS AND SERVICES DESCRIPTIONS

NOTE: If you are a Medicaid beneficiary and have a serious mental illness, SED, developmental disability, or SUD, you may be eligible for some of the Medicaid Specialty Supports and Services listed below.

Before services can be started, you will take part in an assessment to find out if you are eligible for services. It will also identify the services that can best meet your needs.

You need to know that not all people who come to us are eligible for services, and not all services are available to everyone we serve. If a service cannot help you, your CMH will not pay for it. Medicaid will not pay for services that are otherwise available to you from other resources in the community.

During the PCP process, you will be helped to figure out the medically necessary services that you need as well as the sufficient amount, scope, and duration required to achieve the purpose of those services. You will also be able to choose who provides your supports and services. You will receive an IPOS that provides all this information.

In addition to meeting medically necessary criteria, services listed below marked with an asterisk (*) require a doctor's prescription.

Note: the Michigan Medicaid Provider Manual contains complete definitions of the following services as well as eligibility criteria and provider qualifications. The Manual may be accessed at:
http://www.michigan.gov/mdhhs/0,4612,7-132-2945_42542_42543_42546_42553-87572--,00.html

Customer Services staff can help you access the manual and/or information from it.

Assertive Community Treatment (ACT) provides basic supports and services essential for people with serious mental illness to maintain independence in the community. An ACT team will provide behavioral health therapy and help with medications. The team may also help access community resources and supports needed to maintain wellness and participate in social, educational, and vocational activities. ACT may be provided daily for individuals who participate.

Assessment includes a comprehensive psychiatric evaluation, psychological testing, substance abuse screening, or other assessments conducted to determine an individual's level of functioning and behavioral health treatment needs. Physical health assessments are not part of this PIHP service.

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

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

Behavioral Treatment Services/Applied Behavior Analysis are services for children under 21 years of age with Autism Spectrum Disorders (ASD).

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

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

Community Living Supports (CLS) are activities provided by paid staff that help adults with either serious mental illness or developmental disabilities live independently and participate actively in the community. Community Living Supports may also help families who have children with special needs (such as developmental disabilities or SED).

Crisis Interventions are unscheduled individual or group services aimed at reducing or eliminating the impact of unexpected events on behavioral health and wellbeing.

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

Early Periodic Screening, Diagnosis and Treatment (EPSDT) provides a comprehensive array of prevention, diagnostic, and treatment services for low-income infants, children, and adolescents under the age of 21 years, as specified in Section 1905(a)(4)(B) of the Social Security Act (SSA) and defined in 42 U.S.C. § 1396d(r)(5) and 42 CFR 441.50 or its successive regulation.

The EPSDT benefit is more robust than the Medicaid benefit for adults and is designed to assure that children receive early detection and care so that health problems are averted or diagnosed and treated as early as possible.

Health plans are required to comply with all EPSDT requirements for their Medicaid beneficiaries under the age of 21 years. EPSDT entitles Medicaid and Children's Health Insurance Program (CHIP) beneficiaries under the age of 21 years to any treatment or procedure that fits within any of the categories of Medicaid-covered services listed in Section 1905(a) of the SSA if that treatment or service is necessary to "correct or ameliorate" defects and physical and mental illnesses or conditions.

This requirement results in a comprehensive health benefit for children under age 21 enrolled in Medicaid. In addition to the covered services listed above, Medicaid must provide any other medical or remedial care, even if the agency does not otherwise provide for these services or provides for them in a lesser amount, duration, or scope (42 CFR 441.57).

While transportation to EPSDT corrective or ameliorative specialty services is not a covered service under this waiver, the Contractor must assist beneficiaries in obtaining necessary transportation either through the MDHHS or through the beneficiary's Medicaid Health Plan.

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

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

Family Support and Training provides family-focused assistance to family members relating to and caring for a relative with serious mental illness, SED, or developmental disabilities. "Family Skills Training" is education and training for families who live with and or care for a family member who is eligible for the Children's Waiver Program.

Fiscal Intermediary Services help individuals manage their supports and services budget and pay providers if they are using a self-determination approach.

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

Home-Based Services for Children and Families are provided in the family home or in another community setting. Services are designed individually for each family and can include things like behavioral health therapy, crisis intervention, service coordination, or other supports to the family.

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

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

Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) provide 24-hour intensive supervision, health, and rehabilitative services and basic needs to individuals with developmental disabilities.

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

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

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

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

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

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

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

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

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

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

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

Skill-Building Assistance includes supports, services, and training to help an individual participate actively at school, work, volunteer, or community settings, or to learn social skills they may need to support themselves or to get around in the community.

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

Substance Abuse Treatment Services (descriptions follow the behavioral health services)

Supports Coordination or Targeted Case Management is a staff individual who helps write an IPOS and makes sure the services are delivered. His/her role is to listen to an individual's goals and to help find the services and providers inside and outside the local CMHSP that will help achieve the goals. A supports coordinator or case manager may also connect an individual to resources in the community for employment, community living, education, public benefits, and recreational activities.

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

Transportation may be provided to and from an individual's home for them to take part in a non-medical Medicaid-covered service.

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

Wraparound Services for Children and Adolescents with SED and their families that include treatment and supports necessary to maintain the child in the family home.

Services for Only Habilitation Supports Waiver (HSW) and Children's Waiver Participants

Some Medicaid beneficiaries are eligible for special services that help them avoid having to go to an institution for people with developmental disabilities or to a nursing home. These special services are called the Habilitation Supports Waiver (HSW) and the Children's Waiver. To receive these services, people with developmental disabilities need to be enrolled in either of these waivers. The availability of these waivers is very limited. People enrolled in the waivers have access to the services listed above as well as those listed here.

Goods and Services (for HSW beneficiaries) is a non-staff service that replaces the assistance that staff would be hired to provide. This service, used in conjunction with a self-determination arrangement, aids to increase independence, facilitate productivity, or promote community inclusion.

Non-Family Training (for Children's Waiver beneficiaries) is customized training for the paid in-home support staff who provide care for a child enrolled in the waiver.

Out-of-Home Non-Vocational Supports and Services (for HSW beneficiaries) is assistance to gain, retain, or improve in self-help, socialization, or adaptive skills.

Personal Emergency Response Devices (for HSW beneficiaries) help an individual maintain independence and safety in his/her own home or in a community setting. These are devices that are used to call for help in an emergency.

Prevocational Services (for HSW beneficiaries) include supports, services, and training to prepare an individual for paid employment or community volunteer work.

Private Duty Nursing (for HSW beneficiaries) is individualized nursing service provided in the home as necessary to meet specialized health needs.

Specialty Services (for Children's Waiver beneficiaries) are music, recreation, art, or massage therapies that may be provided to help reduce or manage the symptoms of a child's mental health condition or developmental disability. Specialty services might also include specialized child and family training, coaching, staff supervision, or monitoring of program goals.

Services for Individuals with Substance Use Disorders (SUD)

The substance abuse services listed below are covered by Medicaid. These services are available through the Contractor.

Access, Assessment, and Referral (AAR) determines the need for substance abuse services and will assist in getting an individual to the right services and providers.

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

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

Methadone and Levacetylmetahdol (LAAM) Treatment is provided to individuals who have heroin or other opiate dependence. The treatment consists of opiate substitution monitored by a doctor as well as nursing services and lab tests. This treatment is usually provided along with other substance abuse outpatient treatment.

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

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

If you receive Medicaid, you may be entitled to other medical services not listed above. Services necessary to maintain your physical health are provided or ordered by your primary care provider. If you receive CMH services, your local CMHSP will work with your primary care provider to coordinate your physical and behavioral health services. If you do not have a primary care provider, your local CMHSP will help you find one.

Note: **Home Help Program** is another service available to Medicaid beneficiaries who require in-home assistance with ADL and household chores. To learn more about this service, you may call the local MDHHS number below or contact [Customer Services] for assistance.

[Name and telephone number of the local MDHHS office]

Medicaid Health Plan Services

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

- Ambulance
- Chiropractic
- Doctor visits
- Family planning
- Health check ups
- Hearing aids
- Hearing and speech therapy
- Home health care
- Immunizations (shots)
- Lab and X-ray
- Nursing home care
- Medical supplies
- Medicine
- Mental health (limit of 20 outpatient visits)
- Physical and occupational therapy
- Prenatal care and delivery
- Surgery
- Transportation to medical appointments
- Vision

If you already are enrolled in one of the Medicaid Health Plans listed below, you can contact the Health Plan directly for more information about the services listed above. If you are not enrolled in a Health Plan or do not know the name of your Health Plan, you can contact [Customer Services] at [telephone number] for assistance.

[List of health plans and contact telephone numbers]

The Contractor should tailor the contact information in the brackets to reflect their local operations and may add local or additional information to the templates.

Template #12: Service Authorization

Services you request must be authorized or approved by [Contractor or its designee]. That agency may approve all, some, or none of your requests. You will receive notice of a decision within **14 calendar days** after you have requested the service during PCP, or within **72 hours** if the request requires an expedited decision.

Any decision that denies a service you request, or denies the amount, scope, or duration of the service that you request, will be made by a health care professional who has appropriate clinical expertise in treating your condition. Authorizations are made according to medical necessity. If you do not agree with a decision that denies, reduces, suspends, or terminates a service, you may file an appeal.

[Note to Contractor: you may add additional information to this template]

The Contractor should tailor the contact information in the brackets to reflect their local operations and may add local or additional information to the templates.

Template #13: Tag Lines

To establish a methodology for identifying the prevalent non-English languages spoken by beneficiaries and potential beneficiaries throughout the State and in each Contractor service area, the list below is provided. The Contractor must provide tag lines in the prevalent non-English languages in its service area included in the list below.

You have the right to get this information in a different format, such as audio, Braille, or large font due to special needs, or in your language at no additional cost.

English: ATTENTION: If you speak English, language assistance services, free of charge are available to you. Call

Albanian: KUJDES: Në qoftë se ju flisni anglisht, shërbimet e ndihmës gjuhësore, pa pagesë, janë në dispozicion për ty. Telefononi

Arabic: تنبيه: إذا كنت تتحدث العربية فإن خدمة الترجمة متوفرة لك مجاناً فقط إتصل على الرقم

Bengali: দৃষ্টি আকর্ষণ: আপনি ইংরেজি, ভাষা সহায়তা সেবা, নিখরচা কথা বলতে পারেন, আপনার জন্য উপলব্ধ. কল

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電

German: Achtung: Wenn Sie Englisch sprechen, sind Sprache Assistance-Leistungen, unentgeltlich zur Verfügung. Rufen Sie.

Italian: Attenzione: Se si parla inglese, servizi di assistenza di lingua, gratuitamente, sono a vostra disposizione. Chiamare

Japanese: 注意: 英語を話す言語アシスタンス サービス、無料で、あなたに利用できま を呼び出す)

Korean: 주의: 당신이 영어, 언어 지원 서비스를 무료로 사용할 수 있습니다 당신에 게. □ □ .

Polish: UWAGI: Jeśli mówisz po angielsku, język pomocy usług, za darmo, są dostępne dla Ciebie. Wywołanie

Russian: ВНИМАНИЕ: Если вы говорите по-английски, языковой помощи, бесплатно предоставляются услуги для вас. Звоните

Serbo:

Croatian: OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite (TTY- Telefon za osobe sa oštećenim govorom ili sluhom:).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al

Syriac: [illegible]

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa

Vietnamese: Chú ý: Nếu bạn nói tiếng Anh, Dịch vụ hỗ trợ ngôn ngữ, miễn phí, có sẵn cho bạn. Gọi

Non-Discrimination and Accessibility:
In providing behavioral health care services, [Contractor] complies with all applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. [Contractor] does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

[Contractor] provides free aids and services to people with disabilities to communicate effectively with us, such as:

Qualified sign language interpreters
Written information in other formats (large print, audio, accessible electronic formats, Braille)

[Contractor] provides free language services to people whose primary language is not English or have limited English skills, such as:

Qualified interpreters
Information written in other languages

If you need these services, contact [Contractor] at the information below.

If you believe that [Contractor] has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with [Contractor] at the information below.

If you are an individual who is deaf or hard of hearing, you may contact [Contractor] at [TTY telephone number] or MI Relay Service at 711 to request their assistance in connecting you to [Contractor]. You can file a grievance in person or by mail, fax, or email. If you need help in filing a grievance, [Contractor Grievance Counselor] is available to help you.

[Contractor Name]
[Contractor Address]
[Contractor City, ST Zip Code]
[Contractor Telephone Number] [Contractor Fax Number]
[Contractor Email Address]

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights.

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

You may also file a grievance electronically through the Office for Civil Rights Complaint Portal.

Complaint Portal is available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.

You may also file a grievance by mail or by phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

Telephone Number: 1-800-368-1019

The Contractor should tailor the contact information in the brackets to reflect their local operations and may add local or additional information to the templates.

Template #14: Fraud, Waste and Abuse

Fraud, waste, and abuse uses up valuable Michigan Medicaid funds needed to help children and adults access health care. Everyone can take responsibility by reporting fraud, waste, and abuse. Together we can make sure taxpayer money is used for people who really need help.

Examples of Medicaid Fraud:

- Billing for medical services not actually performed
- Providing unnecessary services
- Billing for more expensive services
- Billing for services separately that should legitimately be one billing
- Billing more than once for the same medical service
- Dispensing generic drugs but billing for brand-name drugs
- Giving or accepting something of value (cash, gifts, services) in return for medical services, (kickbacks)
- Falsifying cost reports

Or When Someone:

- Lies about their eligibility
- Lies about their medical condition
- Forges prescriptions
- Sells their prescription drugs to others
- Loans their Medicaid card to others

Or When a Health Care Provider Falsely Charges For:

- Missed appointments
- Unnecessary medical tests
- Telephone services

If you think someone is committing fraud, waste, or abuse, you may report it to Corporate Compliance. You may email concerns to [Email Address], or report them anonymously on the Contractor website – [Instructions for using the website].

Your report will be confidential, and you may not be retaliated against.

You may also report concerns about fraud, waste, and abuse directly to Michigan's Office of Inspector General (OIG):

www.michigan.gov/fraud

Office of Inspector General
PO Box 30062
Lansing, MI 48909

855-MI-FRAUD (643-7283) (voicemail available for after hours)

When you make a complaint, make sure to include as much information as you can, including details about what happened, who was involved (including their address and phone number), Medicaid identification number, date of birth (for beneficiaries), and any other identifying information you have.

The Contractor should tailor the contact information in the brackets to reflect their local operations and may add local or additional information to the templates.