BAY-ARENAC BEHAVIORAL HEALTH AUTHORITY
POLICIES AND PROCEDURES MANUAL

Chapter: 4	**Care and Treatment Services**		
Section: 4	**Eligibility, Intake and Utilization Management**		
Topic: 48	**Conflict Free Access, Planning and Delivery of Services**		
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Policy:

It is the policy of Bay-Arenac Behavioral Health Authority (BABHA) to establish conflict of interest standards for access, planning and delivery of services.

Purpose:

The Centers for Medicare and Medicaid Services (CMS) Home and Community Based Settings Regulations (known commonly as the HCBS Final Rule) requires that assessment and coordination of services are separate from the delivery of services with the goal of limiting any conscious or unconscious bias that a provider may have and safeguarding against financial conflicts of interest. The intent is that a single agency is not both assessing what services an individual needs and then providing those services to them as required by policies in states using Medicaid funds from the Balancing Incentive Program, Community First Choice (1915 k), and 1915(i).

Education Applies to:

☒ All BABHA Staff
☐ Selected BABHA Staff, as follows:
☒ All Contracted Providers: ☐ Policy Only ☒ Policy and Procedure
☐ Selected Contracted Providers, as follows:
☐ Policy Only ☐ Policy and Procedure
☐ Other:

Definitions and Acronyms: (if applicable)

ATP: Ability to Pay
BABHA: Bay Arenac Behavioral Health
CLS: Community Living Support Services
CMS: Center for Medicaid and Medicare Services
HCBS: Home and Community Based Services
IPOS: Individual Plan of Service
MDHHS: Michigan Department of Health and Human Services
PCP: Person Centered Planning

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PDN: Private Duty Nursing
PERS: Personal Emergency Response System

Procedure:

Administrative and/or structural firewalls and/or safeguards shall be put in place to ensure protection against conflict of interest. Individuals are provided with choice, control and options for access to services, person centered service planning and service delivery. Individuals have Rights protections in place and a clear and accessible alternative dispute process.

1. BABH staff shall follow established conflict of interest standards for the assessment of functional need and the person-centered service plan development process that apply to all individuals. At a minimum, the individuals or entities conducting the assessment of functional need and person-centered service plan development process are not:
   a. Related by blood or marriage to the member, or to any paid caregiver of the member.
   b. Financially responsible for the member.
   c. Empowered to make financial or health-related decisions on behalf of the member.
   d. Individuals who would benefit financially from the provision of assessed needs and services.
   e. Providers of HCBS for the member, or those who have an interest in or are employed by a provider of HCBS for the member must not provide case management or develop the person-centered service plan, except when MDHHS demonstrates that the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area also provides HCBS. In these cases, MDHHS must devise conflict of interest protections including separation of entity and provider functions within provider entities, which must be approved by CMS. Members must be provided with a clear and accessible alternative dispute resolution process.

2. Administrative and/or structural firewalls should exist between functions, whenever possible

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A. Assessment & Eligibility/Resource Allocation: This includes the processes for determining eligibility and assigning budgets, hours, or other units of services.

BABHA Emergency and Access Services provides provisional eligibility screening for specialty mental health and substance use disorder services for the residents of Bay and Arenac Counties. Emergency and Access Services staff will screen for specialty mental health services and substance use disorder services. Determination of service authorization will be based on criteria based on BABHA Policy and Procedure, C04-S04-T34 Access and Eligibility for Specialty Mental Health Services.

During the access screening process to determine eligibility, all individuals, including families, children, and youth will be provided understandable and meaningful information to make informed choices regarding services and supports available to them. They will have a voice in determining the services they receive. Services and supports should be delivered in the home and community whenever possible.

If the person meets eligibility criteria, they will be referred to the appropriate BABHA Department or another contracted provider. Based on agency standards, Emergency and Access Services clinicians will provide initial authorization and admission for these referrals. A full assessment for medical necessity and eligibility for services is conducted by a Master's prepared clinician in each service department. This clinician shall not be the assigned primary case holder or the case manager for the individual.

If the person does not meet the eligibility criteria for the target population, he/she will: a). Be informed of the decision, provided information on his/her right to appeal the decision, provided information about local Emergency and Access Services availability, and provided information for alternative community resources. b). Receive an Advance Benefit Determination, which will include the following information: reason for denial, alternative services/resources in the community, and information regarding grievance and appeal options (see C03-S08-T07- Appeals and Grievance Procedural Processes).

Initial and annual eligibility for 1915(c) services currently are and will continue to be assessed and approved through the PIHP/MDHHS process. Initial and Annual eligibility for 1915(i) services will be assessed and approved through the PIHP/MDHHS beginning October 1, 2023. Implementation of this process begins phasing in from September 2022-September 2023.

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B. Plan Development: These are the processes that lead to a person-centered plan.

It is the policy and procedure of BABHA that persons served will be assured Person Centered Planning in accordance with the PCP Practice Guidelines outlined by Michigan Department of Health and Human Services, Michigan Mental Health Code and Home and Community Based Final Rules. (C04-S05-T01 Person/Family Centered Planning Policy and Procedures). As appropriate for the individual, concepts of Self Determination, Recovery, Culture of Gentleness, and treatment for Substance Use Disorders and transition planning are included throughout the planning process. Person Centered Planning is highly individualized and designed to respond to the expressed needs/desires of the individual. The individual can identify facilitators for the process which may include the primary case holder, independent facilitators, or other qualified providers. Development of the Individual Plan of Service is based on the needs of the individual identified by the Person-Centered Planning process. The Individual Plan of Service identifies who is responsible for facilitation, pre-planning, developing, implementing, and monitoring each component of the Plan of Service.

Disability Network of Mid-Michigan and The Arc of Bay County provide professional Independent Facilitation and is available for anyone desiring this service. Allies and other Advocates following Person Centered Planning principles may serve as an Independent Facilitator. All consumers are educated and informed of Independent Facilitation at the Pre-Planning meeting.

C. Monitoring & Service Coordination: These are the processes for ensuring that services are delivered according to guidance included in the plan. Activities include coordinating services, monitoring the quality of the services, and monitoring the individual (e.g., watching for changes in needs or preferences).

BABHA directly provides Case Management services for individuals with more complex needs. There are several contracted providers who provide Case Management services that are available for consumers who have a lower level of need or upon request of the consumer. The consumers have a choice in Case Management providers.

The Primary Case Holder/Targeted Case Manager is responsible for coordinating, linking, monitoring, and ensuring service delivery as identified in the Individual Plan of Service. Implementation, oversight and monitoring of the Individual Plan of Service

include assuring services and supports are provided as outlined, training appropriate staff who are implementing the Individual Plan of Service, review of Unusual Incident Reports and Progress notes, observation of staff providing the direct services and supports, attending/facilitating treatment meetings providing guidance for direct service providers (see C04-S05-T03 Targeted Case Management/Supports Coordination and C04-S07-T03 Treatment Plan Monitoring and Review).

D. Direct Supports & Service Delivery: The supports and/or services provided to the individual in accordance with the person-centered plan.

Direct supports and services for Home and Community Based Services include the following: Community Living Supports, Enhanced Pharmacy, Environmental Modifications, Family Support & Training, Fiscal Intermediary, Housing Assistance, Respite Care, Skill-Building Assistance, Specialized Medical Equipment & Supplies, Supported/Integrated Employment, and Vehicle Modification (1915(i) State plan Home and Community Based Services benefits). The Medicaid Provider Manual, Home and Community Based Services identifies the following services: Skill Building, Community Living Supports, Supported Employment, Adult Day Care. Habilitative Supports Waiver also includes Overnight Health and Safety, goods, PERS, pre-vocational and PDN services.

The Medicaid Provider Manual states that the provider of HCBS for the individual must not be involved in case management or development of the person-centered service plan (p. 857).

Home and Community Based services are provided primarily by externally contracted providers. The Horizon Home and North Bay CLS services are provided for individuals with needs that are higher than the contracted network of providers are able to deliver.

Utilization Management: Utilization management activities are a separate and discrete managed-care function that sit outside of the other processes of assessment/eligibility, plan development, plan monitoring, and service delivery. Utilization management activities ensure that medical-necessity criteria are met for all services and supports.

To obtain Authorized services, the primary case holder (PCH) will complete an Authorization Request via the Electronic Health Record. The authorization

request for all services will be directly reflected in the Individual Plan of Service (IPS). Services that are requested over a pre-determined threshold will need approval by either Emergency and Access Clinical Specialist, Emergency and Access Supervisor, Program Manager, or Director. Approving individual will review the authorization request to ensure that it is consistent with applicable procedures and the Clinical Protocol for that service and meets medical necessity.

Emergency and Access Services reviews authorization requests made by external contractors that are over a pre-determined threshold; in addition, they authorize all DBT services. Emergency and Access Clinical Specialist will review the request to ensure that the services requested are consistent with the protocols for that service. If the request meets the protocol, the authorization will be approved. If problems are identified, the authorization request will not be approved (C04-S04-T03 Authorization Process).

The CLS Assessment Committee and Residential Referral and Placement Review Committee review and authorize CLS services and Specialized Residential Services based on assessments, level of care determinations, recommendations from treatment team and determined by the person- centered planning process. CLS utilization reports are reviewed by the CLS Committee on a regular basis.

Authorization parameters and thresholds are in place. Supervisor approval is required for any authorization needs that exceed the thresholds. MSHN has a utilization management process that identifies outlier authorizations.

E. Denial, Appeals, Grievances, Mediation and Dispute Resolution:

Denial of an authorization may occur if the individual no longer meets criteria for specialty mental health services, the individual's needs do not meet Medicaid service criteria (via the Medicaid Provider Manual) for the service requested, or as the result of a records review (retrospective review). If a service request is denied, the provider or individual will be notified, and alternatives may be suggested. The individual has the right to use the appeal and grievance procedures. Denials will be processed in accordance with established Customer Services procedures and guidelines. If needed, Emergency and Access Services provides for the opportunity of a second opinion from a qualified health care professional within the network, or Emergency and Access Services may arrange for the person to obtain a second opinion from outside the network based on

his/her Medicaid eligibility or at a cost based on his/her calculated Ability to Pay (ATP). It is expected that Access and the out of network provider will coordinate with respect to payment to ensure the cost to the person is no greater than the person's established ATP. The individual and the provider organization will be informed of his/her option to appeal any denials of care resulting from a utilization management decision. The individual is informed of multiple appeal options including (1) the Internal CMHSP Grievance process, (2) the MDHHS Office of Recipient Rights, (3) the Medicaid Fair Hearing process or alternative dispute resolution process, and/or (4) reconsideration by the Medical Director.

Mediation is available for consumers for the following types of disputes:

- Working relationships with treatment team members.
- Care and planning steps.
- Communication, expectations, and boundaries. (The example given: If a person-served calls frequently, has frequent grievances)
- AOT cases ***prior*** to Court Order, once a court order is in effect mediation is not an option as they do not have any authority over court orders of any kind.

Attachments

N/A.

Related Forms

N/A.

Related Materials

C04-S04-T34 Access and Eligibility
C04-S04-T35 Enrollment, Re-enrollment, Screening and Referral
C04-S04-T03 Authorization Process
C04-S05-T01 Person/Family Centered Planning
C04-S05-T03 Targeted Case Management/Supports Coordination
C04-S07-T03 Treatment Plan Monitoring and Review
C04-S29-T12 Community Living Support Services

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References/Legal Authority (if applicable)

Michigan Department of Health and Human Services
Michigan Provider Manual
Home and Community Based Final Rule
Center for Medicaid and Medicare Services

SUBMISSION FORM				
AUTHOR/ REVIEWER	**APPROVING BODY/COMMITTEE/ SUPERVISOR**	**APPROVAL /REVIEW DATE**	**ACTION (Deletion, New, No Changes, Replacement or Revision)**	**REASON FOR ACTION - If replacement list policy to be replaced**
K. Amon	Extended SLT/SLT	7/26/2022	New	1915 (i) requirements for conflict free access and planning.