MACOMB COUNTY
COMMUNITY MENTAL HEALTH

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Date: May 14, 2024

To: Macomb County Community Mental Health (MCCMH) Primary Provider Network, Direct Operated Programs, Managed Care Operations

From: Traci Smith
Interim Chief Executive Officer

RE: Executive Directive – Non-Medicaid Benefit Update

Effective **June 1, 2024,** Non-Medicaid funding is available through the CCBHC and General Fund to provide mental health services to individuals without Medicaid coverage or other insurance as outlined in the attached Benefit Matrix that includes service codes and descriptions along with coverage details.

This directive supersedes all prior General Fund Benefits (GFB) updates.

People without active Medicaid must be assisted in the completion of their Medicaid application. Assistance will be provided by the individual's primary case holder or guardian, if applicable. This assistance will be provided within 30 days of intake or notification of Medicaid termination or lapse.

Individuals determined to have a Medicaid Deductible (Spenddown) through the above process are responsible for the initial cost of their medical bills each month up to the amount of their deductible. Their Individual Plan of Service (IPOS) must clearly explain how their deductible will be met, and it is expected for them to become Medicaid eligible every month. Primary providers are responsible for submitting the required paperwork to MDHHS as soon as the

individual meets their deductible every month to ensure that the spenddown is met in a timely fashion. Individuals with Medicare but without Medicaid, who are not eligible for CCBHC services based on their diagnosis, should be assisted as indicated above and referred to a Medicare provider agency for assistance. If not a CCBHC covered individual, we would not be able to provide service unless authorized through the Non-Medicaid Review Committee as indicated below. Any CCBHC eligible consumers should be referred to an MCCMH Direct Program/Provider or Designated Collaborating Organization ("DCO") service provider for outpatient service needs.

The Local Dispute Resolution process is available to individuals without Medicaid coverage.

Non- Medicaid funds will be budgeted/allocated as follows:

1. Inpatient services meeting medical necessity criteria will be authorized as will partial hospitlization, crisis stabilization and crisis residential servces regardless of ability to pay.
2. People new to the MCCMH system that complete a Medicaid Application (including families not eligible for Medicaid but applying for SED waiver or Children's Waiver) are considered presumptively eligible for sixty (60) days or until Medicaid denial is received. Ability to pay (ATP) must be assessed.
3. A "wait-list" will be established to manage all other requests for services from non-CCBHC eligible services for people without Medicaid.
4. A montly budget for wait-list services is established based on available Non-Medicaid funds expected to be available after set asides for items one (1) and two (2) above.
5. A Non-Medicaid Review Committee (comprised of representatives from the Managed Care Operations, Clinical and Finance Divisions) will review services authorized/performed and provide input to which services should be authroized in the following month.

In addition to the wait list information listed above, the rules for use of Non-Medicaid funds are:

1. Individuals with Medicaid Emergency Services Only (ESO). Non-citizens who are not otherwise eligible for full Medicaid because of immigration status may be elgible for Emergency Services Only (ESO) Medicaid. For ESO coverage, federal Medicaid regulations define an emergency medical condition (including emergency labor and delivery) as a sudden onset of physical or mental condition which causes acute symptoms, including severe pain, where the absence of immediate medical attenion could reasonably be expected to:
    a. Place the person's health in serious jeopardy, or
    b. Cause serious impairment to bodily functions, or
    c. Cause serious dysnfuction of any bodily organ or part.

d. These individuals will be eligible for Crisis Services only, as detailed in the table below, and can be placed on the wait list should they request additional servicses.

2 Individuals who had Medicaid and were receiving services, then lost their Medicaid: Coverage will be able to continue for the services described in their IPOS for up to sixty (60) days after the date they lost their coverage. Reinstating Medicaid needs to be the priority during those sixty (60) days. If coverage is not obtained within sixty (60) days, services may be terminated if not CCBHC eligible.

3 Individuals without Medicaid and outside either of the sixty (60) day periods described above, will be eligible for crisis services only as detailed in the table below and placed on the wait list should they requests additional services.

4 CCBHC eligible individuals will not be restricted from receiving CCBHC covered services at a DCO or MCCMH Direct Operated Program. However, restrictions may be placed on non-CCBHC covered services.

5 Approved exceptions to service and/or time restrictions listed above. Note, the Non-Medicaid exception process takes the place of anything formerly referred to as "protected" such as people living in a "dependent" setting based on the amount of Community Living Supports. Non-Medicaid exceptons will be reviewed on an individual basis with a focus on health/safety and a consideraton of the attempts being made to get Medicaid coverage and the status of the Medicaid application.

REFERENCES

MENTAL HEALTH CODE (EXCERPT)

Act 258 of 1974

330.1124 Waiting lists for admissions.

Sec. 124.

(1) The department shall establish waiting lists for admissions to state operated programs. Waiting lists shall be by diagnostic groups or program categories, age, and gender, and shall specify the length of time each individual has been on the waiting list from the date of the initial request for services.

(2) The department shall require that community mental health services programs maintain waiting lists if all service needs are not met, and that the waiting lists include data by type of services, diagnostic groups or program categories, age, and gender, and that they specify the length of time everyone has been on the waiting list from the date of the initial request for services. The order of priority on the waiting lists shall be based on severity and urgency of need. Individuals determined to be of equal severity and urgency of need shall be served in the order in which they applied for services.

History: 1974, Act 258, Eff. Aug. 6, 1975; -- Am. 1995, Act 290, Eff. Mar. 28, 1996

Macomb County Community Mental Health Non-Medicaid

Effective June 1, 2024

Category	Covered Services	Service Code(s) & Units	Total Units	Authorization Time Frame
#1: New people to MCCMH who do not have active Medicaid and do not qualify or receive CCHBC eligible services. Focus is on getting them active Medicaid. Note: Crisis Services, Crisis Residential, Crisis Stabilization, Partial Hospitalization and Inpatient Psychiatric stays are covered for everyone regardless of insurance type if medically necessary. See #4 below	Assessment by a non-physician Peer Services Targeted Case Management Psychiatric Diagnostic Evaluation Medication Administration Medication Review	90791 H0038 T1017 9079X 96372 929XX	One Encounter 10 units of either (not both) 10 units of either (not both) One Unit Two Units Two Units	60 days IMPORTANT! Everyone in this category should be informed of their ability to enter Care Coordination services through MCCMH or a DCO provider (our CCBHC program). Remember they do not need to be a resident of Macomb County to qualify for CCBHC services. For non-CCBHC services, you must be a Macomb County resident. If they prefer not to enter CCBHC services, they need to receive notice that they will be added to our Non-Medicaid Waist List which is reviewed monthly.
#2: Medicaid ESO (Emergency Services Only) Mental Health Services are limited to emergency stabilization of a psychiatric episode within the emergency department of a medical hospital.	Only Crisis Intervention Services are covered by Medicaid. Screening for an Inpatient Hospitalization & Inpatient Psychiatric Coverage Primary need is for referral to an agency that may be able to help them with their immigration status	H2011 T1023 (GF) Inpatient Psychiatric Coverage (GF) H0018 (GF) Partial Hospitalization (GF)	No limit or prior authorization required	IMPORTANT! Everyone in this category should be informed of their ability to enter Care Coordination services through MCCMH (our CCBHC program). Remember they do not need to be a resident of Macomb County to qualify for CCBHC services. If they prefer not to enter CCBHC services, they need to receive notice that they will be added to our Non-Medicaid Wait List which is reviewed monthly.

Category	Covered Services	Service Code(s) & Units	Total Units	Authorization Time Frame
#3: People who had Medicaid, were receiving services, and then lost their Medicaid coverage		Can continue the current services described in their IPOS in the same amount, scope, and duration for up to 60 days.		60 days The 60-day limitation does not apply to CCBHC eligible consumers receiving CCBHC services.
#4: People without Medicaid and outside either of the 60-day periods described in #1 or #3 above; will be eligible for Crisis Services only as detailed in this table	Crisis Intervention, Crisis Stabilization Screening for an Inpatient Psychiatric Hospitalization & Inpatient Psychiatric Coverage Crisis Residential Partial Hospitalization	H2011 (GF) T1023 (GF) Inpatient Psychiatric Coverage (GF) H0018 (GF) 0912 (GF)		No limit or prior authorization required. IMPORTANT! Everyone in this category should be informed of their ability to enter Care Coordination services through MCCMH (our CCBHC program). Remember they do not need to be a resident of Macomb County to qualify for CCBHC services. If they prefer not to enter CCBHC services, they need to receive notice that they will be added to our Non-Medicaid Wait List which is reviewed monthly.
#5: Approved Exceptions to these services or time restrictions listed above. Non-Medicaid Exceptions will be reviewed on an individual basis with a focus on health/safety and the attempts being made to get Medicaid coverage in place.	The exception request must clearly state the requested services along with their amount, scope, and duration as well as all efforts actively being pursued to obtain active Medicaid. This request should be submitted to NonMedicaid@mccmh.net. The Non-Medicaid review committee will collectively make a determination on authorization of services.	Whatever has been approved through the Exception Request process.	Whatever has been approved through the Exception Request process.	Typically, short term authorizations; less than 60 days only.