Chapter: **FINANCE**
Title: **NON-MEDICAID PAYMENT OF SERVICES**

Prior Approval: N/A
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Proposed by: Traci Smith 09/16/2024
Chief Executive Officer Date

Approved by: Al Lorenzo 09/16/2024
County Executive Office Date

I. ABSTRACT

This policy establishes the standards of Macomb County Community Mental Health (MCCMH), an official agency of the County of Macomb, as a pre-paid inpatient health plan (PIHP), community mental health service program (CMHSP), and certified community behavioral health clinic (CCBHC) to support persons served in the payment of identified service needs.

II. APPLICATION

This policy shall apply to all directly operated and contract network providers of MCCMH.

III. POLICY

It is the policy of MCCMH that non-Medicaid funding be available through MCCMH's CCBHC and general fund to provide mental health services to individuals without Medicaid coverage or other insurance.

IV. DEFINITIONS

A. Certified Community Behavioral Health Clinics (CCBHC)
Clinics designed to provide a broad array of mental health and substance use disorder services to persons of all ages, regardless of ability to play, including those who are underserved, have low incomes, have Medicaid, are privately insured or uninsured, and are active-duty military or veterans.

B. Designated Collaborating Organization (DCO)
Providers agencies that have a formal relationship with a CCBHC to provide a designated range of services.

C. Medicaid Deductible (Spend-Down)

A beneficiary must incur medical expenses each month equal to, or in excess of, an amount determined by the local Michigan Department of Health and Human Services (MDHHS) worker to qualify for Medicaid. Previously referred to as Medicaid spend-down.

V. STANDARDS

A. MCCMH persons served who do not have active Medicaid must be assisted in the completion of their Medicaid application.

1. Assistance shall be provided by the individual's primary case holder or guardian, if applicable.

2. This assistance must be provided within thirty (30) calendar days of intake or notification of Medicaid termination or lapse.

3. Failure to assist could result in services being suspended pending waitlist approval.

B. Persons served who receive inpatient services are required to be assisted with their Medicaid applications while still receiving services.

1. A tracking number for the application will be required on the first continued stay review (CSR).

2. Not providing this information will result in a claims denial and claims will not be processed for payment.

C. Persons served determined to have a Medicaid Deductible (spend-down) are responsible for the initial cost of their medical bills each month up to the amount of their deductible.

1. A person's served individual plans of service (IPOS) must clearly explain how their deductible will be met. It is expected for them to become Medicaid eligible every month.

2. Primary case holders are responsible for submitting the required paperwork to MDHHS as soon as individuals meet their deductible every month to ensure that the spend-downs are met in a timely fashion.

D. Individuals eligible for CCBHC are referred to an MCCMH directly operated program/provider or designating collaborative organization (DCO) service provider for outpatient service needs .

E. CCBHC eligible individuals shall not be restricted from receiving CCBHC covered services at a DCO or MCCMH direct program. However, restrictions may be placed on non-CCBHC covered services.

F. 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.

G. MCCMH does not provide service to individuals not covered under CCBHC or Medicaid unless authorized through the Non-Medicaid Review Committee.

H. The Local Dispute Resolution process is available to persons served without Medicaid coverage.

I. Allocation of Non-Medicaid Funds

1. Medically necessary inpatient, partial hospitalization, crisis stabilization, and crisis residential services meeting medical necessity criteria are authorized regardless of ability to pay.

2. Individuals new to the MCCMH system who have completed a Medicaid Application (including families not eligible for Medicaid but applying for Serious Emotional Disturbances (SED) or Children's Waiver) are considered presumptively eligible for sixty (60) calendar days or until a Medicaid denial is received (whichever comes first). Ability to pay (ATP) must be assessed.

3. A "waitlist" is maintained to manage all other requests for services from non-CCBHC, non-Medicaid eligible individuals. A monthly budget for wait-list services is established based on available non-Medicaid funds expected to be available after set asides for items 1 and 2 above.

4. A Non-Medicaid Review Committee (comprised of representatives from relevant MCCMH departments) shall review services authorized/performed and provide input to which services should be authorized in the following month.

J. Additional Types of Coverage

1. People with Medicaid – Emergency Services (ESO)

    a. Individuals who are non-citizens and not otherwise eligible for full Medicaid because of their immigration status may be eligible for Emergency Services Only (ESO) Medicaid.

    b. For ESO coverage, federal Medicaid regulations define an emergency medical condition (including emergency labor and delivery) as a sudden onset of a physical or mental condition which causes acute symptoms, including severe pain, where the absence of immediate medical attention could be expected to:

        i. Place the person's health in serious jeopardy

        ii. Cause serious impairment to bodily functions

iii. Cause serious dysfunction of any bodily organ or part

iv. These individuals will be eligible for Crisis Services only, as detailed in the table below, and can be placed on the waitlist should they request additional services.

2. Individuals who had Medicaid, were receiving services, and then lost Medicaid coverage will be able to continue the services described in their individual plan of service (IPOS) for up to sixty (60) calendar days after the date they lost their coverage. Reinstating Medicaid must be the priority during those sixty (60) calendar days. If Medicaid benefits are not reinstated, services may be terminated if not CCBHC eligible.

3. Individuals without Medicaid and outside of the 60-day periods will be eligible for crisis services only and placed on the waitlist should they request additional services. This is further detailed in the table below.

4. Approved exceptions to service and/or time restrictions:

    a. The non-Medicaid exception process takes the place of anything formerly referred to as "protected," such as individuals living in a "dependent" setting based on the amount of Community Living Supports (CLS).

    b. Non-Medicaid exceptions are reviewed on an individual basis with a focus placed on the health and safety of individuals and consideration of the attempts being made to get Medicaid coverage and the status of the Medicaid application.

VI. REFERENCES / LEGAL AUTHORITY

A. Michigan Public Act 258 of 1974 Section 330.1124

B. Michigan Public Act 258 of 1974 Section 330.1275

VII. EXHIBITS

A. MCCMH Non-Medicaid Benefit Matrix