COMMUNITY LIVING SUPPORTS HANDBOOK

Community Mental Health
FOR CENTRAL MICHIGAN

Introduction

The purpose of this handbook is to provide a comprehensive introduction for CMHCM case holders who are working with consumers requesting Community Living Supports (CLS). Case holders should first reference this handbook for any questions they may have regarding CLS and should follow up with their supervisors, CCOs, or Utilization Management if additional questions arise.

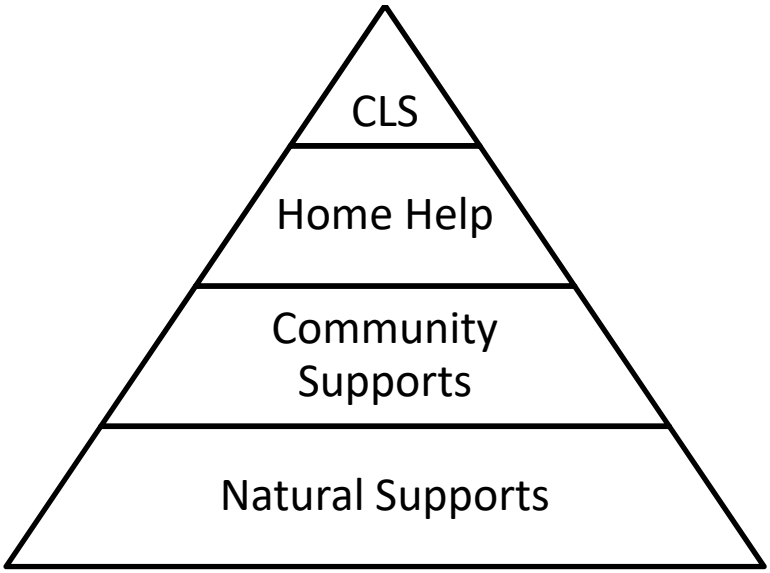
Index

Building and Developing Natural and Community Supports	**Pages 2-5**
What are Home Help (HH) Services?	**Pages 6-8**
Home Help Authorization Breakdown and Guidance	**Pages 9-10**
What are Community Living Support (CLS) Services?	**Pages 11-13**
Medical Necessity	**Pages 14-16**
CLS Guidelines around Community Inclusion and Socialization	**Pages 17-19**
CLS Authorization Guidance	**Page 20**
Behavioral Support Needs Guidelines	**Page 21**
CLS and a Consumer's Choice of Living Environment	**Page 22**
Self-Directed/Choice Voucher Arrangements	**Pages 23-24**
Talking Points for Case Holders around CLS	**Pages 25-28**
Additional Information on the Appeals Process	**Page 29**
Frequently Asked Questions regarding this Process	**Pages 30-31**
Works Cited	**Page 32**

Building and Developing Natural and Community Supports

Why do Natural and Community Supports matter?

Before we talk about CLS services, it is necessary to identify and develop a consumer's natural and community supports first and foremost. CLS is the service of last resort. Natural supports and community supports are always to be considered first regarding who may be of assistance to Community Mental Health for Central Michigan (CMHCM) consumers. The diagram below demonstrates that we assess whether outside supports are available before requesting Home Help and Community Living Support (CLS) services.



Natural supports are important to identify because these supports are generally friends and family of the consumer. These are individuals that the consumer is comfortable with and can often be called their "inner circle." Social relationships are extremely important; relationships are often our number one reason for happiness. Therefore, exploring these natural support relationships first (and thoroughly) is important.

What types of Community Supports exist for consumers?

There are Community Supports all around us if we just take the time to look. Community Supports are organizations, groups, teams, clubs, and associations that a consumer can become involved in. These types of supports meet on a regular basis, and there are generally activities that consumers can participate in to get to know each other. The following list is an example of some organizations/groups that may be in your area:

Artistic Groups: Choir groups, Theatre groups, Writing groups
Charity Organizations: American Cancer Society, American Red Cross, Habitat for Humanity, United Way
Church Groups: Bible Study, Church Volunteer groups, Prayer groups
Community Events: Art Fairs, Farmer's Markets, Holiday events (Fourth of July parades, etc.)
Cultural/Ethnic Events: Cultural events (National Pow Wow (Saginaw Chippewa Tribal Event) etc.), Museum groups
Health and Fitness Groups: Bicycling groups, Special Olympics, Walking groups
Interest Groups: Kennel Club, Vintage Car groups
Neighborhood Associations: Crime Watch, Neighborhood Beautification group
Outdoor Groups: Bird Watching Club (Audubon Society), Garden groups, Conservation clubs
Political Organizations: Democratic Party, Republican Party
Self-Help Groups: Alcoholics Anonymous, Cancer Support Groups, National Alliance on Mental Illness
Service Clubs: Lions Club, Kiwanis Club
Sports Teams: Sportsman's Club, Special Olympics
Study Groups: Bible Study groups, Book Clubs
Veteran's Groups: VA Groups (Veteran's Association), Veteran's community events (Memorial Day parade, etc.)
Youth Groups: 4H, Big Brothers Big Sisters, Youth Recreation groups

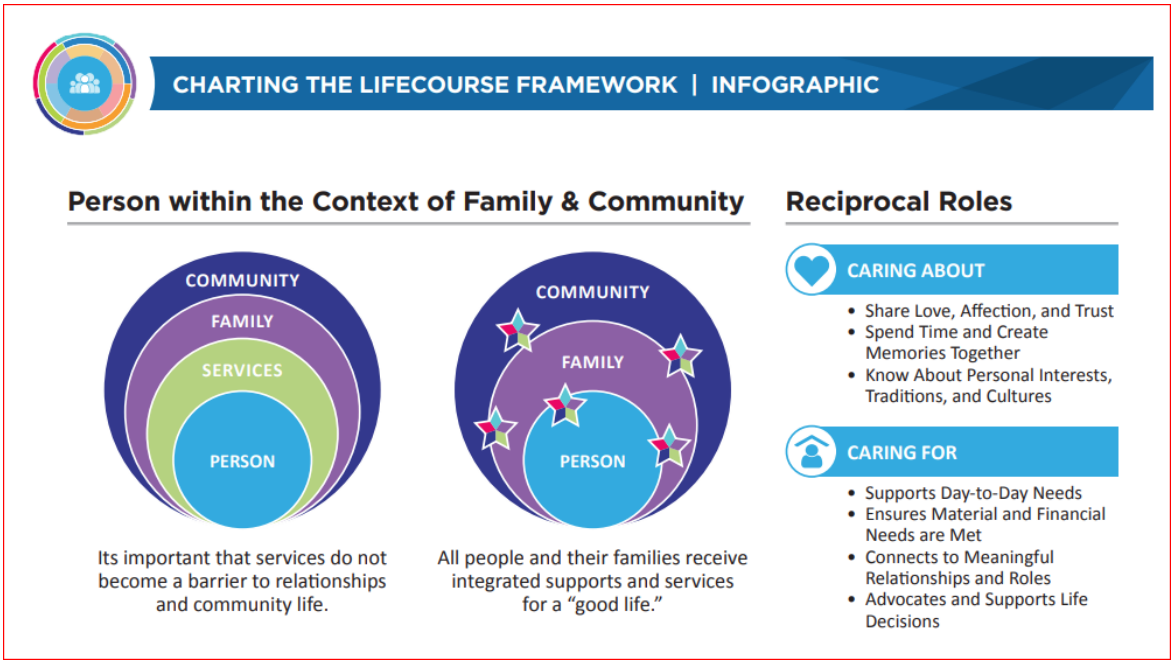
Based on this list, case holders should review and speak with consumers about their interests and help them connect with groups that may be of interest. Being involved in community activities/groups/organizations provides further integration into the community and enhances the self-worth of a person.

What do I do if a consumer does not have any natural or community supports?

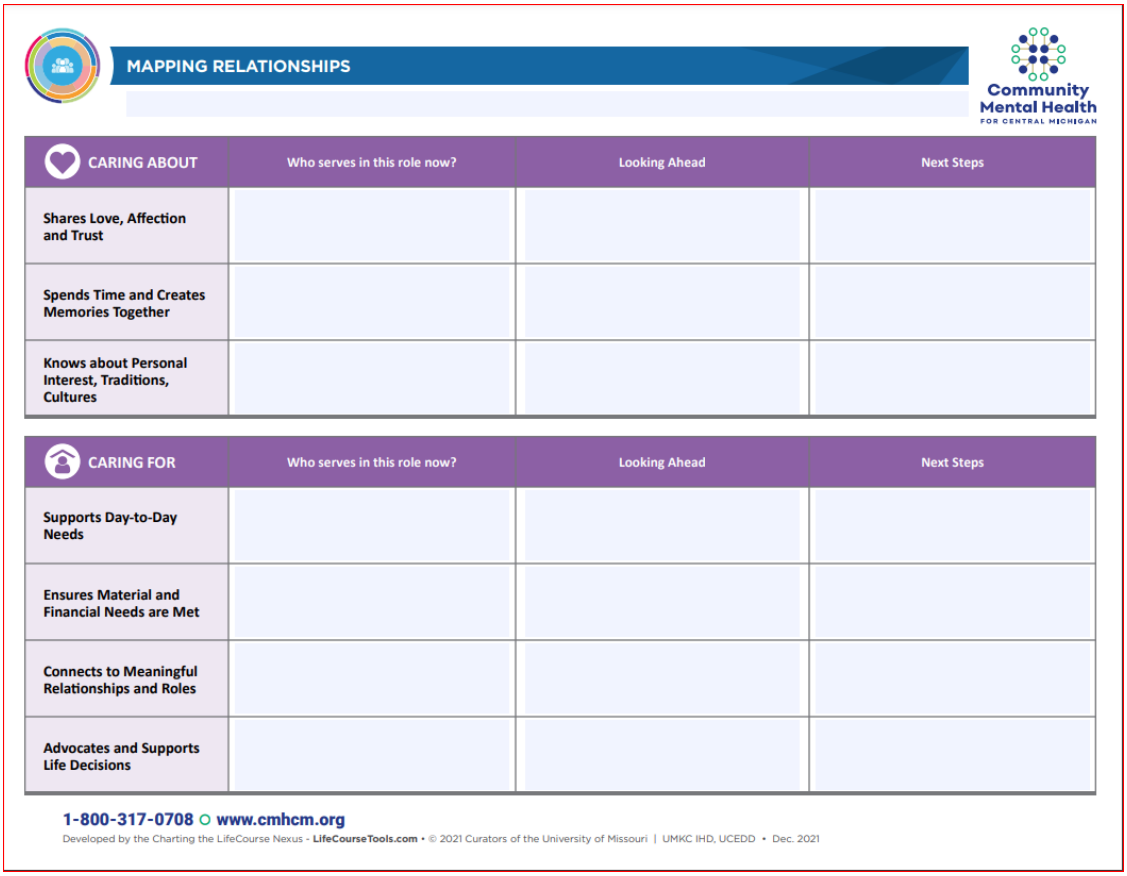
You may have a consumer who does not have any natural or community supports; in these cases, it is up to case holders to help consumers identify who and what these supports may be. CMHCM staff can use Charting the Life Course (CtLC) philosophy and tools. Case holders, reach out to your supervisor if you have questions. The infographics below show some parts of the philosophy (Charting the LifeCourse Nexus, 2020a).

"Each one of us has people in our lives that make a difference. They may be family members, friends, or people that are "like family." They could live in your house with you, down the street, or miles away. It could be your childhood best friend, a close cousin, or maybe someone you sit next to at your favorite restaurant. Each person fulfills a different role in your life. This principle highlights the importance of understanding who these people are and the impact they have on you and that you have on them. To truly understand a person and the supports they might need, it is important to know who the people in their life are and the different roles they play.

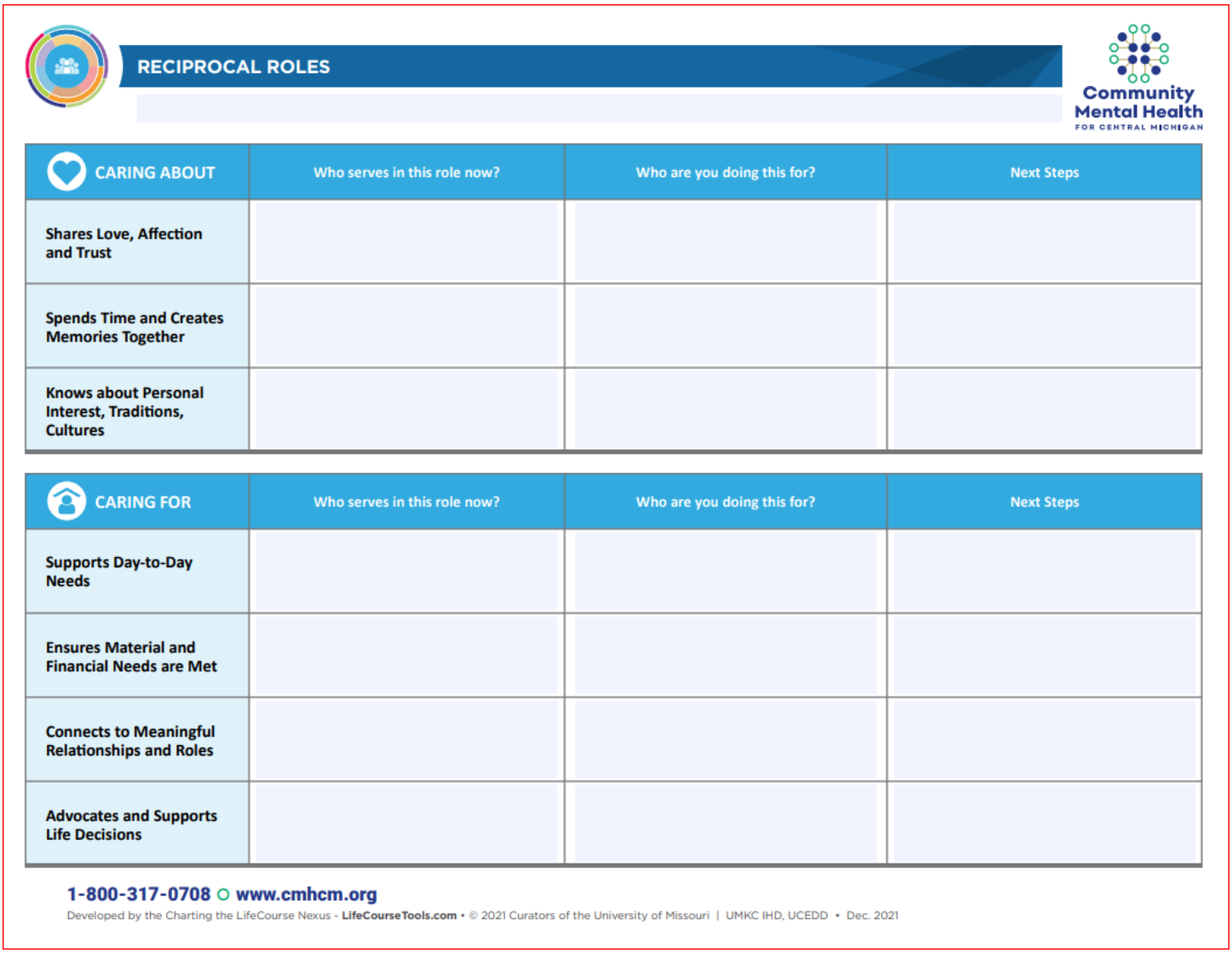
There are two Life Course tools that will help you map relationships. The Reciprocal Roles Tool will help identify the roles people play in one another's lives. The Mapping Relationships Tool helps identify the important people in your life and the different ways they provide support. These two tools can be used by anyone at any age to develop a plan for supporting a person as their needs change or the caregivers' needs change." (Charting the Lifecourse Nexus, 2020b paras 8-9)



Mapping Relationships: (Charting the LifeCourse Nexus, 2021)



Reciprocal Roles: (Charting the LifeCourse Nexus, 2021)



RECIPROCAL ROLES

Community Mental Health FOR CENTRAL MICHIGAN

CARING ABOUT	Who serves in this role now?	Who are you doing this for?	Next Steps
Shares Love, Affection and Trust			
Spends Time and Creates Memories Together			
Knows about Personal Interest, Traditions, Cultures			

CARING FOR	Who serves in this role now?	Who are you doing this for?	Next Steps
Supports Day-to-Day Needs			
Ensures Material and Financial Needs are Met			
Connects to Meaningful Relationships and Roles			
Advocates and Supports Life Decisions			

1-800-317-0708 ○ www.cmhcm.org

Developed by the Charting the LifeCourse Nexus - **LifeCourseTools.com** • © 2021 Curators of the University of Missouri | UMKC IHD, UCEDD • Dec. 2021

What are Home Help (HH) Services?

Home Help is a benefit covered by the Michigan Department of Health and Human Services (MDHHS) and must be requested through the consumer's MDHHS worker.

What do Home Help (HH) services cover?

Services covered are those characterized as unskilled and non-specialized activities including personal care essential to the care of the consumer and maintenance of the home. Services include:

Activities of Daily Living (ADL's):

Eating & Feeding; Toileting; Bathing Grooming; Dressing; Transferring; and Mobility

Instrumental Activities of Daily Living (IADL's):

Taking Medication; Meal Preparation and Clean Up; shopping for food and other necessities of daily living; Laundry; and Housework

Home Help focuses more on doing **FOR** a consumer as well as personal care tasks. Please see below for examples of what HH covers under each of these areas of Activities of Daily Living and Instrumental Activities of Daily Living.

The following are approved HH tasks according to MDHHS's FIA-721, Personal Care Services Provider Log:

APPROVED PERSONAL CARE TASKS

1. **Eating/Feeding –** helping with use of utensils, cup/glass, getting food/drink to mouth, cutting up/manipulating food on plate, cleaning face and hands, as needed after a meal.
2. **Toileting –** helping on/off toilet, commode/bed pan, emptying commode/bed pan, managing clothing, wiping and cleaning body after toileting, cleaning ostomy and/or catheter tubes/receptacles, applying diapers and disposable pads; may include doing catheter, ostomy or bowel programs.
3. **Bathing –** helping with cleaning the body or parts of the body, shampooing hair, using tub or shower, sponge bathing, including getting a basin of water, managing faucets, soaping, rinsing and drying.
4. **Grooming –** helping to maintain personal hygiene and neat appearance, including hair combing, brushing, oral hygiene, shaving, fingernail and toe nail care (unless a physician advises no to do so).
5. **Dressing –** helping with putting on/taking off, fastening/unfastening garments/undergarments, special devices such as back/leg braces, corsets, artificial limbs or splints.
6. **Transferring –** helping to move from one position to another, such as from bed to or from a wheelchair or sofa, to come to a standing position and/or repositioning to prevent skin breakdown.
7. **Mobility –** helping with walking or moving around inside the living area, changing locations in a room, moving from room to room or climbing stairs.
8. **Medication –** helping with administering prescribed or over-the-counter medication.
9. **Meal Preparation –** helping with planning menus, washing, peeling, slicing, opening packages, cans and bags, mixing ingredients, lifting pots/pans, reheating food, cooking, operating stove/microwave, setting the table, serving the meal, washing/drying dishes and putting them away.
10. **Shopping –** helping to compile a list identifying needed items, picking up items at the store, managing cart/baskets, transferring items to home and storing them away.
11. **Laundry –** helping by getting laundry to machines, sorting, handling soap containers, placing laundry into machines, operating machine controls, handling wet laundry, drying, folding and storing laundry.
12. **Light Housework –** helping with sweeping, vacuuming, washing floors, washing kitchen counters and sinks, cleaning the bathroom, changing bed linen, taking out garbage/trash, dusting and picking up, bringing in fuel for heating/cooking purposes if necessary.

According to the Adult Services Comprehensive Assessment by MDHHS; for HH services, Activities of Daily Living and Instrumental Activities of Daily Living are assessed according to the following five-point scale (ASM 120):

1.) Independent (Performs the activity safely with no human assistance)
2.) Verbal Assistance (Performs the activity with verbal assistance such as reminding, guiding or encouraging)
3.) Some Human Assistance (Performs the activity with some direct physical assistance and/or assistive technology)
4.) Much Human Assistance (Performs the activity with a great deal of human assistance and/or assistive technology)
5.) Dependent (Does not perform the activity even with human assistance and/or assistive technology)"

Home Help services may only be authorized for needs assessed to be level 3 or higher. An individual must be assessed to have at least one ADL ranked at level 3 or higher, or a complex care need, to be eligible to receive Home Help services.

Does Home Help cover more medical related tasks?

Home Help services can also accommodate Complex Care Needs. According to MDHHS, Complex Care refers to "conditions requiring intervention with special techniques and/or knowledge. These complex care tasks are performed for clients whose diagnoses and conditions require more management. The conditions may also require special treatment and equipment for which specific instructions by a health professional or client may be required in order to perform." Complex care needs may include the following: "Eating and feeding, catheters or leg bags, colostomy care, bowel program, suctioning, specialized skin care, range of motion exercises, peritoneal dialysis, wound care, respiratory treatment, ventilators (including oxygen or c-pap), injections."

Are there limits on what MDHHS allows for services? If so, what are these?

Yes, there are monthly maximum hour limits on all Instrumental Activities of Daily Living (IADL's) except medication. According to the Adult Services Manual (120) the maximum limits are as follows:

- Five hours/month for shopping
- Six hours/month for light housework
- Seven hours/month for laundry
- 25 hours/month for meal preparation.

What service exists for consumers who are elderly and have high medical needs that are not covered by HH or CLS (other than nursing homes)?

The MI Choice Waiver Program

According to MDHHS, nursing homes used to be the only choice for the aged or disabled who needed help caring for themselves. Today, there may be the choice to stay in the consumer's own home or a community setting, but the consumer or a family member may need assistance in doing so. This is where the MI Choice Waiver comes in.

Through the MI Choice Waiver Program, "eligible adults who meet income and asset criteria can receive Medicaid-covered services like those provided by nursing homes but can stay in their own home or another residential setting. The

waiver became available in all Michigan counties October 1, 1998. Each participant can receive the basic services Michigan Medicaid covers, and one or more of the following services unique to the waiver:

- Adult day health (adult day care)
- Chore services
- Community health worker
- Community living supports
- Community transportation
- Counseling
- Environmental accessibility adaptations
- Fiscal intermediary
- Goods and services
- Home delivered meals
- Nursing services
- Personal emergency response systems (PERS)
- Private duty nursing/respiratory care
- Respite services
- Specialized medical equipment and supplies
- Training in a variety of independent living skills

Eligibility for this program will be determined through MDHHS.

For Clare, Isabella, Gladwin, and Midland Counties, please call the following Waiver Agencies for more information on this program:

A&D Home Health Care, Inc.
Roselyn Argyle, Executive Director
Mike Tysick, Co-Program Director
Karen Harrison, Co-Program Director
3150 Enterprise Drive, Suite 200
Saginaw, Michigan 48603
Tele: 1-800-884-3335
989-249-0929
Fax: 989-249-1147 / 989-249-1153 - Roselyn Argyle

Region VII Area Agency on Aging
Bob Brown, Executive Director
Sue Gittins, Program Director
1615 S. Euclid Avenue
Bay City, Michigan 48706
Tele: 989-893-4506
Fax: 989-893-2651

For Mecosta and Osceola, please call the following Waiver Agencies for more information on this program:

Area Agency on Aging of Western Michigan, Inc.
Jackie O'Connor, Executive Director
Suzanne Filby-Clark, Program Director
3215 Eaglecrest Drive NE
Grand Rapids, Michigan 49525
Tele: 616-456-5664
Fax: 616-456-5692

Reliance Community Care Partners
Steven Velzen-Haner, Executive Director
Sue Baker, Waiver Director
2100 Raybrook SE, STE 203
Grand Rapids, Michigan 49546
Tele: 800-447-3007
616-956-9440
Fax: 616-954-1520

Home Help Authorization Breakdown and Guidance

Why do I have to request a Home Help (HH) assessment through MDHHS before approving CLS?

First and foremost, an HH assessment **MUST** be requested before CLS hours can be approved long term**. Due to Medicaid regulations (*Medicaid Provider Manual, 15.1. Waiver Supports and Services*), CLS hours cannot replace or supplant HH services. It is important that CMHCM know the exact amount of HH a consumer is receiving so these services can be billed to the correct source and to ensure the consumer receives the medically necessary amount of CLS. Case holders are required to obtain the most current MDHHS Time and Task forms. Once the MDHHS HH determination letter (Time and Task) is received by the case holder, it must be scanned into CIGMMO (under the DHHS tab) to ensure that we have the correct breakdown of MDHHS approved services. This allows for review and verification to ensure that proper service authorizations are put into place.

**Temporary approval for CLS services can be provided during the HH assessment process. These authorizations will be provided for no longer than a 90-day duration with the option of extension with Utilization Management review to ensure that appropriate follow-up is completed.

Where do I find the amount of MDHHS approved Home Help Hours?

Once HH services have been approved by MDHHS, a Time and Task form will be sent to the consumer/guardian.
The following image is an example of a Time and Task form sent by MDHHS (please note that under the Provider tab, an agency provider will be listed in the MDHHS Time and Task forms):

SECTION 3 - FUNCTIONAL ASSESSMENT SUMMARY

Tasks	Time/Day	Number of Days	Time/Month
Bathing	00:16	7 days per week	08:02
Dressing	00:10	7 days per week	05:01
Grooming	00:08	7 days per week	04:01
Housework	00:06	7 days per week	03:01
Laundry	00:49	1 day per week	03:31
Medication	00:02	7 days per week	01:00
Meal Preparation	00:25	7 days per week	12:32
Shopping for Food/Meds	00:30	1 day per week	02:09
Travel For Shopping	00:20	1 day per week	01:26
Total per month			40 hours 42 minutes

For this example, 40 hours and 42 minutes were approved by MDHHS per month for a variety of tasks (bathing, grooming, dressing, medications, etc.). As a case holder, you will find important information on this chart to include in a consumer's individualized plan of service; the times and tasks must be carried into the consumer's plan to ensure that these activities are being completed and followed before CLS can be provided (as CLS cannot supplant HH services). As an additional step, the time and task may also be scanned in as an attachment to the consumer's individualized plan of service to ensure that staff know the amount of time and tasks they should be providing under Home Help.

Where do I identify the HH hours in CIGMMO and in the plan of service?

The MDHHS Time and Task form should be scanned into the DHHS tab of the Legal, Consents, Correspondence section of CIGMMO.



In addition, please document the consumer's total hours and the breakdown of the time and tasks associated with Home Help in the intervention section of the consumer's Person-Centered Plan.

If CLS and HH are authorized, how do I as a case holder ensure that there is no overlap in services?

Since HH is a Medicaid State Plan service, those approved for HH must utilize those services for the approved tasks. The "Time and Task" schedule will indicate the HH areas approved as well as the amount of time and the provider. Monitoring needs to occur to make sure the HH is provided by the individual or agency paid by MDHHS. This is especially important if a family member is providing the HH (guardian, for example) and the consumer also receives CLS. If an individual (guardian) is being paid to provide HH, the individual must provide it according to the Time and Task. If it is determined that both an individual (guardian) and CLS agency will provide HH, there must be an agreement about who is responsible for each task. Once an agreement is reached on the split, a meeting with the MDHHS Adult Services Worker must occur. The MDHHS Adult Services Worker will then process the HH authorizations; one for the individual (guardian) and one for the CLS agency. The Time and Task schedules will authorize the time for each provider and task. The Time and Task schedules need to be scanned into CIGMMO under the DHHS link. Ongoing monitoring will ensure there is no overlap in service. It is important to note that while guardians can provide HH services for adults they cannot be a CLS provider for the consumer.

What are Community Living Support (CLS) Services?

What does Community Living Support services cover?

According to the Michigan Medicaid Provider Manual, CLS services are used to increase or maintain personal self-sufficiency, facilitating an individual's achievement of his goals of community inclusion and participation, independence or productivity.

The supports may be provided in the participant's residence or in community settings. Specifically:

Medicaid Services cover assisting, prompting, reminding, cueing, observing, guiding, and/or training in the following activities:

Meal Preparation; Laundry; Routine, Seasonal, and Heavy Household Care and Maintenance; Activities of Daily Living; Shopping for food and other necessities of daily living.

Medicaid Services also include Staff assistance, support and/or training with activities such as:

Money management; Non-Medical Care; Socialization and Relationship Building; Transportation from the residence to, from, and among community activities; Participation in regular community activities and recreation opportunities; Attendance at medical appointments (activities associated with helping the person attend a medical appointment such as getting into the building, finding the correct office, checking in with reception, filling out forms or providing medical history information (especially for individuals who may be unable to reliably provide their own medical info), etc. Once those things have occurred and the other professional begins providing the service, CLS (H2015) would not bill CLS (H2015) at the same time. Even if the CLS staff stays for the duration of the appointment it is considered indirect time (IND18 which is not billable as CLS to CMHCM) because the medical service is the primary service the consumer is experiencing, per MSHN, and mileage to and from medical appointments must be billed through DHHS or through their Medicaid Health Plan. Acquiring or procuring goods and non-medical services; Reminding, observing, and/or monitoring of medication administration; and Assistance with preserving the health and safety of the individual in order that he/she may reside or be supported in the most integrated, independent community setting.

Further Clarification of what CLS is, and what it is not:

CLS is a Medicaid covered service that assists, prompts, reminds, cues, observes, guides, and trains consumers on how to perform activities independently. The goal of CLS services is for consumers to learn and improve their skill sets to become more independent at home and in their community.

CLS is **NOT** a service that does FOR someone.

- CLS is not a cleaning/housekeeping service. The consumer must be directly involved in cleaning tasks, and it must be written in the consumer's plan of service as a treatment goal/objective/intervention.
- CLS staff must not perform CLS tasks without the consumer present. For example, if a consumer's goal is to learn how to prepare a meal, the consumer must be present with the staff to learn the skills associated with this task.

CLS is provided in community settings (for example, the consumer's home, library, grocery store, etc.).

CLS is **NOT** allowed while a consumer is admitted to an institutional setting such as the hospital, nursing home, or jail.

CLS services are meant to increase or maintain personal self-sufficiency, facilitating a consumer's goals of community inclusion and participation, independence and productivity. These services are to be reflected in a consumer's plan of service. If health and safety issues are present, the case holder should coordinate with the consumer and their family/guardian to determine what other supports might be able to assist with these needs.

CLS is **NOT** a safety net put in place for "what if" situations or to monitor/supervise a consumer.

- Community Mental Health for Central Michigan (CMHCM) cannot guarantee that all consumers living in their own home or in a congregate care environment are going to be 100% safe. CMHCM cannot staff for 100% safety or staff for the possibility that something may happen ("what if" situations).
- The public mental health system cannot provide ongoing 24/7 care or one-on-one support to a consumer without clinically supported documentation showing the medical necessity for why a person must live independently with this level of support.
- It is contraindicated for consumers with a diagnosis of personality disorder to have CLS staffing. If a consumer exhibits health and safety issues due to these diagnoses, other treatment options (such as evidence-based practices) must be reviewed and evaluated to determine clinical appropriateness. Supervisor consultation should occur on a case-by-case basis.

CLS can be used to complement Home Help services when the consumer's needs have been officially determined to exceed MDHHS's allowable parameters.

CLS is **NOT** meant to supplant Home Help (HH) services.

- CLS is the service of last resort. Natural Supports and Community Supports must be explored prior to authorizing CLS.
- Home Help through the Department of Human Services must be requested and assessed before CLS can be approved long-term if the person has any hands-on needs with ADL's or IADL's or uses any adaptive equipment.
- CLS services provide teaching and training for skill development related to daily living activities whereas Home Help Services through MDHHS provide direct hands-on assistance to/for the individual.

CLS services are requested on an annual basis within a person's individualized plan of service (or are reviewed if a significant change occurs through a PCP addendum). As such, clinical review by the case holder, during the PCP process, needs to be completed on an annual basis (at a minimum) to determine if continuation of the service is medically necessary. Authorizations for CLS are reviewed for medical necessity by Utilization Management.

CLS is **NOT** meant to be a fixed amount of service; authorizations must be evaluated on an annual basis for medical necessity.

- Different goals must be set each year by the treatment team to demonstrate that a consumer is improving on the skills that have been identified. If the same goal has been in place for several years, it is important to find out more information as to why this is happening:
    - Is this a goal that the consumer has identified as wanting to accomplish, or was this goal identified from another party FOR the consumer (caregiver, natural support, community support)?
    - Does the consumer want to learn this skill?
    - Is this task too difficult for the consumer to accomplish? Can it be broken down?
    - Are staff teaching the skill in a way that the consumer understands?
    - Is the objective/task too vague? Do staff understand how to teach the skill?
- If there is no improvement toward a consumer's goal, the objectives and CLS interventions must be re-assessed to determine whether the objectives or interventions need to be re-written or whether a reduction in hours is medically necessary.

CLS staff are an important part of a consumer's life due to the support they provide. Sometimes, the professional lines may become blurred. It is important that the case holder monitor these interactions to ensure that appropriate boundaries are maintained and a professional relationship is upheld.

CLS staff are **NOT** "paid friends" or "companions".

- Staff should not be taking consumers to their personal homes or apartments. CLS staff are to provide service in a consumer's home or in the community. It is the case manager's job to monitor and evaluate these situations to determine if this is occurring. Secondary gain for the CLS staff must also be reviewed to ensure that staff are not benefiting or taking advantage of the consumer. As of 10/01/2026 the MPM states; "The CLS staff's home, if not the beneficiary's residence, is not an approved setting to provide CLS services."
    - An example of secondary gain is when a CLS staff person takes a consumer back to their home to learn cleaning skills while getting paid for CLS services. This is a secondary gain, as the staff is then benefiting from the consumer cleaning the staff person's home.
- Outings related to community inclusion must relate to a consumer's goals and objectives and must be at locations (in the consumer's community) where the consumer decides to go based on their plan of service.
    - An important aspect of community integration and socialization is to remind staff that outings should include opportunities for the consumer to invite their own friends, or to go with a consumer's natural supports (if they have them). Staff should encourage consumers and guide them in developing natural and community supports to participate in these outings.
- Under no circumstance should a consumer pay for a staff person's meal, food, or beverage when it is related to a CLS activity or services that are in the consumer IPOS. The only exception is if the trip is related to a personal choice to attend, MSHN's compliance officer does not view this as a recipient rights or compliance issue if the client is agreeing to pay the staff's expenses in order for them to travel with the consumer. MSHN does recommend that the agency be clear what is being paid for by CMHCM (CLS service) and what the client/staff is paying for so there is no confusion.

Medical Necessity

What is medical necessity?

According to the Medicaid Provider Manual, medical necessity is the:

"Determination that a specific service is medically (clinically) appropriate, necessary to meet needs, consistent with the person's diagnosis, symptomatology and functional impairments, is the most cost-effective option in the least restrictive environment, and is consistent with clinical standards of care. Medical necessity of a service shall be documented in the individual plan of services" *(Medicaid Provider Manual, Mental Health/Developmental Disabilities/Substance Use, 1.7 Definition of Terms).*

Further, medical necessity criterion is defined in the Medicaid Provider Manual as (*Mental Health/Developmental Disabilities /Substance Use, 2.5.A Medical Necessity Criteria)*:

"Mental health, developmental disabilities, and substance abuse services are supports, services, and treatment:

- Necessary for screening and assessing the presence of a mental illness, developmental disability or substance use disorder; and/or
- Required to identify and evaluate a mental illness, developmental disability or substance use disorder; and/or
- Intended to treat, ameliorate, diminish or stabilize the symptoms of mental illness, developmental disability or substance use disorder; and/or
- Expected to arrest or delay the progression of a mental illness, developmental disability, or substance use disorder; and/or
- Designed to assist the beneficiary to attain or maintain a sufficient level of functioning in order to achieve their goals of community inclusion and participation, independence, recovery, or productivity."

Using the criteria for medical necessity, a PIHP may:

"Deny services:

- That are deemed ineffective for a given condition based upon professionally and scientifically recognized and accepted standards of care;
- that are experimental or investigational in nature; or
- for which there exists another appropriate, efficacious, less-restrictive, and cost-effective service, setting, or support that otherwise satisfies the standards for medically necessary services; and/or
- Employ various methods to determine amount, scope, and duration of services, including prior authorization for certain services, concurrent utilization reviews, centralized assessment and referral, gate-keeping arrangements, protocols, and guidelines.

A PIHP may not deny services based solely on preset limits of the cost, amount, scope, and duration of services. Instead, determination of the need for services shall be conducted on an individualized basis. PIHP decisions, specifically including utilization management, will not replace the PCP process. For example, utilization management review may not remove or change the beneficiary's goals. It may provide for less costly alternatives that accomplish the same goals. Edits to the beneficiary's Individual Plan of Service (IPOS) require the PCP process be reopened." *(Medicaid Provider Manual, Mental Health/Substance Use, 2.5.D PIHP Decisions).*

Decisions regarding the authorization of a BH 1915(i) SPA service (including the amount, scope and duration) must take into account the PIHP's documented capacity to reasonably and equitably serve other Medicaid beneficiaries who also have needs for these services. The BH 1915(i) SPA supports and services are not intended to meet all the individual's needs and preferences, as some needs may be better met by community and other natural supports. (*Medicaid Provider Manual, Mental Health/Substance Use, 17.3 Criteria for Authorizing BH 1915(I) SPA Supports and Services)*.

How does medical necessity relate to CLS services?

It is important that the case holder maintain the distinction of what is medically necessary and what may be requested or wanted by/for a consumer (need vs. want).

CLS is a **Medicaid** covered service, and as such, CMHCM is responsible for assessing the medical necessity of this service, in order to authorize it. For consumers who do not have Medicaid coverage, CLS hours cannot be approved (unless there is a General Funds Exception requested via consult note approved by your Chief Clinical Officer and subsequent authorization review by Utilization Management. This must be approved in advance of service delivery). Case holders must assist consumers without insurance coverage to seek community organizations and natural supports that can assist them with these areas or provide information on how to private pay for those services.

It is important to remember that all CLS requests must meet medical necessity criteria. In general, CLS services are requested to assist the consumer in attaining or maintaining a sufficient level of function to achieve his/her goals of community inclusion and participation, independence, recovery, or productivity. It is the responsibility of the case holder to review for medical necessity before requesting an authorization. The Utilization Management team reviews the requested authorization to ensure medical necessity criteria for CLS services are met.

How do case holders assess for the medical necessity of CLS services?

CLS services are assessed using the tools provided by CMHCM. The tools include the CLS assessment (located in the Performance of Major Life Activities (PMLA) assessment), the psychosocial, the Intervention and Template/Guide, Weekly Schedule, the Level of Care Grid, and the UM Guide Sheet. These tools were developed to be used as a **guide** for service requests and should be utilized by case holders to obtain a full picture of a consumer's CLS needs. The goal of these tools is to provide a comprehensive and complete review of the medical necessity of CLS in each of the areas assessed (Behavioral Supports, Community Integration, etc.). These tools will also assist case holders in developing a CLS plan which will be incorporated into a consumer's individualized plan of service. Once the services are determined to meet medical necessity criteria and the authorizations are approved, the plan of service can be signed and take effect.

How does Utilization Management assess for the medical necessity of CLS services?

Once a CLS authorization has been requested, it is reviewed by a Utilization Review Specialist (URS) for medical necessity. Using the Medical Necessity Utilization Review Tool (found on the CMHCM Intranet under the Utilization Management tab), the URS will review the consumer's clinical chart including the Psychosocial, PCP, Level of Care, PMLA/CLS Assessment, case management and CLS progress notes, HH Time and Task document, and the consumer's utilization data. The URS will complete the review based on the current documentation in the chart. If the documentation does not support the medical necessity of a service UM will complete an NABD and deny, early terminate, or decrease the service depending on the circumstances. The plan should be signed and sent out at this time. The URS may provide feedback on updates to help support the CLS request or updates for compliance. Once all recommended updates are completed a new addendum could be completed to request the service and it will again be reviewed for medical necessity.

CLS Guidelines around Community Inclusion and Socialization

What is Community Inclusion?

Community Inclusion is the opportunity for a consumer with a disability to live and participate in their community and be valued for their own unique abilities. Community Inclusion is when a consumer with a disability or disabilities has similar community presence and participation in their community as others without disabilities.

It is important for consumers to utilize their natural and community supports first (before paid supports: HH and CLS) to be a part of their community and participate in activities. Please refer to Page 4-Relationship Mapping Activity on Developing Natural and Community Supports to work with your consumer on identifying and developing these supports.

What are the benefits of a consumer becoming more independent in the community?

- Consumers will have a wider range of supports, and will have diversity in these relationships
- Less public support is needed once consumers learn skills to be independent; this means that they will not have to rely on paid professionals
- Consumers will have higher self-esteem since they will be able to perform these tasks on their own instead of relying on others

What is the goal of using CLS for Community Inclusion and Socialization?

In terms of Community Inclusion, CLS services are to focus on a consumer's skill development. This means that a staff's job is to teach a consumer the skills that are necessary for participation in the community (if this is one of their goals). Staff should not be taking consumers into the community just to take them into the community; outings are meant to correspond to learning a skill. For example, a staff person shouldn't be taking a consumer to a restaurant just to take them to the restaurant. If the consumer had a goal that incorporates learning how to interact in public by going out to a restaurant, staff must help them learn skills such as picking out healthy meal options, communicating their order, conducting conversations, exhibiting table manners, or paying the bill at the end of the meal. Skills on which to focus might include communication, self-sufficiency, relationship building, and adaptive skills

Another aspect of CLS regarding community inclusion is that CLS staff will ensure that consumers have opportunities for community participation. This means that staff will assist in strategizing access to community opportunities and arranging opportunities for community inclusion if this is a goal within the individualized plan of service.

It is important that case holders identify which environments the consumer accesses and what skills may be helpful for the consumer to identify in their goals of service. Services are to be individualized based on the interests, strengths, and preferences/priorities of a consumer. Questions to ask may include: What are your strengths and interests? What settings and activities are you able to access on your own? Which activities would you like help accessing?

What are some examples of skills related to CLS Community Inclusion Opportunities?

- Volunteer Activities
    - Identifying and signing up for a volunteer project (learning where to locate opportunities)

    - Packing necessary items for volunteer project
    - Getting to the volunteer site (learning to take the bus)
    - Interacting with other volunteers
    - Requesting assistance from other volunteers or a supervisor
- Leisure and Recreation Activities
    - Identifying activities of interest to the consumer
    - Locating activities in the community
    - Registering for activities/joining a league
    - Accessing public transportation to get to recreational setting
    - Performing the skills for the activity
    - Interacting with others at the activity/setting
- Socialization Activities
    - Identifying individuals to build relationships with
    - Requesting and keeping phone numbers/ addresses
    - Taking the bus into the community (learning the bus schedule, locating the bus stop, waiting in line, paying bus fare, getting on and off the bus)
    - Learning how to be safe in the community
- Cultural and Spiritual Activities
    - Identifying events/activities to participate in of interest to the consumer
    - Participating in activities/events
    - Interacting with others at events
- Exercising Civic rights and responsibilities
    - Registering to vote
    - Voting in the election
    - Reviewing candidate proposals or ballot items
    - Attending community gatherings/meetings
- Continuing Education/Postsecondary Education
    - Accessing and registering for adult education classes
    - Securing and utilizing transportation to classes
    - Buying required books and supplies
    - Attending and participating in class
    - Interacting with classmates/instructor
    - Completing assignments

Remember, for consumers who receive CLS services for community integration:

- CLS staff are not to replace natural or community supports that would be able to take a consumer into the community and teach these identified skills.
- CLS staff will teach the consumer skills for gaining independence and becoming integrated into the community.
- Consumers must identify the skills that they would like to learn via the PCP process and determine which community settings would be conducive to this. These skills must be supported with

goals/objectives/interventions identified within their individualized plan of service and must be medically necessary.

What are the guidelines for how often CLS should be requested for community integration? How often are activities typical for a person?

Every request for CLS services is reviewed on a case-by-case basis, and this includes requests for community integration and socialization activities. Again, CLS services are authorized for the purpose of teaching and training so the consumer can fully participate in their community, just as any other person would do so. Services must be provided in a manner that is the least restrictive and most cost effective. An example of a community integration activity which would not be approved would be going to the movie theater multiple times each week. While there may be opportunities to learn skills in this scenario, there are other settings which are more cost effective and conducive to skill development than sitting for a 2-hour movie during which there is little to no opportunity for interaction.

CLS Authorization Guidance

Community Living Support Authorization Guidance:

There are three 15-minute codes that can be used for authorizing CLS. Each authorization requires corresponding amount, scope, and duration to be documented in the intervention section of the PCP. After each code is an example of the required language; the overnight codes also include average sleep times and other compliance language.

- **H2015** is the code for CLS services to be provided during the consumer's normal awake hours.
    - McBride CLS (un)shared H2015 will be provided for X hours per week (X units per week, 1 unit = 15 minutes) for the duration of the plan
    - SD arrangement provider CLS (un)shared H2015 will be provided for X hours per week (X units per week, 1 unit = 15 minutes) for the duration of the plan
- **H2015 UJ** is the overnight code for non-waiver consumers and should be utilized for pre-determined times during which the consumer is normally sleeping as the goal of this service is to assist the consumer with staying in or safely returning to bed. This code should be used when a consumer is not able to have a PERS monitor in place as they would not understand how or be able to safely use the system.
    - SD arrangement provider CLS Overnight services (H2015 UJ) will be provided for health and safety support for the consumer 9 hours per night (between 10pm and 7am) for the duration of the plan. While these sleep hours are the average for this consumer, it is imperative that the consumer retains the ability to freely choose their sleep and wake times.
- **T2027** is the overnight code for consumers that are on a waiver and should also be used for pre-determined times that the consumer is normally sleeping with goal of assisting the consumer with staying in or safely returning to bed. There is a 12-hour cap per day as directed by MDHHS.
    - SD arrangement provider Overnight Health and Safety Supports (OHSS) (T2027) will be provided for 9 hours (36 units, 1 unit = 15 minutes) per night (between 10pm and 7am) for the duration of the plan. While these sleep hours are the average for this consumer, it is imperative that the consumer retains the ability to freely choose his sleep and wake times. The consumer requires an awake staff to provide supports at night to safeguard against injury, hazard, or accident. Consumer is unable to problem solve, complete first aid, contact 9-1-1 or have an understanding in what to do if there was a fire. Consumer has DD dx and often forgets how to complete simple tasks without someone there to walk him through it. Consumer is at risk of wandering or allowing strangers into his home if they came to the door. OHHS staff assist him with caregiving, monitoring, and addressing any care needs that come up over the night including but not limited to problem solving, emergency response, care activities that may be needed during the night that cannot be pre-planned or scheduled. Consumer is not able to have a PERS monitor in place as he would not understand or be able to safely use the system. There are no medical specialty supplies that could address this consumer's needs.

Behavioral Support Needs Guidelines

What does CMHCM provide regarding Behavioral Support Needs?

If a consumer exhibits challenging behaviors such as: Elopement Behaviors, Physical Aggression/Assaultive Behaviors toward others, Intentional Destruction of Property, Stealing, Self-Injurious Behaviors, or Inappropriate Sexual Behaviors; a Behavior Treatment plan is likely going to be needed.

The Behavior Treatment Committee (BTC) is not required to be involved with recommending or developing behavior treatment plans unless restrictive and/or intrusive interventions are being proposed for a consumer. The Behavior Treatment Committee reviews behavior plans and interventions proposing intrusive and/or restrictive interventions as indicated in the MDHHS Technical Requirements for BTPRC's. One of the requirements prior to implementing a treatment plan with intrusive and/or restrictive interventions is evidence of positive support interventions that have been attempted with the individual prior to considering intrusive/restrictive interventions. Case holders are encouraged to develop those positive support interventions as it is not required that the behavioral psychologist author positive behavior plans. However, consultation with a behavioral psychologist is available when additional guidance is needed for a positive support plan and required for a behavior treatment plan that contains restrictive or intrusive elements. If a person-centered plan includes restrictive or intrusive interventions related to behaviors not already approved by BTC the URS will send an email noting that restrictions are present in the plan. UM will approve the authorization if the hours are medically necessary, but this is not an approval of the interventions, and the treatment team will need to follow up with BTC. There are certain elements that need to be included in the plan for any restrictions, additional information on this can be found in the HCBS handbook and the HCBS IPOS Modification Guide on the intranet.

What can CLS staff do in terms of Behavioral Supports and Management?

If any of the above behaviors exist and are problematic; a Behavior Treatment plan should be developed and implemented. CLS staff would then assist in carrying out the Behavior Treatment plan as recommended by the Behavior Treatment Committee and carried through to a consumer's plan of service.

CLS and a Consumer's Choice of Living Environment

The public mental health system is not responsible for providing one-on-one supports for a consumer on a 24/7 basis unless there is clinical documentation as to why a person must live alone with that level of support. The public mental health system is responsible in assuring that medically necessary services and supports are provided to all consumers eligible for public mental health services.

Decisions regarding the authorization of a BH 1915(i) SPA service (including the amount, scope and duration) must consider the PIHP's documented capacity to reasonably and equitably serve other Medicaid beneficiaries who also have needs for these services. The BH 1915(i) SPA supports and services are not intended to meet all the individual's needs and preferences, as some needs may be better met by community and other natural supports. (Medicaid Provider Manual, Mental Health/Substance Use, 17.3 Criteria for Authorizing BH 1915(I) SPA Supports and Services).

For consumers 18 years of age and older, it is important to explore the different available options regarding their living situation. It will be necessary to explore multiple options with them such as living with family/natural supports, living with roommates, and living independently. There are different expectations associated with each living arrangement.

- **Living independently/alone**

  All consumers have a right to live alone if they choose. Saying this, the mental health system does not have an obligation to provide for all a consumer's support needs if there are other options available that may be more cost effective while meeting that consumer's support needs. All other needs would be met via natural supports, identification and connection to community resources, or with the consumer's personal financial resources.

- **Living with roommates/shared housing**

  Currently living with roommates- If a consumer is living with roommates in a shared living environment, it is expected that consumers are provided with a choice in their housing location, as well as choice of roommates. Discussions around the affordability of the living situation as well as the ability to share supports and staffing are expected.

  Living independently and transitioning into a shared living situation- If a consumer is living independently and is receiving staffing; a shared living situation may be recommended by CMHCM based on their level of needs and supports. This ensures that a consumer remains in the least restrictive setting while ensuring that their needs are met.

- **Living with Family/Natural Supports**

  If a consumer is living with family or other natural supports, there is an expectation that natural supports will assist the consumer by providing supervision and care within this setting; however, in the case of an adult, only their spouse has a legal obligation to provide care. In many cases, CLS hours would be limited due to natural supports being present to teach the consumer the skills required to become independent. Each situation should be reviewed to determine the feasibility of natural supports providing assistance.

Self-Directed/Choice Voucher Arrangements

What are Self-Directed Arrangements?

Self-direction is a fundamental human right. As stated in MDHHS's Self-Direction Implementation Technical Advisory, Self-direction is based on four principles:

- **FREEDOM**: The ability for individuals, with assistance from significant others (e.g., chosen family and/or friends), to plan a life based on acquiring necessary supports in desirable ways, rather than purchasing a program. This includes the freedom to choose where and with whom one lives, with whom and how to connect to one's community, the opportunity to contribute in one's own ways, and the development of a personal lifestyle.
- **AUTHORITY**: The assurance for a person with a disability to control a certain sum of dollars in order to purchase these supports, with the backing of their significant others, as needed. It is the authority to control resources.
- **SUPPORT**: The arranging of resources and personnel, both formal and informal, to assist the person in living his/her desired life in the community, rich in community associations and contributions. It is the support to develop a life dream and reach toward that dream.
- **RESPONSIBILITY**: The acceptance of a valued role by the person in the community through employment, affiliations, spiritual development, and caring for others, as well as accountability for spending public dollars in ways that are life-enhancing. This includes the responsibility to use public funds efficiently and to contribute to the community through the expression of responsible citizenship" (Page 1).

What is a Choice Voucher Arrangement?

The Choice Voucher System for Children provides methods that give families of children receiving services and supports from the Children's Waiver program (CWP) or the Habilitation Supports Waiver (HSW) and families of other children receiving mental health specialty services and supports meaningful authority to choose and directly hire providers of authorized services.
Additional information on Choice Vouchers is available in the Self-Determination Implementation Technical Advisory

Why is Self-Determination important?

Self-Determination is important because it means that all people have the freedom to decide how they want to live their lives, where, and with whom. To that end, relationships with others must be encouraged to grow and be protected. All individuals have the ability to contribute to their community in a meaningful way. Community membership includes having an opportunity to be employed, to have your own home, and to be involved in the routines of community life. As consumers gain control over their lives and resources, they assume greater responsibility for their decisions and actions and will receive the support they need to do so. This support comes in many forms, not always from a paid support system. In fact, the goal of the support system should be to remove barriers and build self-reliance.

"Implementing arrangements that support self-determination is a partnership between the PIHP/CMHSP and the people using mental health specialty services and supports. Once an individual plan of service and an individual budget have been developed through person-centered planning and agreed to, the person signs a Self-Determination Agreement with the PIHP/CMHSP. Each person must have an Employment Agreement with each worker and a Purchase of Services Agreement with every other provider of services or supports. To ensure that Medicaid requirements are met, each provider must sign a Self-Determination Provider Agreement with the PIHP/CMHSP" (Michigan Department of Community Health's Self-Directed Implementation Technical Advisory, page 4).

How does a Self-Determination Arrangement impact my job as a case holder?

One of the functions of Case Management is monitoring the delivery of services/supports. Whether or not there is an arrangement that supports self-directed care, the monitoring function is an essential aspect of accountability that the PIHP/CMHSP assumes.

The Medicaid requirements for documentation are the same for those using self-determination arrangements. For CLS, the requirements are the start and stop time as well as a written description of what occurred that "must be sufficiently detailed to allow reconstruction of what transpired for each service billed." And that "documentation for services provided must be signed and dated by the rendering health care professional." (Section 14.7 of the General Information for Providers Chapter of the Michigan Medicaid Provider Manual.)

Additional information on Self-directed may be found in the following:
Self-directed Implementation Technical Advisory
Self-directed and Choice Voucher Handbook for Consumers
CMHCM Policies can be found on the intranet:
2-300-003 Self-Determination
2-300-003A Self-Determination - Guideline

Talking Points for Case Holders around CLS

The following questions and answers are meant to help provide case holders with a basis around which to formulate conversations that may come up with consumers, guardians, and families.

What are Community Living Supports (CLS) Services?

CLS services are meant to help increase and maintain a person's independence, support a consumer's achievement of their goals, and promote community participation and productivity through skills training and personal assistance. These supports are provided by paid staff to help adults who are dealing with intellectual/developmental disabilities or serious mental illness. These supports may also help families who have children with an intellectual/developmental disability or a serious emotional disturbance.

How are CLS services approved?

A person-centered planning (PCP) meeting will be held to create an individualized plan of service in which goals and needs are addressed and discussion around how these goals can be met will occur. Internally, within CMHCM, we will review whether the amount, scope, and duration of the CLS services requested are medically necessary. CLS Services requested at the PCP meeting will be reviewed for medical necessity by the Utilization Management team. It is important to note that services are not automatically approved at the PCP meeting and may need additional review. The consumer/guardian or family will be notified of any changes to the requested services by mail and will have the option to appeal the decision. This will allow for equitable services to be provided across our six CMHCM counties. Please know that there are multiple assessments reviewed along with the individualized plan of service and documentation of service to determine medical necessity of CLS (these may include the LOCUS, MichiCANS, the Psychosocial assessment which includes the CLS assessment, and others).

What is medical necessity and how does it relate to CLS services?

As a mental health provider, we are fiscally responsible for providing equitable services to all consumers (across the six CMHCM counties). Medical necessity is the determination that a specific service is medically (clinically) appropriate, necessary to meet a consumer's needs, consistent with the person's diagnosis, symptoms, and functional impairments, is the most cost-effective option in the least restrictive environment and is consistent with clinical standards of care. Medical necessity of services is documented within a consumer's plan of service.

Again, CLS services must be reviewed to determine whether they are medically necessary for a consumer's case. As a case holder, it is important that we maintain the distinction of what is medically necessary and what may be requested or wanted by/for a consumer (need vs. want). We need to ensure that we promote equity across the six CMHCM counties so that everyone has equal access to CLS services. It is the case holder's responsibility to monitor services and utilization prior to the PCP date to ensure that the requested authorizations and the plan of service follow the Medicaid Provider Manual regarding the provision of CLS services.

Have CLS providers ever NOT been reimbursed for CLS services?

It is important that CMHCM works with consumers to avoid the potential misuse of Federal Medicaid dollars. In saying this, yes, there are certain situations in which CLS providers have not been reimbursed for their provision of CLS services (or they were asked to pay back an amount). Some examples of this include:

- CLS staff billing for CLS services when the service was not provided face to face or they or the consumer are sleeping, (unless authorized for Overnight Health and Safety Supports or Overnight H2015 UJ).
- CLS staff billing when another primary service is billed for at the same time. CLS staff must be performing a CLS intervention during the times billed (for example, CLS staff waiting while a consumer attends a therapy appointment is not an intervention and would not be a medically necessary service).
    - If CLS interventions are medically necessary during times which another primary service is also being billed, the CLS provider must bill their services using the IND18 code. This code must be requested separately from H2015 CLS and is reviewed for medical necessity in the same way as H2015.
- CLS staff billing for times when a consumer is in the hospital, jail, or a nursing home.

What happens if someone doesn't agree with the amount of CLS services CMHCM has approved?

If the consumer does not agree with the services authorized through CMHCM, please have them review the Medicaid or Non-Medicaid that was provided to them. If they have any questions about the appeal options or process, please have them contact CMHCM Customer Service at (989) 772-5938, (800) 317-0708, or for TTY: (989) 773-2890.

For **Medicaid** consumers, please reference the below steps in assisting them in applying for a local or State appeal:

If you do not understand any part of this Notice,
please ask for Customer Service at (989) 772-5938 or (800) 317-0708 or Michigan Relay 7-1-1.

Your Rights

If you are not happy with the determination we have taken, you may do any or all of the following:

- Ask to review your services/plan with your primary clinician or their supervisor; **and/or**
- Contact the CMHCM Recipient Rights Office by calling (989) 772-5938; **and/or**
- Request an Internal Appeal within 60 calendar days by calling our Customer Services Office (see below)

If you were denied access to all services or psychiatric hospitalization by CMHCM, you can request a Second Opinion.

- If a denial of all services, a Second Opinion will be completed within 5 business days of your request.
- If a denial for hospitalization, a Second Opinion will be completed within 3 calendar days (except Sunday/Holidays).
- To request a Second Opinion, please contact Customer Service at (989) 772-5938 or (800) 317-0708 or Michigan Relay 7-1-1.

You may choose to have another person represent you in exercising Your Rights:

- This person can be anyone you choose
- This person may request an appeal or a hearing for you
- You must give this person written permission to represent you. You may provide a letter or a copy of a court order naming this person as your guardian or conservator
- You do not need any written permission if this person is your spouse or attorney

IMPORTANT NOTE: If you file an appeal, you may ask your primary clinician or their supervisor that your services remain in place if you appeal within 10 calendar days of this determination, if the authorization has not expired, if the determination is a reduction, termination, or suspension, and if the authorization was ordered by an authorized provider. If services remain in place, you may have to repay the cost of these services if the hearing or appeal upholds the decision, if you withdraw your appeal or hearing request, or if you or your representative does not attend the hearing.

Internal Appeal Resolution

If you do not agree with this decision, you or your provider (on your behalf and with your written permission) may request an Internal Level Appeal. Your request can be made orally or in writing and must be received by Customer Service within 60 calendar days of the **Date of this Notice**.

Community Mental Health for Central Michigan
Customer Service Coordinator
The George Rouman Center
301 South Crapo, Suite 100
Mt. Pleasant, MI 48858
(989) 772-5938 or (800) 317-0708 or Michigan Relay 7-1-1

Expedited Internal Appeal Resolution:

You have a right to an "expedited" or "faster" appeal if waiting the standard time of 30 calendar days for the appeal would seriously jeopardize your life or health or your ability to attain, maintain or regain maximum function. To request an expedited appeal, you must call the Customer Service Office at the number above.

For consumers **without Medicaid** insurance (General Fund consumers) please reference the below steps in assisting them in applying for a local appeal. A non-Medicaid consumer should receive a 30-calendar day notice before services are reduced, suspended, or terminated:

If you do not understand any part of this Notice, please ask for Customer Service at (989) 772-5938 or (800) 317-0708 or Michigan Relay 7-1-1.

Your Rights

If you are not happy with the action we have taken, you may do any or all of the following:

- Ask to review your services/plan with your primary clinician or their supervisor; **and/or**
- Contact the CMHCM Recipient Rights Office by calling (989) 772-5938; **and/or**
- Request a Local Appeal within 30 calendar days by calling our Customer Services Office (see below).

If you were denied access to all services or psychiatric hospitalization by CMHCM, you can request a Second Opinion.

- If a denial of all services, a Second Opinion will be completed within 5 business days of your request.
- If a denial for hospitalization, a Second Opinion will be completed within 3 calendar days (except Sunday/Holidays).
- To request a Second Opinion, please contact Customer Service at (989) 772-5938 or (800) 317-0708 or Michigan Relay 7-1-1

Local Appeal Resolution

If you do not agree with this decision, you or your provider (on your behalf and with your written permission) may request a Local Level Appeal. Your request can be made orally or in writing and must be received by Customer Service within 30 calendar days of the **Date of this Notice**.

Community Mental Health for Central Michigan
Customer Service Coordinator
The George Rouman Center
301 South Crapo, Suite 100
Mt. Pleasant, MI 48858
(989) 772-5938 or (800) 317-0708 or Michigan Relay 7-1-1

Expedited Local Appeal Resolution:

You have a right to an "expedited" or "faster" appeal if waiting the standard time of 45 calendar days for the appeal would seriously jeopardize your life or health or your ability to attain, maintain or regain maximum function. To request an expedited hearing, you must call the Customer Service Office at the number above.

Additional Information on the Appeal Process

How should authorizations be entered if a case holder knows the consumer/guardian is going to appeal?

Sometimes there is a discrepancy between the amount of services requested by a consumer and the amount Utilization Management determines to be medically necessary. When the amount authorized differs from the amount the consumer has requested, the PCP (or PCP addendum) must be updated to match the authorization and an Adverse Benefit Determination (ABD) mailed or given to the consumer/guardian. The ABD identifies a change or denial of a service, including reduction, suspension, termination, delay, denial, or approval of a modified amount, and provides the opportunity for the consumer/guardian to appeal.

If a **Medicaid eligible consumer** appeals and requests continuation of their previous level of service, CMHCM is required to provide the previous level of service until the hearing occurs and Decisions and Orders are provided by the Administrative Law Judge. The consumer must request continuation of services within 10 calendar days of the ABD or the intended effective date for the ABD for this to occur. It is important that consumers know that if they request services to continue, and if they are not found to be medically necessary, that the consumer may have to repay the costs of those services (if the appeal is found to be in CMHCM's favor). If a consumer requests the continuation of their services, under direction from Customer Service, the case holder will complete a time limited addendum which states "an extension of services is occurring due to an appeal." The corresponding time limited authorization will be approved for the amount which was previously requested or authorized prior to the change outlined in the ABD

If a **non-Medicaid eligible consumer** (General Fund consumer) appeals, CMHCM is not required to provide continuation of services past the effective date of the ABD (30 days). The consumer is entitled to a local appeal and they can grieve the action at the State level. Consumers may request a local appeal first and an Alternative Dispute Resolution later but must exhaust the local appeal process first. Consumers have 45 days in which to file a local appeal. However, CMHCM does not have to continue services during this local appeal process as CMHCM is not mandated to provide Medicaid covered services to consumers who do not have full Medicaid healthcare coverage.

Frequently Asked Questions regarding this Process

I have families under Self-Directed arrangements who are refusing to complete the CLS documentation. They believe this is redundant with timesheets and is time-consuming; do they have to complete the CLS progress notes and documentation?

Yes, they must complete the documentation! Documentation of services is a Medicaid requirement; there are **NO** exceptions to this. SD CLS notes and timecards are completed through the electronic visit verification platform. Documentation is a crucial piece of monitoring a consumer's services, and if there is no documentation, there is no proof that a service was provided. Documentation training is provided by the Provider Network Monitor when the family starts their Self-Directed Arrangement. If a family is having a difficult time with the documentation, please provide them with guidance and instructions around completing the progress notes. You can also contact the Provider Network Monitor to request additional guidance and support for the family. If the family continues to refuse to fill out and provide documentation (which is a contract requirement); this issue should be reported to the Provider Network Monitor as this is a larger issue with their Self-Directed Arrangement and Agreement.

Does the CLS provider HAVE to be at the Psychosocial assessment meeting to determine appropriate CLS levels?

No, the CLS providers are not required to be at the Psychosocial assessment; however, if the consumer is unable to identify their needs appropriately, you should speak with their supports and staff to complete the CLS assessment. It is important that you speak with the staff to have a good understanding of the interventions that are being performed and where the consumer is within their identified goals and objectives around learning skills. It is also important to review CLS notes to help you understand what supports are being provided.

Providers have been asking if it is okay to have multiple individuals on one progress note when there is shared staffing in place; is this okay?

No, providers need to keep separate progress notes for each consumer even if there is a shared staffing situation. This is important because the information is going to be scanned into the consumer's chart, only the consumer who is being served should have their information scanned into their record; it is a potential Recipient Rights violation if there is another consumer's information within your consumer's chart. In addition, each consumer is at a different level of functioning and is at a different level of ability, so the staff should be completing individualized notes for each consumer.

As a case holder, what should I be looking for when I'm monitoring CLS progress notes?

First and foremost, you should monitor that CLS progress notes are being completed and are being completed appropriately (Is the date written down? Are start times and end times of the shift documented? Did the CLS staff sign off on the note?) In addition, one of the most important things for the case holder to review is whether the CLS note provides enough detail to describe the services provided and recreate the shift. The services provided must match the interventions listed in the PCP. This part is particularly important because if staff do not document what occurred, the service never actually happened in the eyes of Medicaid. It is also important to identify that the service is provided with the consumer present as CLS is a face-to-face service and that tasks are being completed with the consumer and not for them. If you have questions about documentation and its content, please discuss this with your supervisor. If further guidance is needed, the Provider Network or Utilization Management departments should be contacted.

We talked a lot in our CLS Training about writing interventions for each area where CLS assistance is needed. Do I really have to provide that much detail in the interventions section within the individual's plan of service?

The short and simple answer is, yes. There needs to be enough information present in the plan to guide staff in the tasks that they are meant to be doing on a daily basis. For example, if the interventions section of a PCP were to say that, "CLS staff are to assist with grooming, community safety, money management, transportation, shopping/errands, laundry, housekeeping, bathing, and dressing."

CLS staff may be wondering what all of this really means as these categories are so broad; specifically, it doesn't say how much time they are supposed to be spending on each task with the consumer. PCP's are meant to be a map/guide for staffing to follow, and that's why staff are trained on the PCP. A better description of this consumer's interventions would be the following,

> "CLS staff will verbally prompt [consumer name] with grooming activities including brushing teeth 3 times daily. CLS staff will assist the consumer in accessing the community two times per week to develop community safety skills by partially assisting the consumer in looking both ways for traffic, using crosswalks appropriately, and modeling appropriate behaviors with others in the community. CLS staff will assist the consumer in bathing at least 5 times weekly and requires hands on physical assistance for using shampoo, shaving, and overall verbally encouraging [consumer name] to practice good hygiene."

These are just some of the examples that provide more guidance to the staff that allows a clearer understanding of CMHCM's expectations regarding the hours that the consumer is authorized for. There is also an interventions template in the Utilization Management tab of the intranet. If you have specific questions regarding intervention wording or what you should include within the PCP, please consult your supervisor.

Where can I find the CLS progress notes?

CLS progress notes are located on the agency internet website, https://www.cmhcm.org/providers/provider-handbook.html , under the Providers tab-in the Provider Handbook.

Works Cited

Charting the LifeCourse Nexus. (2020a, May). *CHARTING THE LIFECOURSE FRAMEWORK INFOGRAPHIC.* Retrieved from LifeCourseTools.com: http://www.lifecoursetools.com

Charting the Lifecourse Nexus. (2020b paras 8-9). *LifeCourse FrameWork Principles*. Retrieved from lifecourse tools: https://www.lifecoursetools.com/lifecourse-library/lifecourse-framework/mapping-relationships/

Charting the LifeCourse Nexus. (2021, Dec.). *LifeCourse Tools*. Retrieved from http://www.Lifecoursetools.com